STANDARD 14: NURSE AIDE SCOPE OF PRACTICE

The nurse aide will perform only the tasks in the course standards and *Resident Care Procedures* manual, unless trained appropriately by licensed staff of the facility with policies and procedures and a system for ongoing monitoring to assure compliance with the task, i.e., (see supplements for examples). This additional training would only apply for tasks, which are not prohibited by paragraphs 2 and 3 of this section and by current rule, which prohibits the giving of injections.

The nurse aide will not perform any invasive procedures, including enemas and rectal temperatures, checking for and/or removing fecal impactions, instillation of any fluids, through any tubing, administering vaginal or rectal installations.

The nurse aide will not administer any medications, perform treatment or apply or remove any dressings. Exception to the above would be the application of creams/ointments to intact skin, such as moisture barrier cream.

ABDOMINAL BINDER	
STEP	**RATIONALE**
1. Do initial steps.	
2. Check the skin for redness, open areas, or incontinence.	2. Allows you to identify early signs of skin breakdown and the need for cleansing prior to binder application.
3. Place binder flat on the bed and have resident lie down with the upper border at the waist and the 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.
4. Bring the ends of the 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.
5. 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.
6. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

ABDUCTION PILLOW	
STEP	**RATIONALE**
1. Do initial steps.	
2. 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.	2. Placing pillow between resident's legs prevents adduction of the hip joint.
3. 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.	3. Securing the straps prevents the pillow from slipping out of place.
4. Do final steps.	
5. Report resident intolerance or complaint of pain upon application to the nurse.	5. Provides nurse with information to assess resident's condition and needs.

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

AM CARE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Put on gloves (according to procedure #2).	2. Protects you from contamination by bodily fluids.
3. Assist resident with elimination needs. Provide perineal care as needed (according to procedure #34).	3. Often residents will need to urinate upon arising in the morning. Provision of perineal care enhances self-esteem while assisting in the prevention of pressure ulcers.
4. Assist resident to wash face, hands, and under arms.	4. Refreshes resident, increases self-esteem.
5. Assist resident with oral hygiene (according to procedure #27), including denture care (according to procedure #26), as indicated.	5. Refreshes resident, increases self-esteem.
6. Shave male residents (according to procedure #24 or #25).	6. Refreshes resident, increases self-esteem.
7. Assist resident with dressing including any jewelry per resident request.	7. Refreshes resident, increases self-esteem.
8. Comb and style resident's hair (according to procedure #29).	8. Refreshes resident, increases self-esteem.
9. Assist with application of any assistive devices/adaptive devices (e.g., glasses or contact lenses, hearing aides, dentures, artifical arm, leg, or breast, etc.).	9. Ensures that resident will be able to function at his/her maximum capabilities.
10. Assist resident out of bed utilizing proper procedure specific to resident.	10. Prepares resident for transportation to Dining Room.
11. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

APPLICATION OF INCONTINENT BRIEFS	
STEP	**RATIONALE**
1. Do initial steps.	
2. Unfasten and remove brief resident is currently wearing.	2. Residents should have soiled briefs removed promptly to decrease risk of skin breakdown.
3. Provide perineal care as indicated (according to procedure #34).	3. Prevents infection, odor, and skin breakdown; improves resident's comfort.
4. Place back of brief under resident's hips, plastic side of disposable brief away from resident's skin.	4. Plastic may cause irritation of the resident's skin.
5. Bring front of brief between resident's legs and up to his/her waist.	
6. Fasten each side of brief and adjust fit.	6. Adjusting brief to a snug fit will prevent leakage.
7. Finish dressing resident.	
8. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

ARJO TUB	
STEP	**RATIONALE**
1. Do initial steps.	
2. Fill tub with water before bringing resident to bathing area.	2. Tub takes an extended time to fill with water.
3. Help resident remove clothing. Drape resident with bath blanket (according to procedure #14).	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
4. Transport resident to tub room via wheelchair, geri-chair, or lift bath trolley.	
5. Have resident check water temperature.	5. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.
6. If not already on trolley, assist resident into lift bath trolley, secure straps, and lower lift bath trolley and resident into tub. Turn system on.	6. Resident must be on lift bath trolley in order to be lowered into tub.
7. Let resident wash as much as possible, starting with face.	7. Encourages resident to be independent.
8. You may shower the resident by using the shower handle to gently spray over the resident's body. Stay with resident during procedure.	8. Staying with resident provides for resident's safety.
9. Turn system off after completion of bath and return shower handle to hook, if used.	
10. Raise trolley out of tub; give resident towel and assist to pat dry.	10. Patting dry prevents skin tears and reduces chaffing.
11. Assist resident out of trolley.	
12. Help resident dress, comb hair, and return to room.	12. Dressing and combing hair in shower room allows resident to maintain dignity when returning to room.
13. Do final steps.	
14. Sanitize tub per manufacturer's instructions.	14. Reduces pathogens and prevents spread of infection.

