Appendix A
**PROCEDURE #1: INITIAL STEPS**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask nurse about resident’s needs, abilities and limitations, if necessary and gather necessary supplies.</td>
<td>1. Prepares you to provide best possible care to resident.</td>
</tr>
<tr>
<td>2. Knock and identify yourself before entering the resident’s room. Wait for permission to enter the resident’s room.</td>
<td>2. Maintains resident’s right to privacy.</td>
</tr>
<tr>
<td>3. Greet resident by name per resident preference.</td>
<td>3. Shows respect for resident.</td>
</tr>
<tr>
<td>4. Identify yourself by name and title.</td>
<td>4. Resident has right to know identity and qualifications of their caregiver.</td>
</tr>
<tr>
<td>5. Explain what you will be doing; encourage resident to help as able.</td>
<td>5. Promotes understanding and independence.</td>
</tr>
<tr>
<td>6. Gather supplies and check equipment.</td>
<td>6. Organizes work and provides for safety.</td>
</tr>
<tr>
<td>7. Close curtains, drapes and doors. Keep resident covered, expose only area of resident’s body necessary to complete procedure.</td>
<td>7. Maintains resident’s right to privacy and dignity.</td>
</tr>
<tr>
<td>8. Wash your hands.</td>
<td>8. Provides for Infection Control.</td>
</tr>
<tr>
<td>10. Use proper body mechanics. Raise bed to appropriate height and lower side rails (if raised).</td>
<td>10. Protects yourself and the resident from injury.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
## PROCEDURE #2: FINAL STEPS

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Remove gloves, if applicable, and wash your hands.</td>
<td>1. Provides for Infection Control.</td>
</tr>
<tr>
<td>2. Be certain resident is comfortable and in good body alignment. Use proper body mechanics</td>
<td>2. Reduces stress and improves resident’s comfort and sense of well-being.</td>
</tr>
<tr>
<td>3. Lower bed height and position side rails (if used) as appropriate.</td>
<td>3. Provides for safety.</td>
</tr>
<tr>
<td>4. Place call light and water within resident’s reach.</td>
<td>4. Allows resident to communicate with staff as necessary and encourages hydration.</td>
</tr>
<tr>
<td>5. Ask resident if anything else is needed.</td>
<td>5. Encourages resident to express needs.</td>
</tr>
<tr>
<td>6. Thank resident.</td>
<td>6. Shows your respect toward resident.</td>
</tr>
<tr>
<td>7. Remove supplies and clean equipment according to facility procedure.</td>
<td>7. Facilities have different methods of disposal and sanitation. You will carry out the policies of your facility.</td>
</tr>
<tr>
<td>8. Open curtains, drapes and door according to resident’s wishes.</td>
<td>8. Provides resident with right to choose.</td>
</tr>
<tr>
<td>9. Perform a visual safety check of resident and environment.</td>
<td>9. Prevents injury to you and resident.</td>
</tr>
<tr>
<td>10. Report unexpected findings to nurse.</td>
<td>10. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>11. Document procedures according to facility procedure.</td>
<td>11. What you document is a legal record of what you did. If you don’t document it, legally, it didn’t happen.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How to Hand wash</strong> <em>(Wash hands when visibly soiled or prior to giving care)</em></td>
<td></td>
</tr>
<tr>
<td>1. Turn on faucet with a clean paper towel.</td>
<td>1. Faucet may be used by resident/visitors and should be kept as clean as possible.</td>
</tr>
<tr>
<td>2. Adjust water to acceptable temperature.</td>
<td>2. Hot water opens pores which may cause irritation.</td>
</tr>
<tr>
<td>3. Angle arms down holding hands lower than elbows. Wet hands and wrists.</td>
<td>3. Water should run from most clean to most soiled.</td>
</tr>
<tr>
<td>4. Apply enough soap to cover all hand and wrist surfaces. Work up a lather.</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> Direct caregivers must rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers.</td>
<td></td>
</tr>
<tr>
<td>5. Rub hands palm to palm.</td>
<td>5. Lather and friction will loosen pathogens to be rinsed away.</td>
</tr>
<tr>
<td>6. Right palm over top of left hand with interlaced fingers and vice versa.</td>
<td></td>
</tr>
<tr>
<td>7. Palm to palm with fingers interlaced.</td>
<td></td>
</tr>
<tr>
<td>8. Backs of fingers to opposing palms with fingers interlocked.</td>
<td></td>
</tr>
<tr>
<td>9. Rotational rubbing, of left thumb clasped in right palm and vice versa.</td>
<td></td>
</tr>
<tr>
<td>10. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa. Clean finger nails</td>
<td></td>
</tr>
<tr>
<td>11. Rinse hands with water down from wrists to fingertips</td>
<td>11. Soap left on the skin may cause irritation and rashes.</td>
</tr>
<tr>
<td>12. Dry thoroughly with single use towels.</td>
<td></td>
</tr>
<tr>
<td>13. Use towel to turn off faucet and discard towel.</td>
<td>13. Prevents contamination of clean hands.</td>
</tr>
<tr>
<td><strong>How to Use Hand rub</strong> <em>(otherwise, use hand rub)</em></td>
<td></td>
</tr>
<tr>
<td>14. Apply a quarter sized amount of the</td>
<td>14. May refer to label for estimated amount</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>product in a cupped hand and cover all surfaces.</strong></td>
<td><strong>of product to be placed in palm.</strong></td>
</tr>
<tr>
<td>15. Rub hands palm to palm.</td>
<td>15. Thorough application will reach all surfaces of concern.</td>
</tr>
<tr>
<td>16. Right palm over left dorsum with interlaced fingers and vice versa.</td>
<td></td>
</tr>
<tr>
<td>17. Palm to palm with fingers interlaced.</td>
<td></td>
</tr>
<tr>
<td>18. Backs of fingers to opposing palms with fingers interlocked.</td>
<td></td>
</tr>
<tr>
<td>19. Rotational rubbing of left thumb clasped in right palm and vice versa.</td>
<td></td>
</tr>
<tr>
<td>20. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.</td>
<td></td>
</tr>
<tr>
<td>21. Allows hands to dry. Waterless hand rubs must be rubbed for at least 10 seconds or until dry to be effective.</td>
<td>21. The product must be dry to be effective.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
<table>
<thead>
<tr>
<th>PROCEDURE #4: GLOVES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP</strong></td>
</tr>
<tr>
<td>1. Wash hands.</td>
</tr>
<tr>
<td>2. If right-handed, slide one glove on left hand (reverse, if left-handed).</td>
</tr>
<tr>
<td>3. With gloved hand, slide opposite hand in the second glove.</td>
</tr>
<tr>
<td>4. Interlace fingers to secure gloves for a comfortable fit.</td>
</tr>
<tr>
<td>5. <strong>Check for tears/holes and replace glove, if necessary.</strong></td>
</tr>
<tr>
<td>6. If wearing a gown, pull the cuff of the gloves over the sleeves of the gown.</td>
</tr>
<tr>
<td>7. Perform procedure.</td>
</tr>
<tr>
<td>8. <strong>Remove first glove by grasping outer surface of other glove, just below cuff and pulling down.</strong></td>
</tr>
<tr>
<td>9. <strong>Pull glove off so that it is inside out.</strong></td>
</tr>
<tr>
<td>10. <strong>Hold the removed glove in a ball of the palm of your gloved hand. Do not dangle the glove downward.</strong></td>
</tr>
<tr>
<td>11. <strong>Place two fingers of un gloved hand under cuff of other glove and pull down so first glove is inside second glove.</strong></td>
</tr>
<tr>
<td>12. <strong>Dispose of gloves without touching outside of gloves and contaminating hands.</strong></td>
</tr>
<tr>
<td>13. Wash hands.</td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature                      Date

_____________________________________  ________________________  
Instructor Signature                   Date
## PROCEDURE #5: GOWN (PPE)

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wash your hands.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Open gown and hold out in front of you. Let the clean gown unfold without touching any surface.</strong></td>
<td>2. Prevents contamination of the gown.</td>
</tr>
<tr>
<td>3. Slip your hands and arms through the sleeves and pull the gown on.</td>
<td></td>
</tr>
<tr>
<td>4. Tie neck ties in a bow.</td>
<td>4. They can easily be un-tied later.</td>
</tr>
<tr>
<td><strong>5. Overlap back of the gown and tie waist ties.</strong></td>
<td>5. Ensures that your uniform is completely covered.</td>
</tr>
<tr>
<td>6. Put on gloves; extend to cover wrist of gown</td>
<td></td>
</tr>
<tr>
<td>7. Perform procedure.</td>
<td></td>
</tr>
<tr>
<td>8. <strong>Remove gloves</strong></td>
<td>8. Outside of gloves are contaminated.</td>
</tr>
<tr>
<td>9. Untie the neck, then waist ties</td>
<td></td>
</tr>
<tr>
<td><strong>10. Pull away from neck and shoulders, touching inside of gown only.</strong></td>
<td>10. By not touching the outside surface of the gown with your bare hands, it prevents contamination</td>
</tr>
<tr>
<td><strong>11. Fold gown with clean side out and place in laundry or discard if disposable.</strong></td>
<td>11. Gowns are for one use only. They must be either discarded or laundered after each use.</td>
</tr>
<tr>
<td>12. Wash your hands.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________
Student Signature       Date

_________________________  ________________________
Instructor Signature       Date
### PROCEDURE #6: MASK

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wash your hands.</td>
<td></td>
</tr>
<tr>
<td>2. Place upper edge of the mask over the bridge of your nose and tie the upper ties. If mask has elastic bands, wrap the bands around the back of your head and ensure they are secure.</td>
<td>2. Your nose should be completely covered.</td>
</tr>
<tr>
<td>3. Place the lower edge of the mask under your chin and tie the lower ties at the nape of your neck.</td>
<td>4. Your mouth should be completely covered.</td>
</tr>
<tr>
<td>4. If the mask has a metal strip in the upper edge, form it to your nose.</td>
<td>5. This will prevent droplets from entering the area beneath the mask.</td>
</tr>
<tr>
<td>5. Perform procedure.</td>
<td></td>
</tr>
<tr>
<td>6. If the mask becomes damp or if the procedure takes more than 30 minutes, you must change your mask.</td>
<td>7. Dampness of the mask will reduce its ability to protect you from pathogens. The effectiveness of the mask as a barrier is greatly diminished after 30 minutes.</td>
</tr>
<tr>
<td>7. If wearing gloves, remove them first.</td>
<td>8. This will prevent contamination of the areas you will touch when untying the mask.</td>
</tr>
<tr>
<td>8. Wash your hands.</td>
<td></td>
</tr>
<tr>
<td>9. Untie each set of ties and discard the mask by touching only the ties. Masks are appropriate for one use only.</td>
<td>10. Hands may be contaminated if you touch an area other than the ties. Masks must be discarded after each use.</td>
</tr>
<tr>
<td>10. Wash your hands.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________
Student Signature       Date

_________________________  ________________________
Instructor Signature       Date
## PROCEDURE #7: FALLING OR FAINTING

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Call for nurse and stay with resident.</strong></td>
<td>1. Allows you to get help, yet continuously provide for resident’s safety and comfort.</td>
</tr>
<tr>
<td>2. <strong>Check if resident is breathing.</strong></td>
<td>2. Provides you with information necessary to proceed with procedure.</td>
</tr>
<tr>
<td>3. <strong>Do not move resident. Leave in same position until the nurse examines the resident.</strong></td>
<td>3. Prevents further damage if resident is injured.</td>
</tr>
<tr>
<td>4. <strong>Talk to resident in calm and supportive manner.</strong></td>
<td>4. Reassures resident.</td>
</tr>
<tr>
<td>5. <strong>Apply direct pressure to any bleeding area with a clean piece of linen.</strong></td>
<td>5. Slows or stops bleeding.</td>
</tr>
<tr>
<td>6. <strong>Take pulse and respiration.</strong></td>
<td>6. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>7. <strong>Assist nurse as directed. Check resident frequently according to facility policy and procedures. Assist in documentation.</strong></td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
# PROCEDURE #8: CHOKING

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Call for nurse and stay with resident.</td>
<td>1. Allows you to get help, yet continuously provide for resident’s safety and comfort.</td>
</tr>
<tr>
<td>2. Ask if resident can speak or cough.</td>
<td>2. Identifies sign of blocked airway (not being able to speak or cough).</td>
</tr>
<tr>
<td>3. If not able to speak or cough, move behind resident and slide arms under resident’s armpits.</td>
<td>3. Puts you in correct position to perform procedure.</td>
</tr>
<tr>
<td>4. Place your fist with thumb side against abdomen midway between waist and ribcage.</td>
<td>4. Positions fist for maximum pressure with least chance of injury to resident.</td>
</tr>
<tr>
<td>5. Grasp your fist with your other hand.</td>
<td>5. Allows you to stabilize resident and apply balanced pressure.</td>
</tr>
<tr>
<td>6. Press your fist into abdomen with quick inward and upward thrust.</td>
<td>6. Forces air from lungs to dislodge object.</td>
</tr>
<tr>
<td>7. Repeat until object is expelled.</td>
<td></td>
</tr>
<tr>
<td>8. Assist with documentation.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

________________________  ________________________
Student Signature       Date

________________________  ________________________
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Call for nurse and stay with resident.</td>
<td>1. Allows you to get help, yet continuously provide for resident’s safety and comfort.</td>
</tr>
<tr>
<td>2. Place padding under head and move furniture away from resident.</td>
<td>2. Protects resident from injury.</td>
</tr>
<tr>
<td>3. Do not restrain resident or place anything in mouth, assist nurse with placing resident on his/her side</td>
<td>3. Any restriction may injure resident during seizure. Positioning resident on his/her side prevents choking if the resident should vomit.</td>
</tr>
<tr>
<td>4. Loosen resident’s clothing especially around neck.</td>
<td>4. Prevents injury or choking.</td>
</tr>
<tr>
<td>5. Note duration of seizure and areas involved.</td>
<td>5. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

Student Signature ______________________ Date ______________

Instructor Signature ______________________ Date ______________
## PROCEDURE #10: FIRE

