

NOTES REGARDING SKILLS

1. This skills checklist was updated on 07/27/26. Occasionally the instructors miss new steps. Please read each skill step as they teach it and let them know if they are missing anything. 😊 If you believe or are told, the skills should be taught differently, if you notice mistakes, or have questions regarding the skill steps that your instructor is unable to explain, please feel free to contact the Director Paulene Kipke via email @ Paulene@QualityCNATraining.com or call 715-281-5064.
2. **ALL SKILLS AND ALL SKILL STEPS LISTED BELOW MUST BE TAUGHT/PERFECTED AS PART OF THIS CLASS.**
3. **SKILL STEP COLORS:** **BLACK** and **BLUE** skill steps are required to be performed on the job. **Highlighted skills** denote a skill you might be tested on during your State of WI Skills Exam. Skill steps in **BLUE** denotes skill steps that are required during state testing, AND **BOLDED BLUE** denotes steps that are critical steps and an automatic failure if missed.
4. A highlighted **BLUE** numbered area, denotes a skill within a skill. Ex: The complete handwashing skill is done at the end of *PPE, Bedpan/Fracture pan, Cath Care and Peri-Care*. Handwashing/hand sanitizing are not independent “Testable” skills.
5. Only demonstration of peri-care and cath-care can be performed on the manikin. ALL of the other skills **MUST** be performed on a class member AND a class member **MUST** perform each skill on you.
6. Preparation and completion steps must be performed for each skill in both the lab and in clinical. Students may perform the actual skill to perfection but tend to fail the overall skill just for missing multiple preparation and completion steps.
7. Vitals, I & O, and urinary output must be written on the provided recording form. This can NOT be verbalized; they are testing you on your documentation abilities. Students frequently fail the final exam for not knowing the normal average numbers for vitals.
8. All supplies/equipment (wash basins, emesis basins, etc.) should be emptied, rinsed, and **DRIED** before returning them to the proper storage area. The only **EXCEPTION** is for supplies containing urine (bed pan, fracture pan and graduates). To prevent cross contamination, urinary supplies are only emptied & rinsed, they are NOT dried.
9. The toilet/sink are considered to be in the client’s room, because you are not “leaving” the room, NO glove change is necessary.
10. ONLY Feeding, Peri-care, and Cath-care **REQUIRE** more than one washcloth to be used. All other skills only require 1 washcloth.
11. When testing, if you are unsure whether you should or shouldn’t do it, do it! 😊 You can’t be docked for doing more, just less.

*** PREPARATION STEPS** SKWIPES ACRONYM - *These steps should be completed BEFORE EVERY skill.*

Preparation steps shown in blue by each skill listed below are specifically tested within that skill.

NOT AN INDEPENDENT SKILL – THIS IS DONE AS PART OF EACH SKILL

- ___ 1 **S**upplies: Gather all necessary supplies and place them in a clean area of the room.
- ___ 2 **K**nock on the door.
- ___ 3 **W**ash or **SANITIZE** your hands and put on gloves if needed.
- ___ 4 **I**dentify the client, address them by their preferred name and **I**ntroduce yourself.
- ___ 5 **P**rivacy: **PULL THE PRIVACY CURTAIN** (*when testing*) OR close the door, window curtains, blinds, or shades when on the job.
- ___ 6 **E**xplain the procedure speaking clearly, slowly & directly, maintaining face-to-face contact with the client when possible.
- ___ 7 **S**afety: Ensure BED and Wheelchair Brakes are locked /Unlocked, and ensure client safety **AT ALL TIMES**.
- ___ 8 Adjust the bed height between mid-thigh and waist level when needed. This is **REQUIRED** when applying Compression Socks, Bed Bath, Dressing Assistance, Perineal-Care, Positioning on the Side and ROM Upper & Lower.
- ___ 9 Maintain respectful, courteous interpersonal interactions the entire time you are with the client. **TALK TO THEM!!**

*** COMPLETION STEPS** CLOUDS ACRONYM - *NOTE: These steps should be completed at the END of EVERY skill*

Completion steps shown in blue by each skill listed below are specifically tested within that skill.

- ___ 1 **C**omfort: Ensure the client is in a **C**omfortable position in good body alignment.
- ___ 2 **L**ower the bed AND **L**ower the side rails (*you can add place call **L**ight within reach here if the 3 L’s makes it easier for you*)
- ___ 3 **O**pen the privacy curtain.
- ___ 4 **W**ash or sanitize your hands after properly removing & disposing of gloves into the waste container without contaminating yourself.
- ___ 5 **D**ocument and Report as needed.
- ___ 6 **S**ignaling device: Place the signaling device (call light, pendant, etc.) within reach.
- ___ 7 Put away all of your supplies and ensure the room is clean and tidy.
- ___ 8 Ask the client... “Is there anything else I can get for you before I leave?”