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Instructor Signature	Date

ASSIST WITH CANE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Check the cane for presence of rubber tips.	2. Presence of intact rubber tips decreases the risk of falls by improving traction and preventing slipping.
3. Assist resident to sit on edge of bed (according to procedure #7).	3. Allows resident to adjust to position change.
4. Assist resident to stand on count of three.	4. Allows you and resident to work together.
5. Allow resident to gain balance.	5. Change in position may cause dizziness due to a drop in blood pressure.
6. Have resident place cane approximately 4-6 inches to the side of his/her unaffected foot. The height of the cane should be level with resident's hip.	
7. Stand to the side and slightly behind resident.	7. Allows clear path for the resident and puts you in a position to assist resident if needed.
8. Have resident move cane forward about 12 inches, step forward with weak (affected) leg to a position even with the cane. Then have resident move the strong leg forward and beyond the weak leg and cane. Repeat the sequence.	8. Reduces risk of resident falling.
9. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

ASSIST WITH CRUTCHES	
STEP	**RATIONALE**
1. Do initial steps.	
2. Check crutches for presence of rubber tips and rubber covers on the shoulder cross piece.	2. Presence of intact rubber tips decreases risk of falls by improving traction and preventing slipping. Presence of intact rubber covers on the shoulder piece provides comfort while preventing injury to the axillary area.
3. Assist resident to sit on edge of bed (according to procedure #7).	3. Allows resident to adjust to position change.
4. Assist resident to stand on the count of three.	4. Allows you and resident to work together.
5. Allow resident to gain balance.	5. Change in position may cause dizziness due to a drop in blood pressure.
6. Have resident place crutch under each arm. Ensure that resident's weight when ambulating is placed on his/her hands rather than on axillary area.	
7. Walk at resident's pace.	7. Reduces risk of resident falling.
8. Stand to side and slightly behind resident.	8. Allows clear path for the resident and puts you in a position to assist resident if needed.
9. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

ASSISTING WITH HEARING AIDS	
STEP	**RATIONALE**
1. Do initial steps.	
2. Gently clean resident's ear with a damp washcloth.	2. To ensure ears are clean prior to insertion of hearing aids thus ensuring maximum hearing acuity.
3. Insert hearing aid into resident's ear.	
4. Assist to adjust the control to a desired level.	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).
5. Do final steps.	
6. Report any abnormalities to nurse.	6. Provides nurse with necessary information to properly assess resident's condition and needs.

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

BED CRADLE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Place bed cradle on bed according to manufacturer's instructions.	2. If equipment is not applied according to manufacturer's instructions, discomfort or injury could result.
3. Cover bed cradle with top sheet and bedspread/blanket.	3. Keeps the top linens from pressing on toes, feet, and lower legs.
4. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

BED SHAMPOOS	
STEP	**RATIONALE**
1. Do initial steps.	
2. Gently comb and brush resident's hair (according to procedure #29).	2. Reduces hair breakage, scalp pain, and irritation.
3. Insert a cotton ball into each ear.	3. Keeps water from entering into resident's ears.
4. Drape resident (according to procedure #14).	4. Maintains resident's dignity and right to privacy by not exposing body.
5. Remove resident's gown or pajama top. Place a towel around resident's neck and shoulders. Lower head of bed.	5. Decreases the chance of resident getting wet.
6. Have resident check temperature of water to be used.	6. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.
7. Place bed shampoo basin under resident's head according to manufacturer's instructions.	7. If equipment is not applied according to manufacturer's instructions, discomfort or injury could result.
8. Place wash basin on chair to catch water.	
9. Pour water carefully over resident's hair.	
10. Lather hair with shampoo using fingertips. Rinse thoroughly.	10. Utilizing fingertips massages the scalp and decreases the risk of scratching resident.
11. Remove cotton balls from resident's ears and squeeze excess water from hair. Towel dry hair.	
12. Replace gown or pajama top.	
13. Comb and brush resident's hair (according to procedure #14). Dry hair with dryer if resident wishes.	13. Helps maintain resident's dignity and self-esteem.