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Remove residents from area of immediate danger.</td>
<td>1. Residents may be confused, frightened or unable to help themselves.</td>
</tr>
<tr>
<td>3. Close doors and windows to contain fire.</td>
<td>3. Prevents drafts that could spread fire.</td>
</tr>
<tr>
<td>4. Extinguish fire with fire extinguisher, if possible.</td>
<td>4. Prevents fire from spreading.</td>
</tr>
<tr>
<td>5. Follow all facility policies.</td>
<td>5. Facilities have different methods of responding to emergencies. You need to follow the procedures for your facility.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________
Student Signature       Date

_________________________  ________________________
Instructor Signature       Date
## PROCEDURE #11: FIRE EXTINGUISHER

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pull the pin.</td>
<td>1. Allows the extinguisher to be functional.</td>
</tr>
<tr>
<td>2. Aim at the base of the fire.</td>
<td>2. Targets the source of the flames, which should be found at the base.</td>
</tr>
<tr>
<td>3. Squeeze the handle.</td>
<td>3. Releases the chemical(s) to extinguish the fire.</td>
</tr>
<tr>
<td>4. Sweep back and forth at the base of the fire.</td>
<td>4. Fully extinguishes the source of the fire.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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Student Signature ___________________________ Date ___________________________

Instructor Signature ___________________________ Date ___________________________
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not take oral temperature for a resident who is unconscious, uses oxygen, or who is confused/disoriented.</td>
<td></td>
</tr>
<tr>
<td>1. Remove thermometer from storage/battery charger.</td>
<td></td>
</tr>
<tr>
<td>2. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>3. Position resident comfortably in bed or chair.</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Put on disposable sheath and place thermometer under the tongue and to one side, press button to activate the thermometer.</strong></td>
<td>4. The thermometer measures heat from blood vessels under the tongue.</td>
</tr>
<tr>
<td>5. The resident should be directed to breathe through their nose.</td>
<td></td>
</tr>
<tr>
<td>6. <strong>Instruct resident to hold thermometer in mouth with lips closed. Assist as necessary.</strong></td>
<td>6. The lips hold the thermometer in position.</td>
</tr>
<tr>
<td>7. Leave thermometer in place until signal is heard, indicating the temperature has been obtained.</td>
<td></td>
</tr>
<tr>
<td>8. <strong>Read the temperature reading on the face of the electronic device, remove the thermometer, discard the sheath, and record the reading.</strong></td>
<td>8. Record temperature immediately so you won’t forget. Accuracy is necessary because decisions regarding resident’s care may be based on your report. What you document is a legal record of what you did. If you don’t document it, legally, it didn’t happen.</td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
<tr>
<td>10. Return thermometer to storage/battery charger.</td>
<td></td>
</tr>
<tr>
<td>11. <strong>Report unusual reading to nurse.</strong></td>
<td>11. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
**PROCEDURE #13: AXILLARY TEMPERATURE**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often taken when inappropriate to take an oral temperature; particularly if resident is confused or combative</td>
<td></td>
</tr>
<tr>
<td>1. Remove thermometer from storage/battery charger.</td>
<td></td>
</tr>
<tr>
<td>2. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>3. Position resident comfortably in bed or chair.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Put on disposable sheath, remove resident’s arm from sleeve of gown, wipe armpit and ensure it is dry. Hold thermometer in place with end in center of armpit and fold resident’s arm over chest.</strong></td>
<td>4. Places thermometer against blood vessels to get reading.</td>
</tr>
<tr>
<td><strong>5. Press button to activate the thermometer.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>6. Hold thermometer in place until signal is heard, indicating the temperature has been obtained.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>7. Read the temperature reading on the face of the electronic device, remove the thermometer, discard the sheath, and record the reading.</strong></td>
<td>7. Record temperature immediately so you won’t forget. Accuracy is necessary because decisions regarding resident’s care may be based on your report. What you document is a legal record of what you did. If you don’t document it, legally, it didn’t happen.</td>
</tr>
<tr>
<td><strong>8. Assist the resident to return arm through sleeve of clothing/gown.</strong></td>
<td></td>
</tr>
<tr>
<td>9. Do final steps</td>
<td></td>
</tr>
<tr>
<td><strong>10. Return thermometer to storage/battery charger.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>11. Report unusual reading to nurse.</strong></td>
<td>11. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

Student Signature

Date

Instructor Signature

Date
### PROCEDURE #14: PULSE AND RESPIRATION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Place resident’s hand on comfortable surface.</td>
<td></td>
</tr>
<tr>
<td>3. Feel for pulse above wrist on thumb side with tips of first three fingers.</td>
<td>3. Because of artery in your thumb, pulse would not be accurate if you use your thumb.</td>
</tr>
<tr>
<td>4. Count beats for 60 seconds, noting rate, rhythm and force.</td>
<td>4. Ensures accurate count. Rate is number of beats. Rhythm is regularity of beats. Force is strength of beats.</td>
</tr>
<tr>
<td>5. Continue position as if feeling for pulse. Count each rise and fall of chest as one respiration.</td>
<td>5. Resident could alter breathing pattern if aware that respirations are being taken.</td>
</tr>
<tr>
<td>6. Count respirations for 60 seconds noting rate, regularity and sound.</td>
<td>6. Ensure accurate count. Rate is number of breaths. Regularity is pattern of breathing. Sound is type of auditory breaths heard.</td>
</tr>
<tr>
<td>7. Record pulse and respiration rates.</td>
<td>7. Record pulse and respirations immediately so you won’t forget. Accuracy is necessary because decisions regarding resident’s care may be based on your report. What you write is a legal record of what you did. If you don’t document it, legally, it didn’t happen.</td>
</tr>
<tr>
<td>8. Report unusual findings to nurse.</td>
<td>8. Provides nurse with information to assess resident’s condition and needs.</td>
</tr>
<tr>
<td>9. Do final steps</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
<table>
<thead>
<tr>
<th>PROCEDURE #15: BLOOD PRESSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP</strong></td>
</tr>
<tr>
<td>1. Do initial steps.</td>
</tr>
<tr>
<td>2. <strong>Clean earpieces and diaphragm of stethoscope with antiseptic wipe.</strong></td>
</tr>
<tr>
<td>3. Uncover resident’s arm to shoulder.</td>
</tr>
<tr>
<td>4. <strong>Rest resident’s arm, level with heart, palm upward on comfortable surface.</strong></td>
</tr>
<tr>
<td>5. <strong>Wrap proper sized sphygmomanometer cuff around upper unaffected arm approximately 1-2 inches above elbow.</strong></td>
</tr>
<tr>
<td>6. Put earpieces of stethoscope in ears.</td>
</tr>
<tr>
<td>7. <strong>Place diaphragm of stethoscope over brachial artery at elbow.</strong></td>
</tr>
<tr>
<td>8. <strong>Close valve on bulb. If blood pressure is known, inflate cuff to 20 mm/hg above the usual reading. If blood pressure is unknown, inflate cuff to 160 mm/hg.</strong></td>
</tr>
<tr>
<td>9. Slowly open valve on bulb.</td>
</tr>
<tr>
<td>10. Watch gauge and listen for sound of pulse.</td>
</tr>
<tr>
<td>11. <strong>Note gauge reading at first pulse sound.</strong></td>
</tr>
<tr>
<td>12. <strong>Note gauge reading when pulse sound disappears.</strong></td>
</tr>
<tr>
<td>13. <strong>Completely deflate and remove cuff.</strong></td>
</tr>
</tbody>
</table>
14. **Accurately record systolic and diastolic readings.**  
14. Record readings immediately so you won’t forget. Accuracy is necessary because decisions regarding resident’s care may be based on your report. What you write is a legal record of what you did. If you don’t document it, legally, it didn’t happen.

15. Do final steps.

16. **Report unusual readings to nurse.**  
16. Provides nurse with information to properly assess resident’s condition.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
## PROCEDURE #16: HEIGHT

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Using standing balance scale:</strong> Assist the resident onto the scale, facing away from the scale. Ask the resident to stand straight. Raise the rod to a level above the resident’s head. Lower the height measurement device until it rests flat on the resident’s head.</td>
<td>2. Measurements are written on the rod in inches.</td>
</tr>
<tr>
<td><strong>3. When a resident is unable to stand:</strong> Flatten the bed and place resident in supine position. Place a mark on the sheet at the top of the head and another at the bottom of the feet. Measure the distance.</td>
<td>3. Places resident in proper position and alignment; allows you to measure resident accurately.</td>
</tr>
<tr>
<td><strong>4. If the resident is unable to lay flat due to contractures:</strong> Utilize a tape measure and beginning at the top of the head, follow the curves of the spine and legs, measuring to the base of the heel.</td>
<td>4. Allows you to obtain an accurate measurement for the resident who cannot fully extend body.</td>
</tr>
<tr>
<td><strong>5. Accurately record resident’s height.</strong></td>
<td>5. Record height immediately so you won’t forget. Accuracy is necessary because decisions regarding resident’s care may be based on your report. What you write is a legal record of what you did. If you don’t document it, legally, it didn’t happen.</td>
</tr>
<tr>
<td>6. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

Student Signature ____________________________ Date ____________________________

Instructor Signature ____________________________ Date ____________________________
**PROCEDURE #17: WEIGHT**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Balance scale.</strong></td>
<td>2. Scale must be balanced on zero for weight to be accurate.</td>
</tr>
<tr>
<td>3. Depending on scale used, assist resident to stand on platform or sit in chair with feet on footrest or transport wheelchair onto scale and lock brakes.</td>
<td>3. When using chair scale, if resident has feet on floor, weight will not be accurate. Wheel locks prevent chair from moving when using a wheelchair scale.</td>
</tr>
<tr>
<td>4. <strong>When using a standard scale – lower weight to fifty pound mark that causes arm to drop. Move it back to previous mark. Move upper weight to pound mark that balances pointer in middle of square. Add lower and upper marks. When using a digital scale – press weigh button. Wait until numbers remain constant.</strong></td>
<td>4. When arm drops, weight is too high. When pointer is suspended, weight is accurate. Total gives accurate weight.</td>
</tr>
<tr>
<td>5. <strong>Subtract weight of wheelchair from total weight, if applicable.</strong></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Accurately record resident’s weight.</strong></td>
<td>6. Record weight immediately so you won’t forget. Weight changes are an indicator of resident condition. Accuracy is necessary because decisions regarding resident’s care may be based on your report. What you write is a legal record of what you did. If you don’t document it, legally, it didn’t happen.</td>
</tr>
<tr>
<td>7. Do final steps.</td>
<td></td>
</tr>
<tr>
<td>8. <strong>Report unusual reading to nurse.</strong></td>
<td>8. Provides nurse with information to assess resident’s condition and needs.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date
**PROCEDURE #18: ASSIST RESIDENT TO MOVE TO HEAD OF BED**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps. Ask another CNA to assist you if needed.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Lower head of bed and lean pillow against head board. Adjust bed height as needed.</strong></td>
<td>2. When bed is flat, resident can be moved without working against gravity. Pillow prevents injury should resident hit the head of bed. Adjusting the bed height decreases risk of injury.</td>
</tr>
<tr>
<td>3. Ask resident to bend knees, put feet flat on mattress.</td>
<td>3. Gives resident leverage to help with move.</td>
</tr>
<tr>
<td>4. <strong>Place one arm under resident’s shoulder blades and the other arm under resident’s thighs. If a draw sheet or pad is under resident, 2 caregivers should grasp the sheet or pad firmly, with trunk centered between hands.</strong></td>
<td>4. Putting your arm under resident’s neck could cause injury. Use of a draw sheet/pad causes less stress on caregiver and reduces risk of injury.</td>
</tr>
<tr>
<td>5. Ask resident to push with feet on count of three.</td>
<td>5. Enables resident to help as much as possible and reduces strain on you.</td>
</tr>
<tr>
<td>6. Place pillow under resident’s head.</td>
<td>6. Provides for resident’s comfort.</td>
</tr>
<tr>
<td>7. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________
Student Signature       Date

_________________________  ________________________
Instructor Signature      Date
## PROCEDURE #19: SUPINE POSITION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Lower head of bed.</td>
<td>2. When bed is flat, resident can be moved without working against gravity.</td>
</tr>
<tr>
<td>3. Move resident to head of bed if necessary.</td>
<td>3. Places resident in proper position in bed.</td>
</tr>
<tr>
<td>4. <strong>Position resident flat on back with legs slightly apart.</strong></td>
<td>4. Prevents friction in thigh area.</td>
</tr>
<tr>
<td>5. <strong>Align resident’s shoulder and hips.</strong></td>
<td>5. Reduces stress to spine.</td>
</tr>
<tr>
<td>6. Use supportive padding and/or float heels, if necessary.</td>
<td>6. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.</td>
</tr>
<tr>
<td>7. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

Student Signature

Date

Instructor Signature

Date
## PROCEDURE #20: LATERAL POSITION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Place resident in supine position.</td>
<td>2. Places resident in proper position and alignment.</td>
</tr>
<tr>
<td>3. <strong>Move resident to side of bed closest to you.</strong></td>
<td>3. Allows resident to be positioned in center of bed when turned.</td>
</tr>
<tr>
<td>4. Cross resident’s arms over chest.</td>
<td>4. Reduces stress on shoulders during move.</td>
</tr>
<tr>
<td>5. <strong>Slightly bend knee of nearest leg to you or cross nearest leg over farthest leg at ankle.</strong></td>
<td>5. Reduces stress on hip joint during turn.</td>
</tr>
<tr>
<td>6. <strong>Place your hands under resident’s shoulder blade and buttock. Turn resident away from you onto side.</strong></td>
<td>6. Prevents stress on shoulder and hip joints.</td>
</tr>
<tr>
<td>7. <strong>Place supportive padding behind back, between knees and ankles and under top arm.</strong></td>
<td>7. Maintains position, prevents friction and reduces pressure on bony prominences.</td>
</tr>
<tr>
<td>8. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
# PROCEDURE #21: FOWLER’S POSITION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Move resident to supine position.</td>
<td>2. Places resident in proper position and alignment.</td>
</tr>
<tr>
<td>3. Elevate head of bed 45 to 60 degrees</td>
<td>3. Improves breathing, allows resident to see room and visitors.</td>
</tr>
<tr>
<td>4. Use supportive padding if necessary.</td>
<td>4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.</td>
</tr>
<tr>
<td>5. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________          ________________________
Student Signature       Date