NOTE: I suggest using a highlighter or writing your supply list off to the right-hand side to identify the supplies you need within each skill so you can easily identify them and when to use them. I did HANDWASHING for you in yellow.

* **HANDWASHING** NOTE: HANDWASHING is only necessary upon completion of PPE, Bedpan/Fracture pan, Cath Care, Peri-Care.

NOT AN INDEPENDENT SKILL – THIS IS DONE AT THE END OF THE 4 REQUIRED SKILLS NOTED ABOVE

- ___ 1 Remove your watch, or push it up your forearm, and roll or push up your sleeves. Ensure uniform and hands do NOT touch the sink.
- ___ 2 Turn on the water at sink and adjust the temperature until it is comfortably warm. Avoid splashing water on your uniform.
- ___ 3 Place BOTH hands under the running water to COMPLETELY wet your hands and wrists - keeping them lower than your elbows.
- ___ 4 Apply **antimicrobial soap** from the dispenser to your hands. Apply a palm-sized amount or enough to create a visible lather.
- ___ 5 Interlace your fingers pointing downwards while rubbing your hands together vigorously to work up a lather.
- ___ 6 Lather all the surfaces of wrists, hands, fingers, and nails producing friction for at least 20 seconds.
 - Rub hands palm to palm.
 - Rub back of right and left hand (fingers interlaced to clean between fingers).
 - Rub palm to palm with fingers interlaced.
 - Perform rotational rubbing of left and right thumbs.
 - Rub fingertips against the palm of opposite hand to clean fingernails.
 - Rub wrists by grasping and circling with other hand.
 - Repeat sequence at least two times.
 - Clean under fingernails with disposable nail cleaner (if applicable).
 - Keep fingertips pointing downward throughout.
 - Keep hands and forearms lower than elbows during the entire washing.
- ___ 9 After lathering for at least 20 (twenty) seconds, rinse all surfaces of wrists, hands, and fingers. Keep your hands lower than the elbows and the fingertips down so that water runs off your fingertips. Do not shake water from your hands.
- ___ 10 Use a clean, dry **paper towel** to dry all the surfaces of your hands, wrists, and fingers then dispose of the paper towel into the waste container. DO NOT wipe up excess water off the edges of the sink or counter.
- ___ 11 Use another clean, dry paper towel to turn off the faucet and then dispose of the paper towel into the waste container. Exit by opening the door with your hip or shoulder. If there is a handle, use another clean, dry paper towel to open the door.
- ___ 12 Do not touch inside of sink at any time. DO NOT RECONTAMINATE YOUR HANDS at any point during the procedure!

* **HAND SANTIZE / HAND HYGIENE** **NOT AN INDEPENDENT SKILL – THIS IS DONE AS PART OF THE SKILLS**

NOTE: Hand sanitization is **REQUIRED** at the beginning and end of each skill, unless otherwise specified.

- ___ 1 Remove jewelry/watch or push it up your arm so it is above your wrists.
- ___ 2 Apply enough **hand sanitizer** into the palm of one hand to cover your hands thoroughly per product directions.
- ___ 3 Rub your hands together, covering all surfaces of your hands and fingers until the alcohol is completely dry (a minimum of 30 seconds)
 - Rub hands palm to palm.
 - Rub back of right and left hand (fingers interlaced).
 - Rub palm to palm with fingers interlaced.
 - Perform rotational rubbing of left and right thumbs.
 - Rub your fingertips against the palm of your opposite hand.
 - Rub your wrists.

* **CONSCIOUS CHOKING ADULT**

DISCUSS DNR AND DISCUSS FACILITY SAFETY PROTOCOLS

- ___ 1 Stand behind person with one foot forward between the victim's legs and the other off to the side for balance. If the person is sitting in a wheelchair or not able to stand, lean them forward in the chair and stand behind them. For a child, move down to their level and keep your head to one side.
- ___ 2 Wrap arms around victim's waist. Using 2 fingers from one hand, find the persons navel. Place the thumb side of your fist against the abdomen just above the navel.
- ___ 3 Cover the fist with other hand and pull inward and upward into the victim's abdomen with quick jerks to give abdominal thrusts.
- ___ 4 For a responsive pregnant victim, any victim you cannot get your arms around, or for anyone in whom abdominal thrusts are not effective, give chest thrusts while standing behind them. Avoid squeezing the ribs with your arms.
- ___ 5 Continue thrusts until the victim expels the object or becomes unresponsive.
- ___ 6 If the person becomes unconscious, perform standard cardiopulmonary resuscitation (CPR) with chest compressions and rescue breaths.
- ___ 7 After choking stops, seek medical attention for the client.