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Instructor Signature	Date

CONVERTING A URINARY DRAINAGE BAG TO A LEG BAG	
STEP	**RATIONALE**
1. Do initial steps.	
2. Put on gloves (according to procedure #2).	2. Protects you from contamination by bodily fluids.
3. Empty Urinary Drainage Bag (according to procedure #39).	
4. Measure and accurately record amount of urine.	4. 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.
5. Place paper towel or cloth towel under the tubing at the point the catheter connects with the urinary drainage bag tubing.	5. Reduces contamination and protects surface from drips.
6. Place the leg bag with tubing within reach for easy access. Make certain the spout of the leg bag is clamped.	
7. Loosen the cap on the leg bag tubing to prepare for connection to catheter.	
8. With the catheter tubing kinked in one hand to prevent urinary drainage during the transition, gently twist the catheter tubing and urinary drainage bag tubing in an effort to separate the two at the connection.	
9. Once separated, continue to hold the kinked catheter tubing in one hand being cautious not to contaminate the open end of the tubing. Cap the open end of the tubing leading to the urinary drainage bag with an available cap or cover the open end of the tubing with alcohol swabs to prevent contamination. Lay the urinary drainage bag with tubing capped/covered aside.	9. Prevents contamination of tubing.
10. Remove the cap on the leg bag drainage tubing and gently insert and secure into the open end of the catheter tubing. Unkink the	

catheter tubing to allow urine to flow freely into the leg bag.	
11. Observe the catheter and leg bag tubing for patency ensuring the urine can flow freely to the collection area of the leg bag.	
12. Check urine for color, odor, amount and character and report unusual findings to nurse.	12. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives attention quickly.
13. Either discard the original urinary drainage bag, or store for later use as per facility policy.	13. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.
14. If clothing is worn on lower extremities of resident first thread the leg bag and tubing through the opening and secure to resident's leg prior to the pulling up or donning of the clothing. Make certain the leg bag is secured below the level of the bladder.	
15. Remove gloves.	
16. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

FEEDING WITH A SYRINGE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Assist resident with elimination, if necessary.	2. Resident will be more comfortable when eating.
3. Assist resident to wash hands.	3. Promotes good hygiene and prevents the spread of infection.
4. Place resident in comfortable sitting position.	4. Puts resident in a more natural position.
5. Check meal card for name and diet. Check tray for correct food, condiments, and utensils. Review any special feeding instructions provided by the speech therapist, if applicable.	5. Since resident's diet is ordered by the doctor, tray should contain foods permitted by the diet.
6. Set tray on table and describe food.	
7. Place napkin or clothing protector under resident's chin and across chest.	7. Protects resident's clothing.
8. Ask resident what food is preferred.	8. Resident has a right to choose.
9. Fill syringe with small amount of food.	
10. Carefully insert tip of syringe into resident's mouth and slowly push food into resident's mouth.	10. Food should be pushed slowly into mouth to decrease risk of choking.
11. Allow resident time to swallow. Give verbal cues as indicated. Offer fluids as resident wishes. Be observant for cough or signs/symptoms of swallowing difficulty. If observed, stop feeding and immediately alert the nurse.	
12. Wipe resident's mouth, as needed.	12. Maintains resident's dignity.
13. Remove napkin or clothing protector and tray.	
14. Wash resident's face and hands.	14. Promotes self-esteem and prevents the spread of infection.
15. Measure and record intake, if required.	15. Provides nurse with necessary information to properly assess resident's condition and needs.
16. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Instructor Signature	Date

FLOSSING	
STEP	**RATIONALE**
1. Do initial steps.	
2. Provide oral care (according to procedure #27).	2. Improves a resident's self-esteem and decreases the risk of oral infections.
3. Put on gloves (according to procedure #2).	3. Flossing may cause gums to bleed.
4. Break off about 18 inches of floss.	
5. Wrap ends of floss around middle fingers on each hand; stretch to give a tight grip.	
6. Gently insert floss between teeth-start at one side of the mouth continuing until all teeth on top are flossed between. Then repeat for bottom teeth. Ensure that floss is not inserted into the gum line.	6. Inserting floss into the gum line increases the risk of bleeding and subsequent gum pain or infection.
7. Assist resident to rinse mouth.	
8. Remove gloves (according to procedure #2).	
9. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

FOOT ELEVATOR	
STEP	**RATIONALE**
1. Do initial steps.	
2. Insert the ankle of the affected foot through the opening in the foam and secure with loop closure strap.	2. Allows affected foot to be elevated off of bed. Securing the strap prevents the elevator from slipping on leg.
3. To minimize pressure on the ankle.	3. Place a pillow under the resident's knees.
4. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