_____________________________________          ________________________
Instructor Signature     Date
### PROCEDURE #22: SEMI-FOWLER’S POSITION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Move resident to supine position.</td>
<td>2. Places resident in proper position and alignment.</td>
</tr>
<tr>
<td>3. Elevate head of bed 30 to 45 degrees.</td>
<td>3. Improves breathing, allows resident to see room and visitors.</td>
</tr>
<tr>
<td>4. Use supportive padding if necessary.</td>
<td>4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.</td>
</tr>
<tr>
<td>5. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

---

Student Signature  
Date

Instructor Signature  
Date
## PROCEDURE #23: SIT ON EDGE OF BED

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do initial steps.</td>
</tr>
</tbody>
</table>
| 2.  | Adjust bed height to lowest position.  
|     | 2. Allows resident’s feet to touch floor when sitting. Reduces chance of injury if resident falls. |
| 3.  | Move resident to side of bed closest to you.  
|     | 3. Resident will be close to edge of bed when sitting up. |
| 4.  | Raise head of bed to sitting position, if necessary.  
|     | 4. Resident can move without working against gravity. |
| 5.  | Place one arm under resident’s shoulder blades and the other arm under resident’s thighs.  
|     | 5. Placing your arm under the resident’s neck may cause injury. |
| 6.  | On count of three, slowly turn resident into sitting position with legs dangling over side of bed. |
| 7.  | Allow time for resident to become steady. Check for dizziness  
|     | 7. Change of position may cause dizziness due to a drop in blood pressure. |
| 8.  | Assist resident to put on shoes or slippers.  
|     | 8. Prevents sliding on floor and protects resident’s feet from contamination. |
| 9.  | Move resident to edge of bed so feet are flat on floor.  
|     | 9. Allows resident to be in stable position. |
| 10. | Do final steps. |

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

________________________  ________________________
Student Signature       Date

________________________  ________________________
Instructor Signature     Date
## PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Assist resident to sit on edge of bed.</strong> Encourage resident to sit for a few seconds to become steady. Check for dizziness.</td>
<td>2. Allows resident to adjust to position change. A change in position may cause dizziness due to drop in blood pressure.</td>
</tr>
<tr>
<td><strong>3. Place belt around resident’s waist with the buckle in front (on top of resident’s clothes) and adjust to a snug fit ensuring that you can get your hands under the belt. Position one hand on the belt at the resident’s side and the other hand at the resident’s back.</strong></td>
<td>3. Buckle is difficult to release if in back and may cause injury to ribcage if on side. Placing the belt on top of resident’s clothes maintains proper infection control procedures. The belt must be snug enough that it doesn’t slip when you are assisting resident to move.</td>
</tr>
<tr>
<td>4. Assist the resident to stand on count of three.</td>
<td>4. Allows you and resident to work together.</td>
</tr>
<tr>
<td><strong>5. Allow resident to gain balance. Ask the resident if dizzy.</strong></td>
<td>5. Change in position may cause dizziness due to a drop in blood pressure.</td>
</tr>
<tr>
<td><strong>6. Stand to side and slightly behind resident while continuing to hold onto belt.</strong></td>
<td>6. Allows clear path for the resident and puts you in a position to assist resident if needed.</td>
</tr>
<tr>
<td>7. Walk at resident’s pace.</td>
<td>7. Reduces risk of falling.</td>
</tr>
<tr>
<td>8. Return resident to chair or bed and remove belt.</td>
<td></td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

______________________________  ________________________
Student Signature       Date

______________________________  ________________________
Instructor Signature       Date
**PROCEDURE #25: TRANSFER TO CHAIR**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Place chair on resident’s unaffected side. Brace firmly against side of bed.</strong></td>
<td>2. Unaffected side supports weight. Helps stabilize chair and is shortest distance for resident to turn.</td>
</tr>
<tr>
<td>3. <strong>Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.</strong></td>
<td>3. Allows resident to adjust to position change. A significant change in position may cause dizziness due to a drop in blood pressure.</td>
</tr>
<tr>
<td>4. <strong>Stand in front of resident and apply gait belt around resident’s abdomen.</strong></td>
<td>4. Gait belts reduce strain on your back and provides for security for the resident.</td>
</tr>
<tr>
<td>5. <strong>Grasp the gait belt securely on both sides of the resident</strong></td>
<td>5. Provides security for the resident and enables them to turn.</td>
</tr>
<tr>
<td>6. <strong>Ask resident to place his hands on your upper arms.</strong></td>
<td>6. You may be injured if resident grabs around your neck.</td>
</tr>
<tr>
<td>7. <strong>On the count of three, help resident into standing position by straightening your knees.</strong></td>
<td>7. Allows you and resident to work together. Minimizes strain on your back.</td>
</tr>
<tr>
<td>8. <strong>Allow resident to gain balance, check for dizziness.</strong></td>
<td>8. Change of position may cause dizziness due to drop in blood pressure.</td>
</tr>
<tr>
<td>9. <strong>Move your feet 18 inches apart and slowly turn resident.</strong></td>
<td>9. Improves your base of support and allows space for resident to turn.</td>
</tr>
<tr>
<td>10. <strong>Lower resident into chair by bending your knees and leaning forward.</strong></td>
<td>10. Minimizes strain on your back.</td>
</tr>
<tr>
<td>11. <strong>Align resident’s body and position foot rests. Remove gait belt</strong></td>
<td>11. Shoulders and hips should be in straight line to reduce stress on spine and joints.</td>
</tr>
<tr>
<td>12. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________
Student Signature       Date

_________________________  ________________________
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Place wheelchair on resident’s unaffected side. Brace firmly against side of bed with wheels locked and foot rests out of way.</td>
<td>2. Unaffected side supports weight. Helps stabilize chair and is shortest distance for the resident to turn. Wheel locks prevent chair from moving.</td>
</tr>
<tr>
<td>3. Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.</td>
<td>3. Allows resident to adjust to position change.</td>
</tr>
<tr>
<td>4. Stand in front of resident and apply gait belt around the resident’s abdomen</td>
<td>4. Gait belts reduce strain on your back and provides for security for the resident.</td>
</tr>
<tr>
<td>5. Grasp the gait belt securely on both sides of the resident</td>
<td>5. Provides security for the resident and enables them to turn.</td>
</tr>
<tr>
<td>6. Ask resident to place his hands on your upper arms.</td>
<td>6. You may be injured if resident grabs around your neck.</td>
</tr>
<tr>
<td>7. On the count of three, help resident into standing position by straightening your knees. Stand toe to toe with resident</td>
<td>7. Allows you and resident to work together. Minimizes strain on your back.</td>
</tr>
<tr>
<td>8. Allow resident to gain balance, check for dizziness.</td>
<td>8. Change of position may cause dizziness due to drop in blood pressure.</td>
</tr>
<tr>
<td>9. Move your feet to shoulder width apart and slowly turn resident.</td>
<td>9. Improves your base of support and allows space for resident to turn.</td>
</tr>
<tr>
<td>10. Lower resident into wheelchair by bending your knees and leaning forward.</td>
<td>10. Minimizes strain on your back.</td>
</tr>
<tr>
<td>11. Align resident’s body and position foot rests. Remove gait belt.</td>
<td>11. Shoulders and hips should be in straight line to reduce stress on spine and joints.</td>
</tr>
<tr>
<td>13. Transport resident up to closed door, open door and back wheelchair through doorway.</td>
<td>13. Prevents door from closing on resident.</td>
</tr>
<tr>
<td>14. Take resident to destination and lock wheelchair.</td>
<td>14. Prevents wheelchair from rolling if resident attempts to get up.</td>
</tr>
</tbody>
</table>
15. Do final steps.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature      Date
**PROCEDURE #27: WALKING**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.</td>
<td>2. Allows resident to adjust to position change.</td>
</tr>
<tr>
<td>3. Assist resident to stand on count of three.</td>
<td>3. Allows you and resident to work together.</td>
</tr>
<tr>
<td>4. Allow resident to gain balance, check for dizziness.</td>
<td>4. Change in position may cause dizziness due to a drop in blood pressure.</td>
</tr>
<tr>
<td>5. Stand to side and slightly behind resident.</td>
<td>5. Allows clear path for the resident and puts you in a position to assist resident if needed.</td>
</tr>
<tr>
<td>6. Walk at resident’s pace.</td>
<td>6. Reduces risk of resident falling.</td>
</tr>
<tr>
<td>7. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
## PROCEDURE #28: ASSIST WITH WALKER

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Assist resident to sit on edge of bed.</strong></td>
<td>2. Allows resident to adjust to position change.</td>
</tr>
<tr>
<td>3. <strong>Place walker in front of resident as close to the bed as possible.</strong></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Have resident grasp both arms of walker.</strong></td>
<td>4. Helps steady resident.</td>
</tr>
<tr>
<td>5. <strong>Brace leg of walker with your foot and place your hand on top of walker.</strong></td>
<td>5. Prevents walker from moving.</td>
</tr>
<tr>
<td>6. <strong>Assist resident to stand on count of three, check for balance and dizziness.</strong></td>
<td>6. Allows you and resident to work together.</td>
</tr>
<tr>
<td>7. <strong>Stand to side and slightly behind resident.</strong></td>
<td>7. Puts you in a position to assist resident if needed.</td>
</tr>
<tr>
<td>8. <strong>Have resident move walker ahead 6 to 10 inches, then step up to walker moving the weak or injured leg forward to the middle of the walker while pushing down on the handles of the walker, and then bringing the unaffected leg forward even with the weak/injured leg.</strong></td>
<td>8. Resident may fall forward if he steps too far into walker.</td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________       ________________________
Student Signature       Date

_____________________________________       ________________________
Instructor Signature       Date
## PROCEDURE #29: ASSIST WITH CANE

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Check the cane for presence of rubber tip(s).</td>
<td>2. Presence of intact rubber tips decrease the risk of falls by improving traction and preventing slipping.</td>
</tr>
<tr>
<td>3. Assist resident to sit on edge of bed.</td>
<td>3. Allows resident to adjust to position change.</td>
</tr>
<tr>
<td>4. Assist resident to stand on count of three.</td>
<td>4. Allows you and resident to work together.</td>
</tr>
<tr>
<td>5. Allow resident to gain balance. Check for dizziness.</td>
<td>5. Change in position may cause dizziness due to a drop in blood pressure.</td>
</tr>
<tr>
<td>6. Have resident place cane approximately 4 inches to the side of his/her stronger/ unaffected foot. The height of the cane should be level with resident’s hip.</td>
<td></td>
</tr>
<tr>
<td>7. Stand to the affected side and slightly behind resident.</td>
<td>7. Allows clear path for the resident and puts you in a position to assist resident if needed.</td>
</tr>
<tr>
<td>8. Have resident move cane forward about 4-6 inches, step forward with weak (affected) leg to a position even with the cane. Then have resident move strong leg forward and beyond the weak leg and cane. Repeat the sequence.</td>
<td>8. Reduces risk of resident falls.</td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
## PROCEDURE #30: TRANSFER: TO STRETCHER/SHOWER BED

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Loosen sheet directly under resident and roll edges close to resident.</td>
<td>2. This sheet will be utilized to slide resident from bed to stretcher.</td>
</tr>
<tr>
<td>3. Place stretcher/shower bed at bedside. NOTE: Make certain wheels are locked. After locking wheels, ensure bed and stretcher/shower bed are at the same height. Then lower side rails.</td>
<td>3. Wheels must be locked to prevent stretcher from moving.</td>
</tr>
<tr>
<td>4. Staff should be present at the bedside as well as on the opposite side of the stretcher/shower bed. (Requires a minimum of two staff members; however the number of staff required will be depended upon the size of the resident).</td>
<td>4. To prevent resident from falling/rolling off of bed or stretcher.</td>
</tr>
<tr>
<td>5. Staff should grasp sheet on each side of resident. On the count of three, slide resident laterally onto stretcher/shower bed.</td>
<td>5. Counting to three enables staff members to work together to distribute weight evenly and prevent injury to resident and/or staff.</td>
</tr>
<tr>
<td>6. Center and align resident. Place pillow under his/her head and cover with a blanket and raise the rails of stretcher/shower bed.</td>
<td>6. Places resident in proper position and alignment. Pillow provides comfort; blanket maintains dignity, provides privacy, and keeps resident warm; raising the rails prevents resident injury.</td>
</tr>
<tr>
<td>7. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

__________________________________________________________________________  ___________________________________________________________________
Student Signature Date

__________________________________________________________________________  ___________________________________________________________________
Instructor Signature Date
**PROCEDURE #31: TRANSFER: TWO PERSON LIFT *ONLY TO BE USED IN AN EMERGENCY**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Place chair at bedside. Brace it firmly against side of bed. Lock wheels of wheelchair or Geri chair.</td>
<td>2. Helps stabilize chair and is the shortest distance for staff to turn. Wheel locks prevent chair from moving.</td>
</tr>
<tr>
<td>3. Assist resident to sit on edge of bed. Ensure there is staff on each sides of the resident.</td>
<td>3. Allows resident to adjust to position change.</td>
</tr>
<tr>
<td>4. Reach around resident’s back and grasp other assistant’s forearm above wrist. Have resident place arms around your shoulders (not your neck) or on your upper arms.</td>
<td>4. Having resident place arms on your shoulders or upper arms reduces the chance of injury to your neck.</td>
</tr>
<tr>
<td>5. Each NA should reach under resident’s knees and grasp other assistant’s forearm above wrist.</td>
<td>5. Grasping your partner’s forearm provides for support and prevents resident from slipping out of your grasp.</td>
</tr>
<tr>
<td>6. On the count of three lift resident.</td>
<td>6. Allows you to work together, and allows weight to be distributed evenly to prevent injury to resident or staff.</td>
</tr>
<tr>
<td>7. Pivot and lower resident into chair.</td>
<td></td>
</tr>
<tr>
<td>8. Align resident in chair.</td>
<td>8. Shoulders and hips should be in a straight line to reduce stress on spine and joints.</td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

____________________________________  ________________________  
Student Signature       Date

____________________________________  ________________________  
Instructor Signature       Date
## PROCEDURE #32: SHOWER/SHAMPOO

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Do initial steps.</strong></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Clean/disinfect shower area and shower chair as per facility policy. Prep the bathing area per facility policy. Gather supplies and take them into the shower area.</strong></td>
<td>2. Reduces pathogens and prevents spread of infection. Have the supplies ready when you bring the resident in the shower room to ensure resident safety.</td>
</tr>
<tr>
<td>3. <strong>Help resident remove clothing. Provide resident privacy</strong></td>
<td>3. Maintains resident’s dignity and right to privacy by not exposing body. Keeps resident warm.</td>
</tr>
<tr>
<td>4. <strong>Turn on water and have resident check water temperature for comfort, if able.</strong></td>
<td>4. Resident’s sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.</td>
</tr>
<tr>
<td>5. <strong>Assist resident into shower via wheelchair. Lock wheels of shower chair and transfer resident to shower chair. Use safety belt to secure resident stability, if indicated. Never take your eyes off the resident or turn your back to the resident while in the shower.</strong></td>
<td>5. Chair may slide if resident attempts to get up. Ensure resident safety at all times. Never transport resident in shower chair.</td>
</tr>
<tr>
<td><strong>SHAMPOO:</strong></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Give resident a washcloth to cover his/her eyes during the shampoo, if he/she desires. Place cotton balls in resident’s ears if desired.</strong></td>
<td>6. Prevents soap and water from entering into resident’s eyes and ears.</td>
</tr>
<tr>
<td>7. <strong>Wet the resident’s hair.</strong></td>
<td></td>
</tr>
<tr>
<td>8. <strong>Put a small amount of shampoo into the palm of your hand and work it into the resident’s hair and scalp using your fingertips.</strong></td>
<td>8. Utilizing fingertips massages the scalp and decreases the risk of scratching the resident.</td>
</tr>
<tr>
<td>9. <strong>Rinse the resident’s hair thoroughly.</strong></td>
<td>9. Leaving soap in the hair can cause dry scalp.</td>
</tr>
<tr>
<td>10. <strong>Use a conditioner if the resident desires you to do so.</strong></td>
<td></td>
</tr>
</tbody>
</table>
11. Let resident wash as much as possible, starting with face. Assist as needed to wash and rinse the entire body going from head to toe. Use a separate washcloth to cleanse the perineal area last.