Note: Contact Precautions (gown & gloves) are part of the State Testable Skill: Emptying / Measuring a Urinary Drainage Bag.

- 1 Gather Supplies: Gown, mask, face shield, goggles, and hand sanitizer. In a facility these will be located outside of the client's door.
- 2 **SANTIZE HANDS**
- 3 Put on the gown
 - Unfold the gown so you are facing the back opening of the gown.
 - Put your arms into the sleeves.
 - Secure the neck opening, then secure the waist. Ensure that the back flaps overlap covering your clothing as much as possible.
- 4 Put on a mask. (NOT WORN DURING TESTING BUT USED FOR AIRBORNE AND DROPLET PRECAUTIONS)
 - Place over the mouth and nose and then bend the nose wire to adjust for comfort and fit
 - If mask ties behind your head, first tie the top strings then the bottom strings or place elastic loops behind ears. Adjust for comfort.
- 5 Put on goggles or face shield. (NOT WORN DURING TESTING BUT USED FOR AIRBORNE AND DROPLET PRECAUTIONS)
 - Place the earpieces of the glasses over your ears or the headband around your head and adjust if needed
- 6 Put on gloves. Put gloves on carefully so they do not tear – If they do, replace with a new glove. Inspect both gloves for rips and tears
 - Pull the gloves up over the wrist cuffs of the gown sleeves
- 7 Knock on the door. Perform “Emptying the Urinary Drainage Bag” as outlined within that skill. (*Taught later in the class – see page 14*)
- 8 When care is complete and before leaving the room, remove the gloves turning them inside out BEFORE removing the gown.
 - With one gloved hand, grasp the other glove at the wrist. Slightly tug or pull to fold the wrist of the glove over so it makes a cuff at the palm area. This will make it easier to slip your fingers from your bare hand under the cuff of the glove to completely remove it without touching the gown (contaminating yourself) AFTER you have completely removed the glove on your other hand.
 - Using your fingertips from the half-gloved hand, grasp the gloved hand at the wrist, and remove the glove turning it inside out.
 - Dispose of the glove or roll it into a ball in the palm of the still half-gloved hand.
 - Slip your fingers from the ungloved hand under the cuff of the remaining glove touching only the clean inside of the glove to ensure that you do NOT contaminate yourself.
 - Remove the glove completely turning it inside out as it is removed.
 - Dispose of the gloves into the designated waste container without contaminating yourself.
- 8 Touching ONLY the earpieces or the headband, remove safety glasses and place in designated receptacle for cleaning or disposal.
- 9 Carefully remove the gown without touching the outside of the gown.
 - Unfasten the gown at the neck AND at the waist.
 - Pull one sleeve JUST OVER the fingertips of your hand by slipping your fingers from opposite hand under the cuff of the sleeve AT the wrist where it was covered with the glove. With your now covered hand, grasp the cuff of the other sleeve pulling it over your fingertips also. Hold both arms out and away from your body to ensure the gown does not touch the floor.
 - Remove the gown by pulling it forward (folding soiled area to soiled area) ensuring you are ONLY touching the inside of the gown.
 - Dispose of gown into the designated container without contaminating yourself
- 10 Remove mask
 - Untie the bottom strings, and then the top strings, or pull the elastic loops from around the ear.
 - Hold the mask by the strings and dispose into the appropriate waste container.
- 11 Perform HANDWASHING skill as outlined within that skill. This must be performed after emptying a urinary drainage bag.

*** COUNT & RECORD RADIAL PULSE AND RESPIRATIONS**

DISCUSS HOW TO TAKE AN APICAL PULSE

- 1 Preparation Steps (SKWIPES). (Sanitize hands & explain) Maintain respectful, courteous interpersonal interactions at all times.
- 2 Make sure that the person is in a comfortable, relaxed position with their arm in a resting position.
- 3 Locate the radial artery by gently pressing 2 - 3 fingers on the thumb side of the inside of the wrist.
- 4 Using the second hand of a clock (your watch or the wall clock), count the beats for one full minute. Cue the instructor/observer when you are going to start and again when you end.
- 5 Note the rhythm and force of the pulse. **Normal PULSE rate for adults is between 60 – 100 beats per minute.**
- 6 Record the pulse rate on your recording slip (*You must be within plus or minus 6 beats of the instructor or observer's reading*).
- 7 Count respirations for one full minute. Cue Instructor/observer when you are going to start and again when you end.
- 8 Note the rhythm and depth of the respirations and whether the client is having difficulty breathing.
- 9 Record the respiration rate on your recording slip (*You must be within plus or minus 2 breaths of the instructor or observer's reading*). **Normal RESPIRATION rate for adults is between 12 – 20 breaths per minute.**
- 10 Completion Steps (CLOUDS). (Provide call light and sanitize hands AGAIN)

MEASURING TEMPERATURE- ORAL, TYMPANIC, TEMPORAL, RECTAL, AXILLARY, VARIOUS ELECTRONIC DEVICES

Normal AVERAGE'S: Oral & Tympanic Temperature - 98.6 Rectal Temperature - 99.6 Axillary temperature - 97.6

DISCUSS OXYGEN ADMINISTRATION, TUBING CARE, FILLING TANKS, ETC

Some facilities require the CNA's to oversee this but we do not provide training. This is discussed. Additional on the job training is needed.