GOWNING	
STEP	**RATIONALE**
1. Wash your hands (according to procedure #1).	
2. Let the clean gown unfold without touching any surface.	2. Prevents contamination of the gown.
3. Slide your hands and arms through the sleeves.	
4. Tie neck ties.	
5. Overlap back of the gown and tie waist ties.	5. Ensures that your uniform is completely covered.
6. If gloves are required, put them on last (according to procedure #2).	
7. Perform procedure.	
8. If wearing gloves, remove them (according to procedure #2).	8. The gloves are likely to be more contaminated than the waist ties.
9. Untie the waist ties.	
10. Untie the neck ties.	
11. Pull the sleeve off by grasping each shoulder at the neckline and turn the sleeves inside out as you remove them from your arms. Do not contaminate your hands by touching the outside of the gown.	11. By not touching gown with your bare hands, it prevents contamination.
12. Fold gown with clean side out and place in laundry or discard if disposable.	12. Gowns are for one use only. They must be either discarded or laundered after each use.
13. Wash your hands (according to procedure #1).	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

HEIGHT	
STEP	**RATIONALE**
1. Do initial steps.	
2. Using standing balance scale: Raise the rod to a level above the resident's head, assist resident onto the scale. Lower the height measurement device until it rests flat on the resident's head.	2. Measurements are written on the rod in inches.
3. When a resident is unable to stand: Flatten the bed and place resident in supine position (according to procedure #3). Place a mark on the sheet at the top of the head and another at the bottom of the feet. Measure the distance.	3. Places resident in proper position and alignment; allows you to measure resident accurately.
4. If the resident is unable to lay flat due to contractures: 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.	4. Allows you to obtain an accurate measurement for the resident who cannot fully extend body.
5. Accurately record resident's height according to current nursing practices.	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.
6. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

ATTENTION: The number of nursing staff required to lift a resident would depend on the specific resident's plan of care and instructions from the charge nurse.

NOTE: The following are standard steps utilized with many mechanical lifts. However, it is the obligation of the facility to compare these steps with the manufacturer's instructions provided for the specific type of lift used by the facility and revise as needed to ensure safe operation. The operator must use care and discretion with all lifts. Special care must be taken with persons who cannot cooperate while being lifted - such as comatose, spastic, agitated or otherwise severely handicapped persons. A mechanical lift, unless specified otherwise, is for transfer only. It is not to be used for transporting or moving a resident from one location to another. The operator of the lift must be knowledgeable of the maximum weight that can be safely lifted using the device.

MECHANICAL LIFT	
STEP	**RATIONALE**
1. Inspect the mechanical lift before each use. Check bolts for tightness, make certain brakes engage and base can be easily widened.	
2. Make certain all necessary items such as slings, chains or straps and wheelchair or bedside chair is ready. If wheelchair is the destination, make certain wheels are in the locked position prior to transfer.	
3. Do initial steps.	
4. Resident should be in the center of the bed. Turn resident to the side (away from you).	
5. Center sling behind resident and fanfold half-way under resident's body with the lower edge of seat slightly below the resident's knees.	
6. Turn resident toward you, across folded sling. Straighten sling and turn resident to back ensuring he/she is centered on sling - with lower edge now right behind the knees.	6. Correct placement permits the resident to be lifted evenly with minimal shifting.
7. Raise head of bed.	7. Makes application of lift to sling easier and places resident in the position they will be in when lifted off of bed in sling.
8. Roll the lift to bedside, raise it and place with open end of the base under the bed positioning the overhead bar directly over the resident.	

9. Widen the base of the lift to its widest position.	9. To provide stronger support during the transfer. If the base is not opened to its widest position, there is increased risk of resident falling out of the sling.
10. Attach the sling to the straps or chains by hooking the short side to sling at the resident's back and the long side at the resident's thighs. The open end of the hooks should face away from resident.	10. Open ends of the hooks should be away from resident to prevent injury to resident.
11. Position resident's arms over the chest or in the lap.	11. To prevent injury during lift and transfer.
12. Pump the lift handle until resident clears the bed. NOTE* Be sure to support resident's head, neck, and feet.	12. Pump the lift gradually as this is less frightening to the resident than a rapid rise. Resident must clear the bed in order for a smooth transfer.
13. Roll the lift slowly away from bed and toward the chair. Have your assistant (if available) guide the resident's body gently until resident is directly over chair seat. Lock mechanical lift brakes.	13. Slow movement decreases swaying and is less frightening. Guidance also decreases swaying and gives resident a sense of security.
14. Slowly lower resident into chair while your assistant (if available) continues to guide his/her body.	14. Slowly lowering resident is less frightening than a quick descent.
15. Detach the chains or straps, leaving sling beneath resident.	15. Leave sling beneath resident so that when resident is ready to go back to bed sling is already in place.
16. Align resident's body in chair and adjust foot rests, if indicated.	16. Shoulders and hips should be in a straight line to reduce stress on spine and joints.
17. Allow resident to be up in accordance with physician's order.	
TO ASSIST BACK TO BED:	
18. Inspect the mechanical lift before use.	