11. Encourages resident to be independent

12. Turn off the water. Cover resident with bath blanket.

13. Remove the cotton balls from the resident’s ears, if utilized.

14. Towel dry the resident’s hair, neck and ears.

15. Give resident towel and assist to pat dry. Ensure to thoroughly pat dry under the breasts, between skin folds, in the perineal area and between toes.

15. Patting dry prevents skin tears and reduces chaffing.

16. Ensure floor area is dry and non-slip device is in place. Assist resident out of shower.

17. Use a dryer on the resident’s hair, if desired.

18. Apply lotion to skin, help resident dress, comb hair and return to room.

19. Do final steps. **Report skin abnormalities to the nurse**

19. Combing hair in shower room allows resident to maintain dignity when returning to room.

---

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Offer resident urinal or bedpan.</td>
<td>2. Reduces chance of urination during procedure which may cause discomfort and embarrassment.</td>
</tr>
<tr>
<td>3. Provide Resident privacy</td>
<td>3. Maintains resident’s dignity and right to privacy by not exposing body. Keeps resident warm.</td>
</tr>
<tr>
<td>4. Fill bath basin with warm water and have resident check water temperature for comfort, if able.</td>
<td>4. Resident’s sense of touch may be different than yours; therefore, resident is best able to identify a comfortable water temperature.</td>
</tr>
<tr>
<td>5. Put on gloves.</td>
<td>5. Protects you from contamination by body fluids.</td>
</tr>
<tr>
<td>6. Fold washcloth and wet.</td>
<td></td>
</tr>
<tr>
<td>7. Gently wash eye from inner corner to outer corner, using a different part of cloth to wash other eye.</td>
<td>7. Helps prevent eye infection. Always wash from clean to dirty. Using separate area of cloth reduces contamination.</td>
</tr>
<tr>
<td>8. Wet washcloth and apply soap, if requested. Wash, rinse and pat dry face, neck, ears and behind ears.</td>
<td>8. Patting dry prevents skin tears and reduces chaffing.</td>
</tr>
<tr>
<td>9. Remove resident’s gown.</td>
<td></td>
</tr>
<tr>
<td>10. Place towel under far arm.</td>
<td>10. Prevents linen from getting wet.</td>
</tr>
<tr>
<td>11. Wash, rinse and pat dry hand, arm, shoulders and underarm.</td>
<td>11. Soap left on the skin may cause itching and irritation.</td>
</tr>
<tr>
<td>12. Repeat steps with other arm.</td>
<td></td>
</tr>
<tr>
<td>13. Place towel over chest and abdomen. Lower bath blanket to waist.</td>
<td>13. Maintains resident’s right to privacy.</td>
</tr>
<tr>
<td>14. Lift towel and wash, rinse and pat dry chest and abdomen.</td>
<td>14. Exposing only the area of the body necessary to do the procedure maintains resident’s dignity and right to privacy.</td>
</tr>
<tr>
<td>15. Pull up bath blanket and remove towel.</td>
<td></td>
</tr>
<tr>
<td>16. Uncover and place towel under far leg.</td>
<td>16. Prevents linen from getting wet.</td>
</tr>
<tr>
<td>17. Wash, rinse and pat dry leg and foot.</td>
<td>17. Soap left on the skin may cause itching</td>
</tr>
<tr>
<td>Be sure to wash, rinse and dry well between the toes.</td>
<td>and irritation.</td>
</tr>
<tr>
<td>18. Repeat with other leg and foot.</td>
<td></td>
</tr>
<tr>
<td>19. Change bath water and gloves, wash hands and use clean gloves and towel.</td>
<td>19. Water is contaminated after washing feet. Clean water should be used for neck and back.</td>
</tr>
<tr>
<td>20. Assist resident to spread legs and lift knees, if possible.</td>
<td>20. Exposes perineal area.</td>
</tr>
<tr>
<td>21. Wet and soap folded washcloth.</td>
<td>21. Folding creates separate areas on cloth to reduce contamination.</td>
</tr>
<tr>
<td>Catheter Care:</td>
<td></td>
</tr>
<tr>
<td>22. If resident has catheter, check for leakage, secretions or irritation. Gently wipe four inches of catheter from meatus out.</td>
<td>22. Washes pathogens away from the meatus.</td>
</tr>
<tr>
<td>Perineal Care:</td>
<td></td>
</tr>
<tr>
<td>23. Wipe from front to back and from center of perineum to thighs. If washcloth is visibly soiled, change cloths.</td>
<td>23. Prevents spread of infection.</td>
</tr>
<tr>
<td>For Females:</td>
<td></td>
</tr>
<tr>
<td>• Separate labia. Wash urethral area first.</td>
<td></td>
</tr>
<tr>
<td>• Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke.</td>
<td></td>
</tr>
<tr>
<td>For Males:</td>
<td></td>
</tr>
<tr>
<td>A. Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning with urethra.</td>
<td></td>
</tr>
<tr>
<td>B. Continue washing down the penis to the scrotum and inner thighs. Rinse off soap and dry. Return</td>
<td>Males: Removes secretions from beneath foreskin which may cause infection and odor.</td>
</tr>
<tr>
<td>Females: Removes secretions in skin folds which may cause infection or odor.</td>
<td></td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>24.</td>
<td>Change water in basin. Wash hands and change gloves. With a clean washcloth, rinse area thoroughly in the same direction as when washing.</td>
</tr>
<tr>
<td>25.</td>
<td>Gently pat area dry with towel in same direction as when washing.</td>
</tr>
<tr>
<td>26.</td>
<td>Assist resident to lateral position, facing away from you.</td>
</tr>
<tr>
<td>27.</td>
<td>Wet and soap washcloth.</td>
</tr>
<tr>
<td>28.</td>
<td>Clean anal area from front to back. Rinse and pat dry thoroughly.</td>
</tr>
<tr>
<td>29.</td>
<td>Change bath water and gloves. Use clean washcloth and towel.</td>
</tr>
<tr>
<td>30.</td>
<td>Wash, rinse and pat dry from neck to buttocks.</td>
</tr>
<tr>
<td>31.</td>
<td>Return to supine position.</td>
</tr>
<tr>
<td>32.</td>
<td>Wash hands and change gloves</td>
</tr>
<tr>
<td>33.</td>
<td>Help resident put on clean gown.</td>
</tr>
<tr>
<td>34.</td>
<td>Do Final Steps</td>
</tr>
<tr>
<td>35.</td>
<td>Report any reddened areas, abrasions or bruises to the nurse.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

Student Signature ________________________ Date ________________________

Instructor Signature ________________________ Date ________________________
## PROCEDURE #34: BACK RUB

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Place resident in lateral position with neck/back toward you.</td>
<td></td>
</tr>
<tr>
<td>3. Expose back and shoulders.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Rub lotion between your hands.</strong></td>
<td>4. Warms lotion and increases resident’s comfort.</td>
</tr>
<tr>
<td><strong>5. Make long, firm strokes along spine from buttocks to shoulders. Make circular strokes down on shoulders, upper arms and back to buttocks.</strong></td>
<td>5. Long upward strokes releases muscle tension. Circular strokes increase circulation in muscle area.</td>
</tr>
<tr>
<td><strong>6. Repeat for at least 3-5 minutes.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>7. Gently pat off excess lotion with towel. Cover and position as resident requests.</strong></td>
<td>7. Provides for resident’s comfort.</td>
</tr>
<tr>
<td>8. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

______________________________  ________________________
Student Signature       Date

______________________________  ________________________
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Gently comb and brush resident’s hair.</td>
<td>2. Reduces hair breakage, scalp pain, and irritation.</td>
</tr>
<tr>
<td>3. Provide the resident privacy.</td>
<td>3. Maintains resident’s dignity and right to privacy by not exposing body.</td>
</tr>
<tr>
<td>4. Remove resident’s gown or pajama top. Place a towel around resident’s neck and shoulders. Lower head of bed.</td>
<td>4. Decreases the chance of resident getting wet.</td>
</tr>
<tr>
<td>5. Have resident check temperature of water to be used for comfort, if able.</td>
<td>5. Resident’s sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature</td>
</tr>
<tr>
<td>6. Place bed shampoo basin under resident’s head according to manufacturer’s instructions.</td>
<td>6. If equipment is not applied according to manufacturer’s instruction, discomfort or injury could result.</td>
</tr>
<tr>
<td>7. Place wash basin on chair to catch water flowing from shampoo basin.</td>
<td></td>
</tr>
<tr>
<td>8. Pour water carefully over resident’s hair.</td>
<td></td>
</tr>
<tr>
<td>9. Lather hair with shampoo using fingertips. Rinse thoroughly. Apply conditioner to resident’s hair if requested. Rinse thoroughly.</td>
<td>9. Utilizing fingertips massages the scalp and decreases the risk of scratching resident.</td>
</tr>
<tr>
<td>10. Squeeze excess water from hair. Towel dry hair.</td>
<td></td>
</tr>
<tr>
<td>11. Replace gown or pajama top.</td>
<td></td>
</tr>
<tr>
<td>12. Comb and brush resident’s hair. Dry hair with dryer if resident wishes.</td>
<td>12. Helps maintain resident’s dignity and self-esteem.</td>
</tr>
<tr>
<td>13. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
**PROCEDURE #36: ORAL CARE FOR THE ALERT AND ORIENTED RESIDENT**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps. Check with nurse if the resident is on swallowing precautions.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Raise head of bed so resident is sitting up.</strong></td>
<td>2. Prevents fluids from running down resident’s throat, causing choking.</td>
</tr>
<tr>
<td><strong>4. Drape towel under resident’s chin.</strong></td>
<td>4. Protects resident’s clothing and bed linen.</td>
</tr>
<tr>
<td>5. Wet toothbrush and put on apply small amount of toothpaste.</td>
<td>5. Water helps distribute toothpaste.</td>
</tr>
<tr>
<td><strong>6. First brush upper teeth and then lower teeth.</strong></td>
<td>6. Brushing upper teeth minimizes production of saliva in lower part of mouth.</td>
</tr>
<tr>
<td>7. Hold emesis basin under resident’s chin.</td>
<td></td>
</tr>
<tr>
<td><strong>8. Ask resident to rinse mouth with water and spit into emesis basin.</strong></td>
<td>8. Removes food particles and toothpaste.</td>
</tr>
<tr>
<td>9. If requested, give resident mouthwash diluted with half water.</td>
<td>9. Full strength mouthwash may irritate resident’s mouth.</td>
</tr>
<tr>
<td><strong>10. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.</strong></td>
<td>10. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>11. Remove towel and wipe resident’s mouth.</td>
<td></td>
</tr>
<tr>
<td><strong>12. Remove gloves.</strong></td>
<td></td>
</tr>
<tr>
<td>13. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
# PROCEDURE #37: ORAL CARE FOR AN UNCONSCIOUS RESIDENT

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Drape towel over pillow and a towel under resident’s chin.</td>
<td>2. Protects linen.</td>
</tr>
<tr>
<td>3. Turn resident onto unaffected side.</td>
<td>3. Prevents fluids from running down resident’s throat, causing choking.</td>
</tr>
<tr>
<td>4. Put on gloves.</td>
<td>4. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>5. Place an emesis basin under resident’s chin.</td>
<td>5. Protects resident’s clothing and bed linen.</td>
</tr>
<tr>
<td>6. Dip swab in cleaning solution of ½ mouthwash and ½ water and wipe teeth, gums, tongue and inside surfaces of mouth, changing swab frequently.</td>
<td>7. Stimulates gums and removes mucous.</td>
</tr>
<tr>
<td>7. Rinse with clean swab dipped in water.</td>
<td>8. Removes solution from mouth.</td>
</tr>
<tr>
<td>8. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.</td>
<td>9. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>10. Remove gloves.</td>
<td></td>
</tr>
<tr>
<td>11. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date  

_____________________________________  ________________________  
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Raise head of bed so resident is sitting up.</td>
<td>2. Prevents fluids from running down resident’s throat, causing choking.</td>
</tr>
<tr>
<td>3. Put on gloves.</td>
<td>3. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>4. Drape towel under resident’s chin.</td>
<td>4. Protects resident’s clothing and bed linen.</td>
</tr>
<tr>
<td>5. Remind resident that you are going to remove their dentures. Remove upper dentures by placing your index finger at the ridge on top of the right upper denture and gently moving them up and down to release suction. Turn lower denture slightly to lift out of mouth.</td>
<td>5. Prevents injury or discomfort to resident. And reduces chances of bite for staff. Removing upper dentures first is more comfortable for the resident and placing your finger at the ridge decreases the chance of stimulating the gag reflex.</td>
</tr>
<tr>
<td>6. Put dentures in denture cup marked with resident’s name and take to sink.</td>
<td></td>
</tr>
<tr>
<td>7. Line sink with towel and fill halfway with water.</td>
<td>7. Prevents dentures from breaking if dropped.</td>
</tr>
<tr>
<td>8. Apply denture cleaner to toothbrush</td>
<td></td>
</tr>
<tr>
<td>9. Hold dentures over sink and brush all surfaces.</td>
<td></td>
</tr>
<tr>
<td>10. Rinse dentures under warm water, place in a clean cup and fill with cool water.</td>
<td>10. Hot water may damage dentures.</td>
</tr>
<tr>
<td>11. Clean resident’s mouth with swab if necessary. Help resident rinse mouth with water or mouthwash diluted with half water, if requested.</td>
<td>11. Removes food particles. Full strength mouthwash may irritate resident’s mouth.</td>
</tr>
<tr>
<td>12. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.</td>
<td>12. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>13. Help resident place dentures in mouth, if requested. Moisturize the lips</td>
<td>13. Restores resident’s dignity and keeps lips from drying and cracking. Improves</td>
</tr>
</tbody>
</table>
resident comfort.