* MEASURE & RECORD WEIGHT OF AMBULATORY CLIENT

DISCUSS HOW TO MEASURE HEIGHT OF CLIENT

- ___ 1 Preparation steps (SKWIPES).
- ___ 2 Ensure that the client has nonskid footwear on and assist the client to a standing position by offering them an arm. The client should pull on your arm/elbow, you should NOT pull on their arm or shoulder) and then walk WITH the client to the scale.
- ___ 3 Balance the scale to zero and assist the client onto the scale. Ensure the client is centered with their arms at their side.
- ___ 4 Stand next to the client. Adjust the scale to obtain the client's weight. Ensure the sliding weight is in the lb. slot and not the kg slot.
- ___ 5 Help the client to step off the scale, and return the client to their chair, assist them to sit in their chair, and provide their call light.
- ___ 6 Record the weight based on the indicator on the scale.
- ___ 7 Finish with your completion steps (CLOWDS).

NOTE: Some facilities may also utilize chair, bed, dependent lift, or wheelchair scales, etc. For accurate measurements, always use the same type of scale obtain the weight around the same time of day. When using a wheelchair scale, subtract the weight of the wheelchair from the total weight. Ensure that footrests, cushions, or other items/devices are also taken into consideration when calculating the weight. Fasting weights are taken in the morning after the client has used the bathroom but before they have eaten breakfast. Weight fluctuations of +/- 2lbs. in one day or +/- 5 lbs. in one week should be reported to the nurse.

MEASURES AND RECORDS BLOOD PRESSURE *(This is taught in addition to the 75-hour training program)*

- ___ 1 Preparation steps (SKWIPES) Supplies Needed: sphygmomanometer, stethoscope, alcohol wipe to clean ear pieces
- ___ 2 Position client. Blood pressure is typically taken with the client in a seated or upright position, the arm should be placed palm up and resting comfortably on the bed, their lap, tabletop, etc. and both feet should be flat on the floor, if sitting.
- ___ 3 Clean the diaphragm and earpieces of the stethoscope with an alcohol wipe and discard the wipe.
- ___ 4 Loosen the screw on the bulb by turning it to the left. Squeeze any excess air out of the cuff. Expose the person's upper arm and locate the brachial pulse. This is found slightly above the crease of the elbow in the upper arm to the medial side of the bicep muscle.
- ___ 5 Place the cuff snugly on person's arm about one inch above the elbow and adjust the cuff so that the arrow/artery marker is directly over the brachial artery.
- ___ 6 Place the earpieces in your ears with the tips facing forward toward your nose. Place the stethoscope diaphragm over the brachial pulse.
- ___ 7 Inflate the cuff by first tightening the screw (turning it to the right) and pumping the bulb to fill the cuff with air. The cuff should be inflated to 30-40 mm Hg above the person's normal systolic blood pressure. Once inflated, let air out slowly (2 – 4 mm Hg per second) while listening for the first pulse sound (the first beat you can hear) – remember that number – and then listen for when the pulse sounds stop - remember that number. The number for the first beat that you hear was the systolic pressure and the number where you stopped hearing beats was the diastolic pressure. Deflate the cuff all the way and remove it from the person's arm.
- ___ 8 Record your reading as a fraction with the systolic pressure on top and the diastolic pressure on the bottom.
- ___ 9 Clean up and put away your supplies. Completion steps (CLOWDS). **Normal AVERAGE blood pressure is 120/80.**

Notes:

- *No caffeine or nicotine should be used 30 minutes prior to taking a blood pressure*
- *Tight clothing or bulky clothing may need to be removed before taking a blood pressure*
- *Taking a blood pressure immediately after a previous measurement will elevate the second reading – You should wait one full minute before retaking or switch to another arm*
- *Affected arms/limbs should not be used to measure blood pressure – Ex. Affected side of a client with a stroke, side of a mastectomy, arm used for dialysis, injured/paralyzed side, etc.*
- *If person was physically active, allow them to rest for at least 5 minutes prior to obtaining their blood pressure*
- *The person should avoid talking while their blood pressure is taken*
- *A cuff that is placed too tightly can artificially elevate blood pressure while a cuff that is too loose can artificially lower blood pressure*

* MEASURING INTAKE **NOT AN INDEPENDENT SKILL – THIS IS DONE AS PART OF THE FEEDING SKILL**

*** FOOD INTAKE NOTE: Record Food intake within +/- 25% of the Instructor/Observer.**

- ___ 1 Visually cut the plate into 10 even sections.
- ___ 2 Total the amount of sections containing little to no food. Each section equals 10%.
- ___ 3 Record the amount per facility procedure (some facilities will round to 25%, 50%, 75%, etc).
- ___ 4 Report any changes in the amount the person normally eats to the nurse.