19. Make certain bed wheels are locked prior to transfer.	
20. Do initial steps.	
21. Roll lift to resident's chair and widen base to its widest point.	21. To provide stronger support during the transfer. If the base is not opened to its widest position, there is increased risk of resident falling out of the sling.
22. Attach the sling to the straps or chains.	
23. Position resident's arms over the chest or in the lap.	
24. Pump the lift handle until resident clears the chair. NOTE: Be sure to support resident's head, neck, and feet.	24. Resident must clear the chair in order for a smooth transfer.
25. Roll lift away from the chair and back to the bed.	
26. Center resident over the bed.	26. Ensures resident will be in good position when lowered onto the bed.
27. Lower resident onto bed.	
28. Unhook sling and remove from beneath resident by turning resident from side to side.	28. Sling can be sent to laundry for use at a future time.
29. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

HS CARE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Provide resident with a bedtime snack that has been received from Dietary Department.	2. State rule requires that residents are offered a bedtime snack.
3. Assist resident with elimination needs. Provide perineal care as needed (according to procedure #34).	3. Often residents will need to urinate before going to bed. Provision of perineal care enhances self-esteem while assisting in the prevention of pressure ulcers.
4. Assist resident with oral hygiene (according #26), as indicated.	4. Refreshes resident, increases self-esteem, and decreases amount of bacteria in mouth.
5. Assist resident to wash face and hands.	5. Refreshes resident.
6. Assist resident to bed utilizing proper procedure specific to resident.	6. Prepares resident for night's rest.
7. Offer resident a backrub (according to procedure #15).	7. Promotes relaxation and increases circulation to help prevent pressure ulcers.
8. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

MASK	
STEP	**RATIONALE**
1. Wash your hands (according to procedure #1).	
2. Place upper edge of the mask over the bridge of your nose and tie the upper ties.	2. Your nose should be completely covered.
3. Place the lower edge of the mask under your chin and tie the lower ties at the nape of your neck.	3. Your mouth should be completely covered.
4. If the mask has a metal strip in the upper edge, form it to your nose.	4. This will prevent droplets from entering the area beneath the mask.
5. Perform procedure.	
6. If the mask becomes damp or if the procedure takes more than 30 minutes, you must change your mask.	6. 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.
7. If wearing gloves, remove them first (according to procedure #2).	7. This will prevent contamination of the areas you will touch when untying the mask.
8. Wash your hands (according to procedure #1).	
9. Untie each set of ties and discard the mask by touching only the ties. Masks are appropriate for one use only.	9. Hands may be contaminated if you touch an area other than the ties. Masks must be disposed of after each use.
10. Wash your hands (according to procedure #1).	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

NASAL CANNULA CARE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Put on gloves (according to procedure #2).	2. Protects you from contamination by bodily fluids.
3. Remove nasal cannula and clean nostrils with a soft cloth or tissue once each shift or as needed.	3. Removes any accumulation of dried drainage that may be present.
4. Note any redness or irritation of the nares or behind the ears and notify nurse if present. Continue procedure only if instructed.	4. Provides nurse with necessary information to properly assess resident's condition and needs.
5. Replace nasal cannula.	
6. Remove gloves (according to procedure #2).	
7. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

PALM CONES	
STEP	**RATIONALE**
1. Do initial steps.	
2. Place palm grip or cone in cleansed and dried resident hand.	2. Cleansing and drying of hands prevents odor and infection.
3. Check hand(s) every shift; cleanse and dry hands. Check for areas of redness, swelling, or open areas and report to the nurse. Replace cone(s).	3. Allows you to identify early signs of skin breakdown.
4. Note covering of palm cone and send to laundry when soiled, re-covering cone with a clean covering.	4. Maintaining cleanliness enhances resident's dignity.
5. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