### 14. Remove gloves.

### 15. Do final steps.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________
Student Signature       Date

_________________________  ________________________
Instructor Signature     Date
PROCEDURE #39: ELECTRIC RAZOR

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Raise head of bed so resident is sitting up.</td>
<td>2. Places resident in more natural position.</td>
</tr>
<tr>
<td>3. <strong>Do not use electric razor near any water source, when oxygen is in use or if resident has pacemaker.</strong></td>
<td>3. Electricity near water may cause electrocution. Electricity near oxygen may cause explosion. Electricity near some pacemakers may cause an irregular heartbeat.</td>
</tr>
<tr>
<td>4. <strong>Drape towel under resident’s chin.</strong></td>
<td>4. Protects resident’s clothing and bed linen.</td>
</tr>
<tr>
<td>5. <strong>Put on gloves.</strong></td>
<td>5. Shaving may cause bleeding. Protects you from potential contamination.</td>
</tr>
<tr>
<td>6. Apply pre-shave lotion as resident requests.</td>
<td></td>
</tr>
<tr>
<td>7. <strong>Hold skin taut and shave resident’s face and neck according to manufacturer’s guidelines.</strong></td>
<td>7. Smoothes out skin. Shave beard with back and forth motion in direction of beard growth with foil (oscillating blades) shaver. Shave beard in circular motion with three head (rotary, circular blades) shaver.</td>
</tr>
<tr>
<td>8. Check for any breaks in the skin. Apply after-shave lotion as resident requests.</td>
<td>8. Decreases risk of pain from aftershave getting into any breaks in the skin. Improves resident’s self-esteem.</td>
</tr>
<tr>
<td>9. Remove towel from resident.</td>
<td>9. Restores resident’s dignity.</td>
</tr>
<tr>
<td><strong>10. Remove gloves.</strong></td>
<td></td>
</tr>
<tr>
<td>11. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________
Instructor Signature  Date
## PROCEDURE #40: SAFETY RAZOR

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Raise head of bed so resident is sitting up.</td>
<td>2. Places resident in more natural position.</td>
</tr>
<tr>
<td>3. Fill bath basin halfway with warm water.</td>
<td>3. Hot water opens pores and causes irritation.</td>
</tr>
<tr>
<td>4. Drape towel under resident’s chin.</td>
<td>4. Protects resident’s clothing and bed linen.</td>
</tr>
<tr>
<td>5. Put on gloves.</td>
<td>5. Shaving may cause bleeding. Protects you from potential contamination.</td>
</tr>
<tr>
<td>6. Moisten beard with washcloth and spread shaving cream over area.</td>
<td>6. Softens skin and hair.</td>
</tr>
<tr>
<td>7. Hold skin taut and shave beard in downward strokes on face and upward strokes on neck.</td>
<td>7. Maximizes hair removal by shaving in the direction of hair growth.</td>
</tr>
<tr>
<td>8. Rinse resident’s face and neck with washcloth.</td>
<td>8. Removes soap which may cause irritation.</td>
</tr>
<tr>
<td>9. Pat dry with towel.</td>
<td></td>
</tr>
<tr>
<td>10. Apply after-shave lotion, as requested.</td>
<td>10. Improves resident’s self-esteem.</td>
</tr>
<tr>
<td>11. Remove towel.</td>
<td></td>
</tr>
<tr>
<td>12. Remove gloves.</td>
<td></td>
</tr>
<tr>
<td>13. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
## PROCEDURE #41: COMB/BRUSH HAIR

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Raise head of bed so resident is sitting up.</td>
<td>2. Places resident in position to access hair.</td>
</tr>
<tr>
<td>3. <strong>Drape towel over pillow.</strong></td>
<td>3. Protects resident’s clothing and bed linen.</td>
</tr>
<tr>
<td>4. Remove resident’s glasses and any hairpins or clips.</td>
<td></td>
</tr>
<tr>
<td>5. <strong>Remove tangles by dividing hair into small sections and gently combing out from the ends of hair to scalp.</strong></td>
<td></td>
</tr>
<tr>
<td>6. Use hair products, as resident requests.</td>
<td></td>
</tr>
<tr>
<td>7. <strong>Style hair as resident requests.</strong></td>
<td>7. Improves resident’s self-esteem.</td>
</tr>
<tr>
<td>8. Offer mirror.</td>
<td></td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________
Student Signature       Date

_________________________  ________________________
Instructor Signature     Date
PROCEDURE #42: FINGERNAIL CARE

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Check fingers and nails for color, swelling, cuts or splits. Check hands for extreme heat or cold. Report any unusual findings to nurse before continuing procedure.</td>
<td>2. Provides nurse with information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>3. Raise head of bed so resident is sitting up.</td>
<td>3. Places resident in more natural position.</td>
</tr>
<tr>
<td>4. Fill bath basin halfway with warm water and have resident check water temperature for comfort.</td>
<td>4. Resident’s sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.</td>
</tr>
<tr>
<td>5. Soak resident’s hands and pat dry.</td>
<td>5. Nail care is easier if nails are softened.</td>
</tr>
<tr>
<td>7. Clean under nails with orange stick.</td>
<td>7. Pathogens can be harbored beneath the nails.</td>
</tr>
<tr>
<td>8. Clip fingernails straight across, then file in a curve.</td>
<td>8. Clipping nails straight across prevents damage to skin. Filing in a curve creates smooth nails and eliminates edge which may catch on clothes or cause skin tear.</td>
</tr>
<tr>
<td>9. Remove gloves.</td>
<td></td>
</tr>
<tr>
<td>10. Do final Steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
## PROCEDURE #43: FOOT CARE (BASIN)

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Fill the basin halfway with warm water. Have resident check the water temperature</td>
<td>2. To prevent resident from scalding or burning his/her feet.</td>
</tr>
<tr>
<td>3. Place basin on towel or bathmat.</td>
<td></td>
</tr>
<tr>
<td>4. Remove resident’s socks. Completely submerge resident’s feet in water and soak for five to ten minutes.</td>
<td></td>
</tr>
<tr>
<td>5. Put on gloves.</td>
<td></td>
</tr>
<tr>
<td>6. Remove one foot from water. Wash entire foot, including between the toes and around the nail beds using a soapy washcloth.</td>
<td></td>
</tr>
<tr>
<td>7. Rinse entire foot, including between the toes.</td>
<td>7. Soap left on the skin may cause itching and irritation.</td>
</tr>
<tr>
<td>8. Dry entire foot, including between the toes.</td>
<td>8. Thoroughly drying skin reduces irritation and chaffing.</td>
</tr>
<tr>
<td>9. Repeat steps with the other foot.</td>
<td></td>
</tr>
<tr>
<td>10. Place lotion in hand, warm lotion by rubbing hands together, and then massage lotion into entire foot (top and bottom) except between toes, removing excess with a towel.</td>
<td></td>
</tr>
<tr>
<td>11. Assist resident to replace socks.</td>
<td></td>
</tr>
<tr>
<td>12. Do final steps.</td>
<td></td>
</tr>
<tr>
<td>13. Report any cuts, sores, or other findings to the nurse</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
### PROCEDURE #44: CHANGING RESIDENT’S GOWN

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Untie soiled gown.</strong></td>
<td>2. Maintains resident’s dignity and right to privacy by not exposing body. Keeps resident warm.</td>
</tr>
<tr>
<td>3. Raise top sheet over resident’s chest.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Remove resident’s arms from gown, unaffected arm first.</strong></td>
<td>4. Undressing unaffected arm first requires less movement.</td>
</tr>
<tr>
<td><strong>5. Roll soiled gown from neck down and remove from beneath top sheet. Place soiled gown in dirty linen bag.</strong></td>
<td>5. Rolling reduces spread of infection.</td>
</tr>
<tr>
<td><strong>6. Slide resident’s arms into clean gown, affected arm first.</strong></td>
<td>6. Dressing affected side first requires less movement and reduces stress to joints.</td>
</tr>
<tr>
<td>7. Tie gown.</td>
<td></td>
</tr>
<tr>
<td><strong>8. Remove top sheet from beneath clean gown and cover resident.</strong></td>
<td>8. Maintains resident’s dignity and right to privacy.</td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

__________________________  ________________________  
Student Signature       Date

__________________________  ________________________  
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Assist resident to choose clothing.</strong></td>
<td>2. Allows resident as much choice as possible to improve self-esteem.</td>
</tr>
<tr>
<td>3. Move resident onto back.</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Provide privacy.</strong></td>
<td>4. Maintains resident’s dignity and right to privacy by not exposing body. Keeps resident warm.</td>
</tr>
<tr>
<td>5. <strong>Guide feet through leg openings of underwear and pants, affected leg first. Pull garments up legs to buttocks.</strong></td>
<td>5. Dressing affected side first requires less movement and reduces stress to joints.</td>
</tr>
<tr>
<td>6. <strong>Slide arm into shirt sleeve, affected side first.</strong></td>
<td>6. Dressing lower and upper body together reduces number of times resident needs to be turned.</td>
</tr>
<tr>
<td>7. <strong>Turn resident onto unaffected side. Pull lower garments over buttocks and hip. Tuck shirt under resident.</strong></td>
<td></td>
</tr>
<tr>
<td>8. <strong>Turn resident onto affected side. Pull lower garments over buttocks and hip and straighten shirt.</strong></td>
<td></td>
</tr>
<tr>
<td>9. <strong>Turn resident onto back and slide arm into shirt sleeve, align and fasten garments.</strong></td>
<td></td>
</tr>
<tr>
<td>10. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_________________________  ________________________  
Student Signature       Date

_________________________  ________________________  
Instructor Signature       Date
### PROCEDURE #46: ASSIST TO BATHROOM

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Assist resident to put on non-skid socks/footwear.</strong></td>
<td></td>
</tr>
<tr>
<td>3. Walk with resident into bathroom.</td>
<td></td>
</tr>
<tr>
<td>4. Assist resident to lower garments and sit.</td>
<td>4. Allows resident to do as much as possible to help promote independence.</td>
</tr>
<tr>
<td>5. <strong>Provide resident with call light and toilet tissue if resident has been identified as safe to be provided privacy and not mandated to remain attended by staff.</strong></td>
<td>5. Ensures ability to communicate need for assistance; Provides for resident’s right to privacy.</td>
</tr>
<tr>
<td>6. <strong>Put on gloves.</strong></td>
<td>6. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>7. <strong>Assist resident to wipe area from front to back.</strong></td>
<td>7. Prevents spread of pathogens toward meatus which may cause urinary tract infection.</td>
</tr>
<tr>
<td>8. <strong>Remove gloves. Wash hands</strong></td>
<td></td>
</tr>
<tr>
<td>9. Assist resident to raise garments.</td>
<td></td>
</tr>
<tr>
<td>10. <strong>Assist resident to wash hands.</strong></td>
<td>10. Hand washing is the best way to prevent the spread of infection.</td>
</tr>
<tr>
<td>11. Walk with resident back to bed or chair.</td>
<td></td>
</tr>
<tr>
<td>12. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_______________________________  ________________________  
Student Signature       Date

_______________________________  ________________________  
Instructor Signature       Date
## PROCEDURE #47: BEDSIDE COMMODE

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Assist resident to put on non-skid socks/footwear.</td>
<td></td>
</tr>
<tr>
<td>3. Place commode next to bed on resident’s unaffected side.</td>
<td>3. Helps stabilize commode and is the shortest distance for resident to turn.</td>
</tr>
<tr>
<td>4. Assist resident to transfer to commode by transferring the safest way the resident is able.</td>
<td></td>
</tr>
<tr>
<td>5. Give resident call light and toilet tissue if resident has been identified as safe to be provided privacy and not attended by staff.</td>
<td>5. Ensure ability to communicate need for assistance. Provides resident’s right to privacy.</td>
</tr>
<tr>
<td>6. Put on gloves.</td>
<td>6. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>7. Assist resident to wipe from front to back.</td>
<td>7. Prevents spread of pathogens toward meatus which may cause urinary tract infection.</td>
</tr>
<tr>
<td>8. Wash hands and change gloves</td>
<td>8. Infection control</td>
</tr>
<tr>
<td>9. Assist resident to bed or chair.</td>
<td></td>
</tr>
<tr>
<td>10. Remove and cover pan and take to bathroom.</td>
<td>9. Pan should be covered to prevent the spread of infection.</td>
</tr>
<tr>
<td>11. Prior to disposal, observe urine and/or feces for color, odor, amount &amp; characteristics and report unusual findings to nurse.</td>
<td>10. Changes may be the first sign of a medical problem. By alerting the nurse, you ensure that the resident receives prompt attention.</td>
</tr>
<tr>
<td>12. Dispose of urine and/or feces, sanitize pan and return pan according to facility policy.</td>
<td>11. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.</td>
</tr>
<tr>
<td>13. Remove gloves. Wash hands</td>
<td></td>
</tr>
<tr>
<td>14. Assist resident to wash hands.</td>
<td>13. Hand washing is the best way to prevent the spread of infection.</td>
</tr>
<tr>
<td>15. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
# Procedure #48: Bedpan/Fracture Pan