*** FLUID INTAKE NOTE: Recorded Intake within +/- 60 mL of the Instructor/Observer. Record in mL/cc/oz depending on facility policy.**

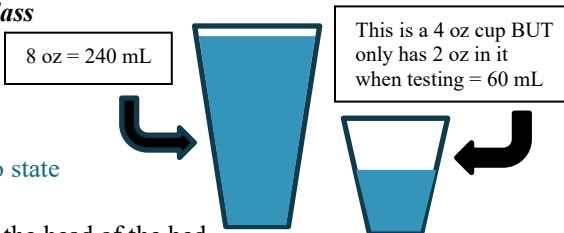
- ___ 1 Use only facility approved measurements and abbreviations.
- ___ 2 Estimate the amount consumed from each glass and combine the totals. **1 oz (ounce) = 30 mL (milliliters)**
- ___ 3 Record the total estimated intake per facility policy.

*** ASSIST CLIENT WHO IS DEPENDENT WITH A MEAL** Supplies: Prepared meal tray, clothing protector, washcloth, pen, sanitizer

NOTE: When testing... the tall 8 oz glass has 240 mL of fluid in it and the short 4 oz glass

when full holds 120 mL BUT it is only HALF full, meaning that it starts with 60 mL.

This is for residents on fluid restrictions. The combined total of the 2 glasses is 300 mL.



- 1 Preparation steps (SKWIPES). (Sanitize, Explain)
- 2 Before feeding the client, pick up their name card from the tray and ask the client to state their name. Verify the diet, diet texture, and liquid consistency matches the card.
- 3 Assist the client to an upright seated position (AT LEAST 45 degrees) by elevating the head of the bed.
- 4 Protect the client's clothing by placing a clothing protector or towel on the client. Then position the tray directly in front of the client.
- 5 Provide hand hygiene for the resident BEFORE feeding covering ALL surfaces of the resident's hands and ensuring they are dry. You can also use hand sanitizer but QCNAT encourages a wet washcloth that is rung out well so the hands dry quickly. (My mother always sent me to WASH my hands before supper, never to sanitize them. Our residents deserve the same courtesy.)
- 6 Move the tray table over the bed in front of the client and sit down FACING the client at eye level. Make sure to sit down on the opposite side of the tray table support bar. The table should be easy to push out of the way if the resident starts to choke.
- 7 Remember to wipe the client's mouth at least once during the meal and then as needed throughout the meal.
- 8 Tell client what foods are on the tray. Be specific. Don't say "pudding" say "choc. pudding". Ask them what they would like to eat first.
- 9 Offer the food in small amounts, telling the client the contents of each spoonful. Allow the client plenty of time to chew and swallow.
- 10 Offer EACH beverage frequently during the meal or as directed on the menu card.
- 11 Ask the client if they are ready for the next bite of food or sip of beverage, telling the client the content of each spoonful. If the client is unable to respond, make sure the client's mouth is empty before offering more.
- 12 When the client states that they are full, clean the client's face and hands with the wet washcloth and leave the client sitting upright at least 30 degrees for at least 30 minutes. Leave the client clean and free of food debris.
- 13 Remove the food tray. Record the intake of solid food eaten within +/- 25% of the Instructor/Observer and record the fluid intake within +/- 60ml of the Instructor/Observer on the previously signed recording form.
- 14 Place the tray in the designated storage area.
- 15 Completion steps (CLOUDS). (Be Respectful, Call light, Sanitize)

DISCUSS IDDSI DIET, DIET TYPES, ADAPTIVE EQUIPMENT, MEAL SAFETY, GASTROSTOMY FEEDINGS

WHEELCHAIR (W/C) TRANSPORT GUIDANCE NOTE: ALWAYS ensure the brakes are UNLOCKED before leaving client!!!!!!

- 1 Ensure the client's feet are positioned properly on the footrests.
- 2 Walk on the right side of hall.
- 3 Turn W/C around to walk backwards down ramp so the client is facing uphill, this prevents them from tipping forward out of the W/C.
- 4 Enter and exit rooms /elevators backwards.
- 5 Use caution when walking past doorways, around corners, and at hallway intersections.
- 6 Take care not to bump the client's arms and legs on doorframes when passing through doorways.
- 7 Lock the brakes of an unoccupied wheelchair so that it will not roll away if a client attempts to self-transfer into it.