PASSING FRESH ICE WATER	
STEP	**RATIONALE**
1. Do initial steps.	
2. Obtain cart, ice container, and ice scoop and go to ice machine. Keep ice scoop covered.	
3. Fill container with ice using ice scoop.	
4. Replace ice scoop in proper covered container, or cover it with a clean towel or plastic bag to prevent contamination.	4. Keeping the ice scoop covered maintains infection control practices.
5. Proceed to resident rooms, noting any fluid restriction(s) prior to pass and any residents who require thickened liquids.	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.
6. Empty water from pitcher and bedside glass into the sink.	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.
7. Take pitcher into hall and fill it with ice. NOTE: Do not touch the pitcher with the ice scoop.	7. The ice scoop is utilized for all residents thus should not be contaminated by touching a water pitcher.
8. Replace the scoop in covered container, clean towel or plastic bag between rooms to prevent contamination.	8. Maintains infection control practices.
9. Return to resident's room and fill pitcher with water at bathroom sink.	9. Ensures that resident has fresh ice water in pitcher.
10. Pour fresh water into bedside glass and leave a straw with the glass if needed.	10. Ensures that water is available and ready for resident when he/she desires it.
11. Offer the resident a drink of fresh water if resident is present.	11. Resident may be unable to independently get a drink of water.
12. Repeat procedure until all residents have been provided with fresh ice water.	12. Ensures that all residents receive fresh ice water.
13. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Instructor Signature	Date

PEDICULOSIS TREATMENT	
STEP	**RATIONALE**
1. Do initial steps.	
2. Put on gloves (according to procedure #2).	2. Maintains contact precautions in that pediculosis is spread by direct contact.
3. Shampoo infected scalp area using prescribed medicated shampoo obtained from nurse.	3. Utilizing prescribed medicated shampoo will kill the pediculosis.
4. Comb hair with a fine tooth comb (according to procedure #29).	4. Removes any remaining pediculi in the hair.
5. Assist resident to put on clean clothing.	5. Prevents re-infestation of the resident.
6. Strip bedclothes and send to laundry.	6. Prevents re-infestation of the resident and decreases risk of transmission to other residents.
7. Disinfect combs and brushes according to facility policy.	7. Prevents re-infestation of the resident.
8. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

POST-MORTEM CARE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Put on gloves (according to procedure #2).	2. Protects you from contamination by bodily fluids.
3. Respect the family's religious restrictions regarding the care of the body, if applicable.	3. Residents/families have the right to freedom of religion.
4. Assist roommate to leave the area until body is prepared and removed, if appropriate.	4. Reduces the roommate's stress.
5. Place body in supine position (according to procedure #3).	5. Prepares body for procedure.
6. Place one pillow beneath resident's head.	6. Prevents blood from discoloring the face by settling in it.
7. Close the eyes.	
8. Insert dentures, if this is the facility policy, and close the mouth.	8. It is easier to put dentures in the mouth right away and gives the face a natural appearance.
9. Cleanse body as necessary. Comb hair (according to procedure #29).	9. Prepares the body for viewing by family and friends.
10. Place a pad under the buttocks to collect any drainage.	10. Due to total loss of muscle tone, urine and/or stool may drain from the body even after death.
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.	
12. Remove gloves (according to procedure #2).	
13. Do final steps.	
14. After the mortuary has removed the body, strip the bed and clean the room according to facility policy.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Student/CNA Signature	Date
_____	_____
Instructor Signature	Date

PROSTHESIS CARE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Prepare affected area according to physician order. Observe affected area for skin breakdown or irritation, redness, or tenderness and notify nurse if present. Continue procedure only if instructed.	2. Allows you to identify early signs of skin breakdown.
3. Apply prosthesis according to manufacturer's directions.	3. Equipment used incorrectly may cause discomfort and injury to the resident.
4. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

SCABIES TREATMENT	
STEP	**RATIONALE**
1. Do initial steps.	
2. Put on gown.	
3. Put on gloves (according to procedure #2).	3. Use of gown and gloves maintains contact precautions. Scabies is spread by direct contact.
4. Shower resident (according to procedure #32).	4. Ensures resident is clean prior to application of prescribed lotion.
5. While in shower apply prescribed lotion obtained from nurse to entire body except face.	5. Utilizing prescribed lotion will kill the scabies. Lotion may be irritating to sensitive facial skin.
6. Allow the lotion to dry and assist resident to get dressed in clean clothes.	6. Lotion is left on the body thus should dry prior to dressing resident. Dressing the resident in clean clothing assists in the prevention of re-infestation.
7. 12-24 hours later, shower resident with regular soap (according to procedure #32) and dress in clean clothes.	7. Showering with regular soap will remove the medicated lotion. Medicated lotion left on the skin may be irritating. Dressing resident in clean clothes prevents reinfestation.
8. Strip bedclothes and send to laundry.	8. Prevents re-infestation of the resident and decreases risk of transmission to other residents.
9. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