<table>
<thead>
<tr>
<th>Step</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Lower head of bed.</td>
<td>2. When bed is flat, resident can be moved without working against gravity.</td>
</tr>
<tr>
<td>3. Put on gloves.</td>
<td>3. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>4. Turn resident away from you.</td>
<td></td>
</tr>
<tr>
<td>5. Place bedpan or fracture pan under buttocks according to manufacturer directions.</td>
<td>5. Equipment used incorrectly may cause discomfort and injury to resident.</td>
</tr>
<tr>
<td>7. Cover resident with sheet/blanket.</td>
<td>7. Provides for resident’s privacy.</td>
</tr>
<tr>
<td>8. Raise head of bed to comfortable position for resident.</td>
<td>8. Increases pressure on bladder to encourage with elimination.</td>
</tr>
<tr>
<td>9. Give resident call light and toilet paper.</td>
<td>9. Ensures ability to communicate need for assistance.</td>
</tr>
<tr>
<td>10. Leave resident and return when called.</td>
<td>10. Provides for resident’s privacy.</td>
</tr>
<tr>
<td>11. Lower head of bed.</td>
<td>11. Places resident in proper position to remove pan.</td>
</tr>
<tr>
<td>13. Wipe resident from front to back. Wash hands and change gloves.</td>
<td>13. Prevents spread of pathogens toward meatus which may cause urinary tract infection.</td>
</tr>
<tr>
<td>14. Provide perineal care, if necessary.</td>
<td></td>
</tr>
<tr>
<td>15. Cover bedpan and take to bathroom.</td>
<td>15. Pan should be covered to prevent the spread of infection.</td>
</tr>
<tr>
<td>16. Check urine and/or feces for color, odor, amount and characteristics and report unusual findings to nurse.</td>
<td>16. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives prompt attention.</td>
</tr>
<tr>
<td>17. Dispose of urine and/or feces, sanitize pan and return pan according to facility policies.</td>
<td>17. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.</td>
</tr>
<tr>
<td>18. Remove gloves. Wash hands</td>
<td></td>
</tr>
<tr>
<td>19. Assist resident to wash hands.</td>
<td>19. Hand washing is the best way to</td>
</tr>
</tbody>
</table>
20. Do final steps.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________    ________________________
Student Signature       Date

_____________________________________    ________________________
Instructor Signature     Date
**PROCEDURE #49: URINAL**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Raise head of bed to sitting position.</td>
<td>2. Increases gravity on top of bladder to encourage urination.</td>
</tr>
<tr>
<td>3. Put on gloves.</td>
<td>3. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>4. Offer urinal to resident or place urinal between his legs and insert penis into opening.</td>
<td>4. Allows resident to do as much as possible to help promote independence.</td>
</tr>
<tr>
<td>5. Cover resident.</td>
<td>5. Maintains resident’s right to privacy.</td>
</tr>
<tr>
<td>6. Give resident call light and toilet paper.</td>
<td>6. Ensures ability to communicate need for assistance.</td>
</tr>
<tr>
<td>7. Leave resident and return when called.</td>
<td>7. Provides for resident’s privacy.</td>
</tr>
<tr>
<td>8. Remove and cover urinal.</td>
<td>8. Urinal should be covered to prevent the spread of infection.</td>
</tr>
<tr>
<td>9. Take urinal to bathroom, check urine for color, odor, amount and characteristics and report unusual findings to nurse.</td>
<td>9. Changes may be first sign of medical problems. By alerting the nurse you ensure that the resident receives prompt attention.</td>
</tr>
<tr>
<td>10. Dispose of urine, rinse urinal, sanitize and return urinal according to facility policies.</td>
<td>10. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.</td>
</tr>
<tr>
<td>11. Remove gloves. Wash hands</td>
<td></td>
</tr>
<tr>
<td>21. Assist resident to wash hands.</td>
<td>12. Hand washing is the best way to prevent the spread of infection.</td>
</tr>
<tr>
<td>22. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Put on gloves.</td>
<td>2. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>3. Place paper towel on floor beneath bag and place graduated cylinder on paper towel.</td>
<td>3. Reduces contamination of graduate cylinder and protects floor from spillage.</td>
</tr>
<tr>
<td>4. Detach spout (if bag has one) and point the drainage tube into center of graduated cylinder without letting tube touch sides.</td>
<td>4. Prevents contamination of tubing.</td>
</tr>
<tr>
<td>5. Unclamp spout and drain urine.</td>
<td></td>
</tr>
<tr>
<td>6. Clamp spout.</td>
<td></td>
</tr>
<tr>
<td>7. Replace spout in holder.</td>
<td></td>
</tr>
<tr>
<td>8. Check urine for color, odor, amount and characteristics and report unusual findings to nurse.</td>
<td>8. Changes may be first signs of medical problem. By alerting the nurse you ensure that the resident receives prompt attention.</td>
</tr>
<tr>
<td>9. Measure and accurately record amount of urine.</td>
<td>9. Accuracy is necessary because decisions regarding resident’s care may be based on your report. What you write is a legal record of what you did. If you don’t document it, legally it didn’t happen.</td>
</tr>
<tr>
<td>10. Dispose of urine, rinse, sanitize and return graduated cylinder according to facility policies.</td>
<td>10. Facilities have different methods of disposal and sanitation. Follow facility policy and procedures.</td>
</tr>
<tr>
<td>11. Remove gloves.</td>
<td></td>
</tr>
<tr>
<td>23. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
## PROCEDURE #51: URINE SPECIMEN COLLECTION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Prepare label for specimen with appropriate information and place it on specimen container, not the lid.</strong></td>
<td>2. Label contains resident’s identifying information which is essential for the laboratory. Label should be placed on the specimen container in the event the lid is misplaced or thrown away.</td>
</tr>
<tr>
<td>3. <strong>Put on gloves.</strong></td>
<td>3. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>4. Assist resident to bathroom or commode, or offer bedpan or urinal.</td>
<td></td>
</tr>
<tr>
<td>5. <strong>Provide peri-care to the resident</strong></td>
<td>5. To ensure area is clean and free of possible contamination of the specimen.</td>
</tr>
<tr>
<td>6. <strong>Ask resident to void into the urine hat placed on the toilet, or to urinate in the bedpan. Ask the resident not to put toilet paper with the sample.</strong></td>
<td>6. A clean collection device is necessary for accurate lab evaluation. Toilet paper will contaminate the urine and produce an inaccurate result.</td>
</tr>
<tr>
<td>7. <strong>After urination, assist the resident as necessary with perineal care and to wash the resident’s hands. Change your gloves and wash your hands.</strong></td>
<td></td>
</tr>
<tr>
<td>8. <strong>Take bedpan, urinal, and commode pail to bathroom and pour urine in to the specimen container. The container should be at least half full.</strong></td>
<td></td>
</tr>
<tr>
<td>9. <strong>Cover the urine container with its lid. Do not touch the inside of the container. Wipe off the outside with a paper towel.</strong></td>
<td></td>
</tr>
<tr>
<td>10. <strong>Place the specimen container in the bag supplied by the lab for transport.</strong></td>
<td></td>
</tr>
<tr>
<td>11. Discard excess urine in bedpan or urinal; clean and disinfect equipment as per facility policy.</td>
<td></td>
</tr>
<tr>
<td>12. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Prepare label for specimen with appropriate information and place it on specimen container, not the lid.</td>
<td>2. Label contains resident’s identifying information which is essential for the laboratory. Label should be placed on the specimen container in the event the lid is misplaced or thrown away.</td>
</tr>
<tr>
<td>3. Put on gloves.</td>
<td>3. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>4. When the resident is ready to move bowels, ask him/her not to urinate at the same time. Ask the resident not to put toilet paper with the sample.</td>
<td>4. A clean collection device is necessary for accurate lab evaluation. Urine contaminated stool will produce an inaccurate result.</td>
</tr>
<tr>
<td>5. Provide the resident with a bedpan, assisting if needed.</td>
<td></td>
</tr>
<tr>
<td>6. After the bowel movement, assist as needed with perineal care.</td>
<td></td>
</tr>
<tr>
<td>7. Remove gloves, wash hands and put on clean gloves.</td>
<td></td>
</tr>
<tr>
<td>8. Using two tongue blades, take about two tablespoons of stool and put in the container. Try to collect material from different areas of the stool.</td>
<td>8. In order to ensure adequate amount of stool for test ordered. Obtaining material from different areas ensures that all possible contents will be identified.</td>
</tr>
<tr>
<td>9. Cover the container with lid. Label as directed per facility policy and procedure and place in the plastic bag supplied by the lab for transport. Dispose of remaining stool; clean and disinfect equipment as per facility policy. Notify nurse of collection.</td>
<td></td>
</tr>
<tr>
<td>10. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
## PROCEDURE #53: APPLICATION OF INCONTINENT BRIEF

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Put on gloves.</td>
<td></td>
</tr>
<tr>
<td>3. Provide the resident privacy.</td>
<td>3. Privacy</td>
</tr>
<tr>
<td>4. Unfasten and remove brief resident is currently wearing and place in small plastic trash bag for disposal in soiled utility bag.</td>
<td>4. Residents should have soiled briefs removed promptly to decrease risk of skin breakdown.</td>
</tr>
<tr>
<td>5. Provide perineal care as indicated.</td>
<td>5. Prevents infection, odor, and skin breakdown; improves resident’s comfort.</td>
</tr>
<tr>
<td>6. Wash hands and change gloves.</td>
<td></td>
</tr>
<tr>
<td>7. Place back of brief under resident’s hips, plastic side of disposable brief away from resident’s skin.</td>
<td>7. Plastic may cause irritation of the resident’s skin.</td>
</tr>
<tr>
<td>8. Bring front of brief between resident’s legs and up to his/her waist.</td>
<td></td>
</tr>
<tr>
<td>9. Fasten each side of brief and adjust fit.</td>
<td>9. Adjusting brief to a snug fit will prevent leakage.</td>
</tr>
<tr>
<td>10. Apply resident’s clothing</td>
<td></td>
</tr>
<tr>
<td>11. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps</td>
<td></td>
</tr>
<tr>
<td>2. Collect clean linen in order of use.</td>
<td>2. Organizing linen allows procedure to be completed faster.</td>
</tr>
<tr>
<td>3. Carry linen away from your uniform</td>
<td>3. If linen touches your uniform, it becomes contaminated.</td>
</tr>
<tr>
<td>4. Place linen on clean surface (bedside stand, over bed table or back of chair).</td>
<td>4. Prevents contamination of linen.</td>
</tr>
<tr>
<td>5. Place bed in flat position.</td>
<td>5. Allows you to make a neat, wrinkle free bed.</td>
</tr>
<tr>
<td>6. Loosen soiled linen. Roll linen from head to foot of bed and place in barrel at door or room or in bag and place at foot of bed or chair.</td>
<td>6. Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination.</td>
</tr>
<tr>
<td>7. Fanfold bottom sheet to center of bed and fit corners.</td>
<td></td>
</tr>
<tr>
<td>8. Fanfold top sheet to center of bed.</td>
<td></td>
</tr>
<tr>
<td>10. Tuck top linen under foot of mattress and miter corner.</td>
<td>10. Mitering prevents resident’s feet from being restricted by or tangled in linen when getting in or out of bed.</td>
</tr>
<tr>
<td>11. Move to other side of bed.</td>
<td>11. Completing one side of bed at a time allows procedure to be completed faster and reduces strain on the caregiver.</td>
</tr>
<tr>
<td>12. Fit corners of bottom sheet, unfold top linen, tuck it under foot of mattress, and miter corner.</td>
<td></td>
</tr>
<tr>
<td>13. Fold top of sheet over blanket to make cuff.</td>
<td></td>
</tr>
<tr>
<td>14. With one hand, grasp the clean pillow case at the closed end, turning it inside out over your arm.</td>
<td></td>
</tr>
</tbody>
</table>
15. Using the same hand that has the pillow case over it, grasp one narrow edge of the pillow and pull the pillow case over it with your free hand.

16. **Place the pillow at head of bed with open edge away from the door.**

17. **For open bed:** make toe pleat and fanfold top linen to foot of bed with top edge closest to center of bed.  
   17. Top edge of top linen must be closest to head of bed so resident can easily reach covers.

18. **For closed bed:** pull bedspread over pillow and tuck bedspread under lower edge of pillow. Make toe pleat.  
   18. Toe pleat automatically reduces pressure of top linen on feet when resident returns to bed.

19. **Removed soiled linens.**  
   19. Prevents contamination.