*** MAKING AN UNOCCUPIED BED**

DISCUSS FLOATING HEELS, FOOT CRADLE'S

- 1 Preparation steps (SKWIPES). Place your linens on a barrier. Arrange them in the order they will be used (fitted sheet should be on top).
- 2 Raise the bed between mid-thigh and waist level. Adjust the bed so that it is in a supine (flat) position.
- 3 Put on clean gloves and remove any personal client items, including clean blankets and the bedspread. Place them in a clean area.
- 4 Remove the pillowcases. Place dirty pillowcases in the hamper and place the pillows in a clean area.
- 5 Without contaminating your uniform, move around the bed to loosen linens, then fold or roll them towards the center of the bed.
- 6 Remove the dirty linens and place them in the hamper (do not put dirty linens on the over-bed table or on the floor).

NOTE: ONLY if your gloves are VISIBLY soiled, do you need to remove them. If not, you may leave them on to put on the clean linens as the linens will only have this resident's "dirt" on them OR you can make the bed without gloves on because the linens are clean.

- 7 Apply the mattress pad (if used – not used in labs), then apply a fitted sheet and secure all 4 corners of the bottom fitted sheet.
- 8 Ensure the bottom fitted sheet is centered, smooth, tight, and free of wrinkles.
- 9 Place the draw sheet (if needed), centering it and tucking it under the mattress. Then place a bed protector/chux (if needed).
- 10 Place the top sheet, blanket, and/or bedspread on top of the bed, seam side towards the ceiling and center them. Tuck/secure all of the linens together at the foot of the bed.
- 11 Make mitered corners at the foot of the bed to hold the linens in place.
 - While facing the foot of the bed, create a 45-degree angle from the corner of the bed with the sheet.
 - Place the angled edge of the sheet on top of the bed and tuck in anything hanging below the bed frame.
 - Lower the angled sheet back over the edge of the bed.
- 12 Properly apply clean pillowcases with the zippers and/or tags to the inside of the pillowcase. For presentation purposes, place the open end of the pillowcases facing AWAY from the door so the client and guests only see the clean seam when they enter the room.
- 13 Lower the bed and finish with your completion steps (CLOUDS).

* **MAKE AN OCCUPIED BED** – *NOTE: If the client has a catheter, IV, straps, etc. ensure that they are safely secured in place.*

- ___ 1 Preparation steps (SKWIPES). Place your linens on a barrier. Arrange them in the order they will be used (fitted sheet should be on top).
- ___ 2 Raise the bed between mid-thigh and waist level. Adjust the bed so that it is in a supine (flat) position. Raise the side rail on the opposite side of the bed.
- ___ 3 Put on clean gloves and remove personal client items, including clean blankets and the bedspread. Place them in a clean area.
- ___ 4 Cover the client and the dirty top sheet with a clean bath blanket, making sure the client is unexposed at all times.
- ___ 5 If able, ask the client to hold the bath blanket while you slowly remove the soiled top sheet by rolling it down to the foot of the bed to remove it. If client is unable to assist, you will need to lift the bath blanket to remove the dirty sheet. Place the soiled sheet in hamper.
- ___ 6 Explain to the client that you are going to assist them to roll onto their side towards the side rail. If able, ask them to reach out to grasp the siderail to support themselves. DO NOT lay the client on the bare mattress at any time.
- ___ 7 Adjust the client's pillow for comfort, keep the client covered at all times and if needed, properly clean the client's skin.
- ___ 8 Loosen the fitted/bottom sheet and mattress pad (if used) on the working side of the bed and roll or fan fold the fitted/bottom sheet and mattress pad toward the center of the bed placing it close to the client's back (almost tucking it up and under the client).
- ___ 9 If needed, clean and disinfect the mattress with disinfectant wipes.
- ___ 10 Properly place the clean mattress pad (if used), fitted/bottom sheet securing the corners, then draw sheet and/or bed protector (if used) on the exposed area. Roll or fan fold the layered linens together to tuck them under the client and the dirty linens. Ensure the bath blanket is NOT tucked also.
- ___ 11 Raise the second side rail. Assist the client to roll back onto the clean linens. Explain that they will feel a "bump" in the center.
- ___ 12 Adjust their pillow for comfort and ensure that the client remains covered at all times.
- ___ 13 Go to the opposite side of the bed. Lower the side rail. Remove the dirty linens without shaking them. Place them in the dirty hamper.
- ___ 14 If needed, clean the client's skin. Clean and disinfect the mattress with disinfectant wipes, if needed.
- ___ 15 Unroll the clean linens onto the remaining exposed area of the bed. Secure the fitted corners and smooth out the wrinkles.
- ___ 16 If needed, help the client to roll onto their back to the center of the bed. Adjust the pillow and ensure good body alignment.
- ___ 17 Place a clean top sheet over the covered client and remove the bath blanket, making sure that the client is unexposed at all times.
- ___ 18 If able, ask the client to hold the top sheet while you slowly remove the bath blanket by rolling it down to the foot of the bed to remove it. If client is unable to assist, you will need to lift the top sheet to remove the bath blanket. Place the soiled bath blanket in hamper.
- ___ 19 Gently lift the client's head while removing the pillow. Properly remove and dispose of the soiled pillowcase.
- ___ 20 Properly replace the pillowcase. Gently lift the client's head. Adjust the pillow for comfort. Ensure the opening faces away from door.
- ___ 21 Replace the blankets and bedspread, ensure the linens are centered on the bed, tuck the sheets under the foot of the mattress, make mitered corners, and create a cuff along the top of the linens to leave the bed neatly made. Lift the linens over the feet upward to create a toe pleat (this will allow the client to move their feet and prevent pressure).
- ___ 22 Completion steps (CLOUDS) - Return the bed to the low position. Lower the side rails. Ensure the client is comfortable. Remove and dispose of your dirty gloves. Gloves can and should be replaced at any time during the procedure if they become visibly soiled/dirty to prevent contaminating the fresh linens or soiling the client. Document any reddened areas or sores and take the appropriate action.