SHAMPOOING HAIR	
STEP	**RATIONALE**
1. Do initial steps.	
2. Help resident into shower room.	2. Shampooing is usually done during the shower. The majority of long-term care residents are unable to maintain a position that would allow washing hair at the sink.
3. Help resident remove clothing and drape with a bath blanket.	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
4. Turn on water and have resident check water temperature.	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.
5. Place cotton in the resident's ears, if he/she desires.	5. Keeps water from entering resident's ears.
6. Give the resident a washcloth to cover his/her eyes during the shampoo, if he/she desires.	6. Prevents soap and water from entering into resident's eyes.
7. Assist resident into the shower.	
8. Wet the resident's hair.	
9. 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.	9. Utilizing fingertips massages the scalp and decreases the risk of scratching the resident.
10. Rinse the resident's hair thoroughly.	10. Leaving soap in the hair can cause excess dry scalp.
11. Use a conditioner if the resident desires you to do so, following steps 9 & 10.	
12. Shower resident (according to procedure #32).	
13. Turn off the water.	
14. Remove cotton balls from the resident's ears, if utilized.	
15. Dry the resident's neck and ears.	

16. Towel dry the resident's hair.	
17. Use a dryer on the resident's hair, if desired.	
18. Comb and style resident's hair (according to procedure #29).	18. Helps maintain resident's dignity and self-esteem.
19. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

SHOWERING A RESIDENT USING A SHOWER BED	
STEP	**RATIONALE**
1. Do initial steps.	
2. Assist/transfer resident to shower bed and transport to shower room.	
3. Undress the resident.	
4. Turn on water and have resident check water temperature.	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.
5. Shampoo and rinse resident's hair, if necessary.	
6. Let resident wash as much as possible, starting with face.	6. Encourages resident to be independent.
7. Turn off the water.	
8. Pat dry the resident and cover him/her with a bath blanket.	8. Patting dry prevents skin tears and reduces chaffing. Covering with a bath blanket maintains resident's dignity and right to privacy by not exposing body and keeps resident warm.
9. Transport back to room and transfer back to bed.	
10. Dress resident (according to procedure #20) and comb resident's hair (according to procedure #29).	
11. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

SPLINTING DEVICES	
STEP	**RATIONALE**
1. Do initial steps.	
2. Check affected joints. If swelling, redness, or warmth is present or if resident complains of pain, notify nurse. Continue procedure only if instructed.	2. Indicates inflammation in joint which can be worsened if splint is applied.
3. Apply splint according to therapy recommendations and physician's order.	3. Application of splint not in accordance with therapy recommendation could cause injury or discomfort to resident.
4. Remove splint after designated period of time again assessing for swelling, redness, warmth, or complaint of pain and notifying the nurse if present.	4. Indicates inflammation in joint. Notifying nurse provides him/her with information to assess resident's condition and needs.
5. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

STOOL SPECIMENS	
STEP	**RATIONALE**
1. Do initial steps.	
2. Prepare label for specimen with appropriate information and place it on specimen container, not the lid.	2. Label contains resident's identifying information which is essential for the laboratory. Label should be placed on specimen container in the event lid is misplaced or thrown away.
3. Put on gloves (according to procedure #2).	3. Protects you from contamination by bodily fluids.
4. Have resident utilize a clean bedpan or other collecttion device during bowel movement. Instruct resident not to urinate into specimen or place toilet paper in it.	4. A clean collection device is necessary for accurate lab evaluation. Urine contaminated stool will produce an inaccurate result.
5. Use a wooden tongue blade to remove 1-2 tablespoons of feces from collection device. Try to collect material from different areas of the stool.	5. In order to ensure adequate amount of stool for test ordered. Obtaining material from different areas ensures that all possible contents will be identified.
6. Put lid on specimen container and dispose of remaining stool.	
7. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

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

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

TEPID SPONGE BATH	
STEP	**RATIONALE**
1. Do initial steps.	
2. Take resident's temperature by route appropriate for resident (according to procedure #42 or #43).	2. Provides nurse with a baseline temperature reading.
3. Exposing one part of the body at a time, gently sponge with tepid water (lukewarm) for approximately 5 minutes. Begin with face and extremities, then back.	3. Slow, gentle motions are indicated because firm rubbing motions increase heat production. Cool sponges given rapidly or for a short period of time tend to increase the body's heat production.
4. While sponging, place cool compresses on forehead, axillas, and groin.	4. The axillary and groin areas contain large blood vessels that are close to the skin's surface, which aid the transfer of heat.
5. Monitor temperature every ten minutes while sponging resident.	5. To evaluate the effectiveness of the bath.
6. After completing the bath, take resident's temperature again.	6. To evaluate the effectiveness of the bath.
7. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