20. **Do final steps.**

---

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
### PROCEDURE #55: OCCUPIED BED

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps</td>
<td></td>
</tr>
<tr>
<td>2. Collect clean linen in order of use</td>
<td>2. Organizing linen allows procedure to be completed faster</td>
</tr>
<tr>
<td>3. Carry linen away from your uniform</td>
<td>3. If linen touches your uniform, it becomes contaminated.</td>
</tr>
<tr>
<td>4. Place linen on clean surface (bedside stand, over bed table or back of chair)</td>
<td>4. Prevents contamination of linen.</td>
</tr>
<tr>
<td>5. Lower head of bed and adjust bed to a safe working level, usually waist high. Lock bed wheels.</td>
<td>5. When bed is flat, resident can be moved without working against gravity.</td>
</tr>
<tr>
<td>6. Drape the resident</td>
<td></td>
</tr>
<tr>
<td>7. The caregiver will make the bed one side at a time. The caregiver will raise the side rail on far side of bed (if rail not in use, ensure there is a second caregiver on the opposite side of the bed to ensure that the resident does not roll over the side of bed). Assist resident to turn onto side moving away from you toward raised side rail (or second caregiver).</td>
<td></td>
</tr>
<tr>
<td>8. Loosen bottom soiled linen on the side of bed on which you are working.</td>
<td></td>
</tr>
<tr>
<td>9. Roll bottom soiled linen toward resident and tuck it snuggly against the resident’s back.</td>
<td>9. 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.</td>
</tr>
<tr>
<td>10. Place clean bottom linen on unoccupied side of bed and roll remaining clean linen under resident in the center of the bed.</td>
<td></td>
</tr>
<tr>
<td>11. Smooth bottom sheet out and ensure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>12.</td>
<td>Raise the side rail nearest you (or remain in place if a second caregiver is being utilized) and assist the resident to turn onto clean bottom sheet. Move to opposite side of bed, as resident will now be facing away from you.</td>
</tr>
<tr>
<td>13.</td>
<td>Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination.</td>
</tr>
<tr>
<td>14.</td>
<td>Place soiled linen in barrel or bag at foot of bed or in chair.</td>
</tr>
<tr>
<td>15.</td>
<td>Pull clean bottom linen as was done on the opposite side.</td>
</tr>
<tr>
<td>16.</td>
<td>Assist resident to roll onto back, keeping resident covered and comfortable.</td>
</tr>
<tr>
<td>17.</td>
<td>Maintains resident’s dignity and right to privacy by not exposing body.</td>
</tr>
<tr>
<td>18.</td>
<td>Mitering prevents resident’s feet from being restricted by or tangled in linen when getting in or out of bed. Prevents pressure on feet which can cause pressure sores.</td>
</tr>
<tr>
<td>19.</td>
<td>Remove pillow and remove the soiled pillow case by turning it inside out.</td>
</tr>
<tr>
<td>20.</td>
<td>With one hand, grasp the clean pillow case at the closed end, turning it inside out over your arm.</td>
</tr>
</tbody>
</table>
case over it, grasp one narrow edge of the pillow and pull the pillow case over it with your free hand.

| 22. Place the pillow under resident’s head with open edge away from the door. |
| 23. Assist resident to comfortable position and return the bed to the appropriate position. |
| 24. Removed soiled linens from room – carrying away from uniform. |

25. Do final steps.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Instructor Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
## PROCEDURE #56: THICKENED LIQUIDS

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Obtain thickener and measuring spoon.</td>
<td>2. Measuring spoon is required to ensure proper amount of thickener is utilized to obtain ordered thickness.</td>
</tr>
<tr>
<td>3. Thicken liquids to desired consistency following manufacturer’s instructions.</td>
<td>3. Physician will specify thickness. Various brands of thickener require different amounts of product to be added.</td>
</tr>
<tr>
<td>4. Offer thickened fluid to resident. Encourage resident to consume thickened fluids.</td>
<td>4. Decreases risk of resident becoming dehydrated.</td>
</tr>
<tr>
<td>5. Ensure the water pitcher has been removed from the bedside unless facility policy states otherwise.</td>
<td>5. Resident may attempt to drink liquids that have not been thickened which will increase risk of choking.</td>
</tr>
<tr>
<td>6. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

______________________________  ________________________
Student Signature       Date

______________________________  ________________________
Instructor Signature       Date
# PROCEDURE #57: PASSING FRESH ICE WATER

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Obtain cart, ice container, ice scoop and go to ice machine. Keep ice scoop covered.</td>
<td></td>
</tr>
<tr>
<td>3. Fill container with ice using ice scoop.</td>
<td></td>
</tr>
<tr>
<td>4. Replace ice scoop in proper covered container, or cover it with a clean towel or plastic bag to prevent contamination.</td>
<td>4. Keeping the ice scoop covered maintains infection control practices.</td>
</tr>
<tr>
<td>5. Proceed to resident rooms, noting any fluid restriction(s) prior to pass and any residents who require thickened liquids.</td>
<td>5. Residents who require a fluid restriction or thickened liquids should not have a water pitcher placed at the bedside unless facility policy states differently.</td>
</tr>
<tr>
<td>6. Empty water from pitcher and bedside glass into the sink. If resident is on I&amp;O’s – record intake of water.</td>
<td>6. Emptying the pitcher of old water will allow you to fill it with ice and fresh water. Emptying the glass will allow you to fill it with fresh water.</td>
</tr>
<tr>
<td>7. Take pitcher into hall and fill it with ice. NOTE: Do not touch the pitcher with the ice scoop.</td>
<td>7. The ice scoop is utilized for all residents thus should not be contaminated by touching a water pitcher.</td>
</tr>
<tr>
<td>8. Replace the scoop in covered container, clean towel or plastic bag between rooms to prevent contamination.</td>
<td>8. Maintains infection control practices.</td>
</tr>
<tr>
<td>9. Return to resident’s room and fill pitcher with water at bathroom sink, not allowing pitcher to touch faucet.</td>
<td>9. Ensures that resident has fresh ice water in pitcher.</td>
</tr>
<tr>
<td>10. Pour fresh water into bedside glass and leave a straw with the glass, if needed.</td>
<td>10. Ensures that water is available and ready for resident when he/she desires it.</td>
</tr>
<tr>
<td>11. Offer the resident a drink of fresh water if resident is present.</td>
<td>11. Resident may be unable to independently obtain a drink of water.</td>
</tr>
<tr>
<td>12. Repeat procedure until all residents have been provided with fresh ice water.</td>
<td>12. Ensures that all residents receive fresh ice water.</td>
</tr>
<tr>
<td>13. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature     Date
## PROCEDURE #58: FEEDING

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Confirm diet card/tray. Check name, diet, utensils and condiments.</td>
<td>2. This will ensure that the resident is being served the diet as ordered; at the appropriate consistency.</td>
</tr>
<tr>
<td>3. Explain procedure.</td>
<td></td>
</tr>
<tr>
<td>4. Have resident wash hands, help the resident if needed.</td>
<td>4. Provides good hygiene in preparation for meal consumption.</td>
</tr>
<tr>
<td>5. Sit on unaffected side eye level with resident and facing them.</td>
<td>5. Encourages interaction with the resident and placement of spoon at an appropriate angle.</td>
</tr>
<tr>
<td>6. Resident’s head should be elevated at least 45 degrees, if in bed.</td>
<td>6. Places resident at an angle to promote swallowing and reduce risk of choking.</td>
</tr>
<tr>
<td>7. Protect the resident’s clothing with a clothing protector or per facility policy and procedures.</td>
<td>7. Use of a napkin or clothing protector (if resident desires) preserves dignity by keeping clothing clean and free of spillage.</td>
</tr>
<tr>
<td>8. Offer different foods; ask resident’s preference.</td>
<td>8. Involving the resident encourages consumption.</td>
</tr>
<tr>
<td>9. Food should be in bite sized pieces or with the spoon half full. Food should be fed to the unaffected side of the mouth.</td>
<td>9. Reduces risk of choking.</td>
</tr>
<tr>
<td>10. Allow time for resident to chew and empty mouth between bites. Notify nurse immediately should choking occur.</td>
<td>10. Reduces risk of choking.</td>
</tr>
<tr>
<td>11. Frequently offer beverage. If required, measure I&amp;O’s and percentage of food eaten.</td>
<td>11. Encourages swallowing.</td>
</tr>
<tr>
<td>12. Make conversation with the resident; atmosphere should be pleasant.</td>
<td>12. Enhances meal experience, thus encourages consumption.</td>
</tr>
<tr>
<td>13. Cleanse the resident’s hands/face as needed during the meal and after.</td>
<td>13. Promotes good hygiene.</td>
</tr>
<tr>
<td>14. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
**PROCEDURE #59: ASSIST TO EAT**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Confirm diet card/tray. Check name, diet, utensils and condiments.</td>
<td>2. This will ensure that the resident is being served the diet as ordered; at the appropriate consistency.</td>
</tr>
<tr>
<td>3. Confirm any adaptive equipment is present, if indicated.</td>
<td>3. Provision of adaptive equipment will encourage resident participation.</td>
</tr>
<tr>
<td>4. Assist to protect the resident’s clothing, if desired.</td>
<td>4. Use of a napkin or clothing protector (if resident desires) preserves dignity by keeping clothing clean and free of spillage.</td>
</tr>
<tr>
<td>5. Assist to open carton(s), arrange food items within reach, season foods per resident preference, etc.</td>
<td>5. The resident may have limited hand dexterity and/or weakness, making it difficult to open cartons/containers.</td>
</tr>
<tr>
<td>6. Offer assistance if resident appears to be having difficulty during meal.</td>
<td>6. Residents may refrain from “asking” for assistance, thus, staff should be pro-active in observing the need for assistance and offer the same.</td>
</tr>
<tr>
<td>7. Offer to assist in cleansing resident’s hands/face following the meal.</td>
<td>7. Promotes good hygiene.</td>
</tr>
<tr>
<td>8. Assist resident to room or location of choice.</td>
<td></td>
</tr>
<tr>
<td>9. Do final steps. Measure I&amp;O’s if required.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

____________________________________  ________________________  
Student Signature       Date

____________________________________  ________________________  
Instructor Signature       Date
# PROCEDURE #60: INSPECTING SKIN

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Provide the resident privacy.</strong></td>
<td>2. Maintains resident’s dignity and right to privacy by not exposing body. Keeps resident warm.</td>
</tr>
<tr>
<td>3. <strong>Check bony areas including ears, shoulder blades, elbows, coccyx, hips, knees, ankles and heels for redness and warmth.</strong></td>
<td>3. Redness and warmth indicates that the skin is under pressure and position should be changed more frequently.</td>
</tr>
<tr>
<td>4. <strong>Check friction areas including under breasts and arms, between buttocks, groin, thighs, skin folds, contracted areas, and around any tubing for redness, irritation, moisture and odor.</strong></td>
<td>4. Pressure, rubbing and perspiration will cause skin to break down.</td>
</tr>
<tr>
<td>5. <strong>Undrape resident.</strong></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Report any unusual findings to the nurse immediately.</strong></td>
<td>6. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>7. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
PROCEDURE #61: FLOAT HEELS

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Lift resident’s lower extremity.</td>
<td></td>
</tr>
<tr>
<td>3. Inspect the skin, especially the heels.</td>
<td>3. To identify any potential skin problems/breakdown.</td>
</tr>
<tr>
<td>4. Place a full pillow under calves, leaving heels in the air and free from pressure. (Do not use rolled pillows or blankets.)</td>
<td>3. Placing the pillow directly under the heels can increase pressure on heels.</td>
</tr>
<tr>
<td>5. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
## PROCEDURE #62: BED CRADLE

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Place bed cradle on bed according to manufacturer’s instructions.</strong></td>
<td>2. If equipment is not applied according to manufacturer’s instructions, discomfort or injury could result.</td>
</tr>
<tr>
<td><strong>3. Cover bed cradle with top sheet and bedspread/blanket.</strong></td>
<td>3. Keeps the top linens from applying pressure/weight to toes, feet and lower legs.</td>
</tr>
<tr>
<td>4. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

________________________  ________________________  
Student Signature         Date

________________________  ________________________  
Instructor Signature      Date
### PROCEDURE #63: PASSIVE RANGE OF MOTION

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Position resident in good body alignment.</strong></td>
<td>2. Reduces stress to joints.</td>
</tr>
<tr>
<td>3. Observe joints. If swelling, redness or warmth is present, or if resident complains of pain, notify nurse. Continue procedure only if instructed.</td>
<td>3. Indicates inflammation in joint which can be worsened if procedure is continued.</td>
</tr>
<tr>
<td>4. Support limb above and below joint.</td>
<td></td>
</tr>
<tr>
<td><strong>5. Begin range of motion at shoulders and include the shoulders, elbows, wrists, thumbs, fingers, hips, knees, ankles and toes.</strong></td>
<td>5. Allows you to control joint movement and minimize resident’s discomfort.</td>
</tr>
<tr>
<td>6. Slowly move joint in all directions it normally moves.</td>
<td>6. Rapid movement may cause injury.</td>
</tr>
<tr>
<td><strong>7. Repeat movement at least five times.</strong></td>
<td>7. Ensures benefit from procedure.</td>
</tr>
<tr>
<td><strong>8. Encourage resident to participate as much as possible.</strong></td>
<td>8. Promotes resident’s independence and self-esteem.</td>
</tr>
<tr>
<td>10. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date       

_____________________________________  ________________________  
Instructor Signature       Date
**PROCEDURE #64: SPLINT APPLICATION**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Observe affected joints. If swelling, redness, or warmth is present or if resident complains of pain, notify nurse. Continue procedure only if instructed.</td>
<td>2. Indicates inflammation in joint which can be worsened if splint is applied.</td>
</tr>
<tr>
<td>3. Apply splint according to therapy recommendation and physician’s order.</td>
<td>3. Application of splint not in accordance with therapy recommendation could cause injury or discomfort to resident.</td>
</tr>
<tr>
<td>4. Remove splint after designated period of time. Cleanse the skin, dry thoroughly and again observe for swelling, redness, warmth, complaint of pain or open area. Notify the nurse if present.</td>
<td>4. Indicates inflammation in joint. Notifying nurse provides him/her with information to assess resident’s condition and needs.</td>
</tr>
<tr>
<td>5. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
## PROCEDURE #65: ABDOMINAL BINDER

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do initial steps.</td>
</tr>
<tr>
<td>2.</td>
<td>Check the skin for redness, open areas, or needed incontinence care. 2. Allows you to identify early signs of skin breakdown and the need for cleansing prior to binder application.</td>
</tr>
<tr>
<td>3.</td>
<td>Place binder flat on the bed and ask resident to lie down with upper border at the upper waist and lower border at the level of the gluteal fold. If resident is in bed, assist him/her to roll side-to-side while placing binder underneath him/her in the same position. 3. A binder placed above the waist interferes with breathing; one placed too low interferes with elimination and walking.</td>
</tr>
<tr>
<td>4.</td>
<td>Bring the ends of binder around the resident, and overlap them. Beginning at the bottom of the binder, secure the Velcro fastener strip so that the binder fits snugly. 4. A snug fit provides maximum support. If the binder is too loose, efficacy is impaired. If it is too tight, resident may be uncomfortable.</td>
</tr>
<tr>
<td>5.</td>
<td>Ensure that there are no wrinkles or creases in the binder. 5. Wrinkles and creases put pressure on the skin increasing the risk for excoriation.</td>
</tr>
<tr>
<td>6.</td>
<td>Do final steps.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
# PROCEDURE #66: ABDUCTION PILLOW