NOTES REGARDING BED MAKING: *Never allow linens to touch your uniform - Do not transfer linens from one room to another - Never place soiled linens on the floor - If clean linens touch the floor, they should be placed in the soiled laundry for cleaning and not used - Do not shake linens because it can spread airborne pathogens – Store clean linens in a closed closet or a covered cart.*

NECK EXERCISES FOR ACTIVE RANGE OF MOTION (ROM)

- ___ 1 Preparation steps (SKWIPES)
- ___ 2 Instruct the client to follow your directions for active range of motion, repeating each exercise 5 times or the number outlined in the client's care plan.
- ___ 3 Instruct the client to notify you if they are experiencing any pain/discomfort during the exercises.
- ___ 4 Demonstrate bending your head forward until your chin is close to or touching your chest and then let your head fall back until you are looking up at the ceiling. Have the client follow your lead. (As if saying "YES")
- ___ 5 Demonstrate turning your head as far as you can to one side, looking over your shoulder and have the client follow your lead. Hold the position for 10 seconds and then switch to the opposite side. (As if saying "NO")
- ___ 6 Demonstrate tilting your head to one side toward your shoulder and have the client follow your lead. Hold the position for 10 seconds and then switch to the opposite side. Ex: Ear to shoulder (As if saying "MAYBE SO") 😊
- ___ 7 Demonstrate pulling your chin in by moving your neck backward and then push your chin out by moving your neck forward again. Have the client follow your lead.
- ___ 8 Finish with your completion steps (CLOUDS).

* **PERFORM PASSIVE RANGE OF MOTION (PROM) - LOWER EXTREMITIES**

- 1 Preparation steps (SKWIPES). (Sanitize, Explain, Privacy) Repeat each exercise 5 times or the number outlined in the client's care plan.
- 2 Raise the bed to a comfortable height. Lay the bed in a flat position and assist the client to a supine position in good body alignment.
- 3 Explain the procedure. Instruct the client to tell you if they experience any pain or discomfort during the exercises. Watch the client's face and eyes for any expression of pain. **Do not cause any discomfort or pain during the exercise.**
- 4 **While performing the ROM exercises, you MUST ask client at least once if they're experiencing any pain or discomfort.**
- 5 **Hip & Knee Exercises:** Support the leg by placing one hand under the knee and the other under the ankle. Move the joint gently, slowly, and smoothly throughout the exercises. Discontinue if the client verbalizes pain. Do not force any joint beyond the point of resistance.
 - *Extension/Flexion: Bend the client's knee moving it up toward the head to flex, then straighten the client's leg to the normal position.
 - *Abduction/Adduction: Gently move the entire leg away from the other leg. Then return it to the center of the bed towards other leg.
 - Hip Rotation: Keeping the client's leg straight, pivot the client's entire leg inward and then outward as one movement to rotate the hip.
- 6 **Ankle Exercises:** Support the leg by placing one hand under the ankle and grasp the foot with the other hand. Keep the foot close to the bed. Move the joint gently, slowly, and smoothly through the ROM. Discontinue the exercise if the client verbalizes discomfort.
 - Dorsiflexion & Plantar Flexion: Push the foot towards the head (dorsiflexion). Pull the foot down towards the bed (plantar flexion).
 - Inversion and Eversion: Pivot the entire foot inward, then outward. This stretches/strengthens the muscles on the sides of the ankles.
- 7 **Toe Exercises:** Support the foot with one hand. Gently move the toes with the other hand slowly, smoothly, and gently through the ROM discontinuing the exercise if the client verbalizes any pain or discomfort.
 - Extension/Flexion: Place your hand on top of the toes. Curl the toes downward to curl them, then upward to straighten them.
 - Abduction/Adduction: Separate each toe from the one next to it, moving them apart and then together again.
- 8 Repeat on opposite leg. Finish completion steps (CLOUDS). (Comfortable Position, Lower Bed, Be Respectful, Call Light, Sanitize)