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

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

TRANSFER TO STRETCHER/SHOWER BED	
STEP	**RATIONALE**
1. Do initial steps.	
2. Loosen sheet directly under resident and roll edges close to resident.	2. This sheet will be utilized to slide resident from bed to stretcher.
3. Place stretcher/shower bed at bedside. NOTE: Make certain wheels are locked.	3. Wheels must be locked to prevent stretcher from moving.
4. Staff should be present at the bedside as well as on the opposite side of the stretcher/shower bed. (Number of staff required will be dependent upon size of resident.)	4. To prevent resident from falling/rolling off of bed or stretcher.
5. Staff should grasp sheet on each side of resident. On the count of three, slide resident laterally onto stretcher/shower bed.	5. Counting to three enables staff members to work together to distribute weight evenly and prevent injury to resident and/or staff.
6. Center and align resident. Place pillow under his/her head and cover with a blanket and raise the rails of stretcher/shower bed.	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.
7. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

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

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

TUB BATH	
STEP	**RATIONALE**
1. Do initial steps.	
2. Help resident into the bathroom.	
3. Turn on water and have resident check water temperature.	3. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.
4. Fill tub to level resident wishes.	
5. Help resident undress and get into the tub.	
6. Help resident shampoo and rinse hair, if resident desires.	
7. Let resident wash as much as possible, starting with face.	7. Encourages resident to be independent.
8. Stay with resident during the bath.	8. Provides for resident's safety.
9. Help resident out of the tub.	9. Reduces risk of falling.
10. Help resident pat self-dry.	10. Patting dry prevents skin tears and reduces chaffing.
11. Check skin for redness, open areas, or irritation.	11. Allows you to identify early signs of skin breakdown.
12. Help resident dress, comb and dry hair, and return to room.	12. Combing hair in tub room allows resident to maintain dignity when returning to room.
13. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

URINE SPECIMENS	
STEP	**RATIONALE**
1. Do initial steps.	
2. Prepare label for specimen with appropriate information and place it on specimen container, not the lid.	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.
3. Put on gloves (according to procedure #2).	3. Protects you from contamination by bodily fluids.
4. Have resident urinate in specimen cup or clean bedpan, urine hat, etc. Instruct resident not to place toilet paper in collection container.	4. A clean collection device is necessary for accurate lab evaluation. Toilet paper will contaminate the urine and produce an inaccurate result.
5. If utilizing a bedpan or other collection container, pour appropriate amount of urine into specimen container.	5. Urine specimen should be no less than 30-60 ccs.
6. Put lid on specimen container and dispose of remaining urine. Be certain to measure and record amount if resident is on intake and output.	6. Intake and output measures all fluid excreted.
7. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

USING A GAIT BELT TO ASSIST WITH AMBULATION	
STEP	**RATIONALE**
1. Do initial steps.	
2. Assist resident to sit on edge of bed (according to procedure #7).	2. Allows resident to adjust to position change.
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.	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.
4. Assist the resident stand on count of three.	4. Allows you and the resident to work together.
5. Allow resident to gain balance.	5. Change in position may cause dizziness due to a drop in blood pressure.
6. Stand to side and slightly behind resident while continuing to hold onto belt. Position one hand on the belt at the resident's side and the other hand at the resident's back.	6. Allows clear path for the resident and puts you in a position to assist resident if needed.
7. Walk at resident's pace.	7. Reduces risk of falling.
8. Return resident to chair or bed and remove belt.	
9. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date

VAPORIZERS/HUMIDIFIERS	
STEP	**RATIONALE**
1. Do initial steps.	
2. Prepare vaporizer/humidifier according to manufacturer's instructions.	2. Equipment used incorrectly may cause discomfort and injury to resident.
3. Position vaporizer/humidifier on the bedside stand or a nearby table.	
4. Plug vaporizer into electrical outlet.	
5. Steam should be permitted to flow generally into the room.	5. Steam should not be allowed to flow directly onto resident due to risk of burns.
6. Frequently check the water level; refill as necessary.	6. Vaporizer/humidifier will not function properly without adequate amount of water.
7. Do final steps.	
8. Clean vaporizers/humidifiers routinely according to facility policy.	

I verify that this procedure was taught and successfully demonstrated according to facility policy.

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Student/CNA Signature Date

_____ _____

Instructor Signature Date