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Place the pillow between the supine resident’s legs. Slide it with the narrow end pointing toward the groin until it touches the legs all along its length.</strong></td>
<td>3. Securing the straps prevents the pillow from slipping out of place.</td>
</tr>
<tr>
<td>3. <strong>Place the upper part of both legs in the pillow’s indentations. Raise each leg slightly by lifting under the knee and ankle to bring straps under and around leg and then secure the straps to the pillow.</strong></td>
<td></td>
</tr>
<tr>
<td>4. Do final steps.</td>
<td></td>
</tr>
<tr>
<td>5. <strong>Report resident intolerance or complaint of pain upon application to the nurse.</strong></td>
<td>5. Provides nurse with information to assess resident’s condition and needs.</td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
## PROCEDEURE #67: KNEE IMMOBILIZER

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td><strong>2. With resident lying supine in bed, one caregiver will support the leg above the knee and at the ankle and lift the leg in one motion, providing enough height for a second caregiver to place the immobilizer under the affected leg. Check skin prior to applying the immobilizer.</strong></td>
<td><strong>2. It is important to maintain the leg in a straight position while placing the immobilizer and to monitor for any skin problems/breakdown.</strong></td>
</tr>
<tr>
<td>3. The caregiver will lower the leg into the open immobilizer, keeping the leg straight.</td>
<td></td>
</tr>
<tr>
<td>4. Pull both sides of the immobilizer to center of front of leg and wrap one side over the other, securing the Velcro strip holding the immobilizer in place. Make sure the Velcro stabilizer bar strips are attached to opposite sides of the immobilizer to prevent any motion of the knee medially or laterally.</td>
<td></td>
</tr>
<tr>
<td>5. Bring straps around each side and secure to stabilize the immobilizer.</td>
<td></td>
</tr>
<tr>
<td><strong>6. When removing the immobilizer for bathing/care, support the leg in the same manner, keeping the leg straight at all times. Observe for any reddened areas, particularly at the upper and lower edge of the immobilizer, which is in contact with the resident’s skin.</strong></td>
<td><strong>6. Constant contact with the edge of the immobilizer can place the skin at risk of breakdown. Early detection of any concern can prevent further breakdown.</strong></td>
</tr>
<tr>
<td>7. <strong>Report to the nurse any skin irritation, open area, or complaint of pain.</strong></td>
<td><strong>7. Reporting to the nurse will ensure that treatment is obtained, if needed.</strong></td>
</tr>
<tr>
<td>8. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________
Student Signature       Date

_____________________________________  ________________________
Instructor Signature       Date
## PROCEDURE #68: PALM CONES

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Cleanse and thoroughly dry resident hand.</td>
<td>2. Cleansing and drying of hands prevents odor and infection.</td>
</tr>
<tr>
<td>3. Place cone with clean cover in resident palm.</td>
<td>3. Allows you to identify early signs of skin breakdown.</td>
</tr>
<tr>
<td>4. Observe hand(s) every shift; cleanse and thoroughly dry hands. Observe for areas of redness, swelling or open areas and report to the nurse, if noted.</td>
<td></td>
</tr>
<tr>
<td>5. Note covering of palm cone and send to laundry when soiled, re-covering cone with a clean covering, as needed.</td>
<td>4. Maintaining cleanliness enhances resident’s dignity.</td>
</tr>
<tr>
<td>6. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
**PROCEDURE #69: NASAL CANNULA CARE**

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Put on gloves.</td>
<td>2. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>3. Remove nasal cannula and clean nostrils with a soft cloth or tissue once each shift or as needed.</td>
<td>3. Removes any accumulation of dried drainage that may be present.</td>
</tr>
<tr>
<td>4. Note any redness or irritation of the nares or behind the ears and notify nurse if present. Continue procedure only if instructed.</td>
<td>4. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>5. Replace nasal cannula. Do not cinch side up too tightly</td>
<td>5. Nasal cannula too tight can cause discomfort.</td>
</tr>
<tr>
<td>6. Remove gloves.</td>
<td></td>
</tr>
<tr>
<td>7. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

__________________________  ________________________  
Student Signature       Date

__________________________  ________________________  
Instructor Signature       Date
<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td>2. Gently clean resident’s ear with a damp washcloth. Clean hearing aid of wax and dirt when needed according to manufacturer’s instructions</td>
<td>2. To ensure ears are clean prior to insertion of hearing aids, thus ensuring maximum acuity.</td>
</tr>
<tr>
<td>3. Insert hearing aid into resident’s ear.</td>
<td></td>
</tr>
<tr>
<td>4. Assist to adjust the volume control to a desired level.</td>
<td>4. To ensure that aid is turned up high enough for resident to hear, but not so high that noises will hurt resident’s ear(s).</td>
</tr>
<tr>
<td>5. Do final steps.</td>
<td></td>
</tr>
<tr>
<td>6. Report any abnormalities to nurse.</td>
<td>6. Provides nurse with necessary information to properly assess resident’s condition and needs.</td>
</tr>
<tr>
<td>7. Keep hearing aid in safe place when not in use.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________  ________________________
Student Signature       Date

_____________________________  ________________________
Instructor Signature       Date
# PROCEDURE #71: ELASTIC/COMPRESSION STOCKING APPLICATION OR TED HOSE

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Observe skin prior to applying the stockings for any redness, warmth, swelling, excessive dryness, or open area. Notify nurse if abnormalities present. Continue procedure only if instructed.</strong></td>
<td>2. Provides nurse with information to assess resident’s condition and needs.</td>
</tr>
<tr>
<td>3. Apply the hose before resident gets out of bed.</td>
<td>3. Hose should be applied before veins become distended and edema (swelling) occurs.</td>
</tr>
<tr>
<td>4. Hold heel of stocking and gather the rest in your hand turning hose inside out to mid foot area.</td>
<td></td>
</tr>
<tr>
<td>5. Support foot at the heel and slip the front of the stocking over the toes, foot and heel.</td>
<td></td>
</tr>
<tr>
<td>6. Pull the stocking up until it is fully extended.</td>
<td></td>
</tr>
<tr>
<td>7. Smooth away any wrinkles or twisted areas.</td>
<td>7. Wrinkles, creases, or twisted areas can irritate the skin and interfere with circulation.</td>
</tr>
<tr>
<td><strong>8. Remove the hose at least twice daily for skin care unless otherwise indicated by physician.</strong></td>
<td>8. Allows you to identify early signs of skin break down.</td>
</tr>
<tr>
<td>9. Do final steps.</td>
<td></td>
</tr>
</tbody>
</table>

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

______________________________  ____________________
Student Signature       Date

______________________________  ____________________
Instructor Signature       Date
### PROCEDURE #72: POST MORTEM CARE

<table>
<thead>
<tr>
<th>STEP</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do initial steps.</td>
<td>2. Protects you from contamination by bodily fluids.</td>
</tr>
<tr>
<td>2. Put on gloves.</td>
<td>3. Residents/families have the right to freedom of religion.</td>
</tr>
<tr>
<td>3. Respect the family’s religious restrictions regarding the care of body, if applicable.</td>
<td>4. Reduces the roommates stress.</td>
</tr>
<tr>
<td>4. Assist roommate to leave the area until body is prepared and removed, if applicable.</td>
<td>5. Preparates body for procedure.</td>
</tr>
<tr>
<td>5. Place body in supine position.</td>
<td>6. Prevents blood from discoloring the face by settling in it.</td>
</tr>
<tr>
<td>6. Place one pillow beneath resident’s head.</td>
<td>7. Close the eyes.</td>
</tr>
<tr>
<td>8. Insert dentures, if this is the facility policy, and close the mouth.</td>
<td>8. It is easier to put dentures in the mouth right away and gives the face a natural appearance.</td>
</tr>
<tr>
<td>9. Cleanse body as necessary. Comb hair.</td>
<td>9. Prepares the body for viewing by family and friends.</td>
</tr>
<tr>
<td>10. Place a pad under the buttocks to collect any drainage.</td>
<td>10. Due to total loss of muscle tone, urine and/or stool may drain from the body even after death.</td>
</tr>
<tr>
<td>11. Put a clean hospital gown on resident and place body in a comfortable looking position to allow family and friends to view the body.</td>
<td>12. Remove gloves.</td>
</tr>
<tr>
<td>13. Do final steps.</td>
<td>14. After the mortuary has removed the body, strip the bed and clean the room according to facility policy.</td>
</tr>
</tbody>
</table>
I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____________________________________  ________________________  
Student Signature       Date

_____________________________________  ________________________  
Instructor Signature       Date
Answers to Review Questions

Lesson 1
1. The licensed nurse
2. An objective observation is factually seen, heard, felt or smelled by the person reporting; a subjective observation is what one “thinks” or “heard” happened from someone else. 
3. Time to get dressed in the morning; whether to shower or bathe in a tub; what time to go to bed in the evening.

Lesson 2
1. Examine survey results, voice grievances, self administer medications
2. The caregiver must immediately report signs/symptoms of abuse, neglect or misappropriation
3. Verbal, physical, emotional/mental, sexual, neglect, involuntary seclusion, misappropriation
4. Leaving a resident in bed soiled. Leaving the call light or water out of resident reach
5. Using a resident’s personal telephone to make calls. Taking a resident’s money or personal belongings.
6. Report it immediately. Follow your facility’s policies and procedures for reporting abuse

Lesson 3
1. Causative Agent, Reservoir, Portal of Exit, Mode of Transmission, Portal of Entry, Susceptible Host
2. Hand washing
3. Before resident/patient contact, before aseptic task, after exposure to blood/body fluids, after resident/patient contact, after contact with resident/patient surroundings
4. Proper usage will provide a barrier between the caregiver and the pathogen, thus, preventing the spread of infection

Lesson 4
1. Touching an infected person and then proceeding to touch another person without washing one’s hands
2. Touching a contaminated object and then proceeding to touch a person without washing one’s hands.
3. No

Lesson 5
1. Clutching the throat
2. MSDS – Material Safety Data Sheet
3. Call for nurse and stay with resident, assist the nurse with positioning the resident on
his/her side, place padding under head and move furniture away from resident, do not restrain resident or place anything in mouth, loosen resident’s clothing, especially around the neck, after the seizure stops, assist nurse to check for injury, note duration of seizures and areas involved.

Lesson 6
1. **Remove** residents from area of immediate danger; **Activate** the fire alarm; **Contain** the fire, if possible (close doors); **Extinguish**, if possible.
2. **Pull** the pin; **Aim** at the base of the fire; **Squeeze** the handle; **Sweep** back and forth at the base of the fire
3. **Stop**, **drop** and **roll** to smother the flames

Lesson 7
1. **60 – 100** beats per minute
2. The average **BP** range for adults is systolic blood pressure: **100-139**; Normal range for **Diastolic** blood pressure is **60-89** however, it depends on the individual.
3. Place your hand on the resident’s chest and feel the chest rise and fall during breathing

Lesson 8
1. The resident’s shoulders are directly above their hips; their head and neck are straight; their arms and legs are in a natural position
2. **Supine**, **Lateral**, **Fowler’s** and **Semi-Fowler’s**
3. **Semi-Fowler’s**
4. **Less**
5. **False**

Lesson 9
1. **False**

Lesson 10
1. Female: **Separate** labia; wash urethral area first; wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use a different part of washcloth for each stroke.
   Male: **Pull back** foreskin if male is uncircumcised. Wash and rinse the tip of the penis using circular motion beginning with urethra. Continue washing down the penis to the scrotum and inner thighs
   **Rationale/Importance:** Prevents the spread of infection by washing pathogens **away from** the urethra and not toward the urethra where pathogens could enter.
Lesson 11
1. Irritation, raised areas, coated or swollen tongue, sores, complaint of mouth pain, white spots, loose/chipped or decayed teeth
2. Due to poor circulation, even a small sore on the foot can become a large wound

Lesson 12
1. A clean catch mid-stream requires that genitalia be cleansed prior to collecting the urine specimen.
2. True

Lesson 13
1. Calendar, clock, familiar pictures, visual cues
2. True

Lesson 14
1. Dry mouth, weight loss, foul smelling urine, dark urine, cracked lips and sunken eyes
2. Water
3. Nectar thick, honey thick, pudding thick
4. True

Lesson 15
1. True
2. True
3. True

Lesson 16
1. True
2. At least once every hour and more frequently if the resident’s condition requires
3. At least every two hours, or more often if necessary except when the resident is asleep

Lesson 17
1. Active range of motion exercises are done by the resident himself; Passive range of motion exercises are done by caregivers providing support and moving the resident’s joints through the range of motion when the resident cannot move on their own.
2. Contractures
3. Restorative Services

Lesson 18
1. False
2. True
3. True
Lesson 19
1. redness, warmth, tenderness, open area
2. True
3. True

Lesson 20
1. Change in vital signs – B/P, pulse, respiration, nausea, vomiting, sweating, tearful or frowning, sighing, moaning or groaning, breathing heavy or shortness of breath, restless or having difficulty moving, holding or rubbing a body part, tightening jaw or grinding teeth
2. Medication administration, such as antibiotics, nutrition administration, hydration, blood products, solutions are administered by gravity or through a portable pump
3. Fear of addiction to pain medication, feeling caregivers are too busy to deal with pain, fear pain medication will cause other problems, i.e., drowsiness, sleepiness, constipation

Lesson 21
1. A delusion – a fixed, false belief.
2. An elopement
3. Validation Therapy
4. Sundowning

Lesson 22
1. Immediately
2. Remain calm, step out of the way, remove other residents, never strike back or respond verbally, leave the resident alone to calm down (if safe) and report the behaviors to the nurse immediately.

Lesson 23
1. True
2. False

Lesson 24
1. True
2. True

Lesson 25
1. cold/clammy skin, double or blurry vision, shaking/trembling, hunger, tingling or numbness of skin
2. True

Lesson 26
1. True
2. True

Lesson 27
1. Prepare the room for the resident’s arrival; introduce self to resident and family/responsible party and explain role; explain surroundings to resident, including use of call light to summon help, if needed; create a trusting relationship; be available to family; become a resource and support for the family; refer family members requesting information about a resident to the nurse.
2. Personal inventory record.

Lesson 28
1. Cyanosis
2. True

Lesson 29
1. Draw a single line through the error, print word “error” above entry and initial and date the correction.
2. Report any resident condition that will need the attention of the oncoming shift (e.g., resident is on the bedpan, etc.)

Lesson 30
1. Exhibiting anger toward co-workers and/or residents; arguing with a supervisor or co-workers about assignments; complaining about responsibilities; feeling tired, even when you are well rested; difficulty focusing on residents and job duties.
2. The CNA must work for a healthcare provider at least one eight hour shift every twenty-four months.