* **PERFORM PASSIVE RANGE OF MOTION (PROM) - UPPER EXTREMITIES**

- 1 Preparation Steps (SKWIPES). (Sanitize, Explain, Privacy) Repeat each exercise 5 times or the number outlined in the client's care plan.
- 2 Raise the bed to a comfortable height. Lay the bed in a flat position and assist the client to a supine position in good body alignment.
- 3 Explain the procedure. Instruct the client to tell you if they experience any pain or discomfort during the exercises. Watch the client's face and eyes for any expression of pain. **Do not cause any discomfort or pain during the exercise and do NOT force the joint beyond the point of free movement or the point of resistance.**
- 4 **While performing the ROM exercises, you MUST ask client at least once if they're experiencing any pain or discomfort.**
- 5 **Shoulder Exercises:** Support the limb by using one hand to hold the client's wrist and the other hand under the elbow. Move the joint gently, slowly, and smoothly throughout the range of motion exercises. Discontinue the exercise if the client verbalizes any pain.
 - *Extension/Flexion: From the client's side, raise their straightened arm (palm side down towards the bed), straight upward toward the ceiling, then back towards their head to ear level, then lower the arm back down to the side of the client's body onto the bed.
 - *Abduction/Adduction: With the palm facing the thigh, move the client's straightened arm out and away from the body to shoulder level, then return it to the side of the body.
 - Horizontal Abduction/Adduction: Start by placing the client's straightened arm away from the body at shoulder level (palm up), move the arm upward so the fingers are pointing towards the ceiling, then bend the arm at the elbow to touch the client's fingertips to the opposite shoulder. Then reverse the motions to return the arm to the original position at shoulder level.
 - Rotation: With the arm still at shoulder level, bend the client's arm at the elbow so the palm is facing the foot of the bed. Move the hand back toward the head of the bed and then downward towards the floor. This movement rotates the shoulder joint.
- 5 **Elbow Exercises:** Support the limb by using one hand to hold the client's wrist and the other hand under the elbow. Move the joint gently, slowly, and smoothly throughout the range of motion exercises. Discontinue the exercise if the client verbalizes pain.
 - Extension/Flexion: With the client's arm by their side (palm facing up), bend the client's arm at the elbow so that the hand moves toward the shoulder on the same side, then straighten the arm back down to the bed.
 - Pronation/Supination: Position the client's arm with the elbow bent but sitting on the bed. Gently turn the client's hand so that the palm is facing the foot of the bed, then turn the hand so that the palm is facing the head of the bed. This motion rotates the elbow.
- 6 **Wrist Exercises:** Support the limb by using one hand to hold the client's wrist and the other hand to hold the fingers. Move the joint gently, slowly and smoothly throughout the range of motion. Discontinue the exercises if the client verbalizes pain.
 - Extension/Flexion: With the client's elbow still bent, bend the wrist to move the client's hand forward, then straighten the wrist.
 - Radial and ulnar deviation: With the client's elbow still bent, gently tilt the client's hand to the side toward the thumb, then tilt the hand toward the little finger. "The Princess Wave"
- 7 **Finger/Thumb Exercises:** Support the limb by using one hand to hold the client's wrist and the other hand supporting the fingers. Move the joint gently, slowly, and smoothly through the range of motion. Discontinue the exercises if the client verbalizes pain.
 - Extension/Flexion: Bend each of the client's fingers forward (one at a time). The thumb to the palm of the hand. This makes a fist. Then reverse the motions, extending each finger (one at a time) starting with the thumb.
 - Abduction/Adduction: Gently separate each finger from the finger next to it and then return them together.
 - Thumb opposition: Touch the tip of the thumb to each finger.
- 8 Repeat with the opposite arm and then finish with your completion steps (CLOUDS). (Leave the Resident in a Comfortable Position, Lower the Bed, Provide Call Light, Sanitize your Hands)

TRANSFER (GAIT) BELT PLACEMENT AND USE

***NOT AN INDEPENDENT SKILL – THIS IS DONE AS PART OF
AMBULATION & TRANSFER BED TO W/C***

- ___ 1 Place the belt over the clothes (not on bare skin) at the waistline. Check to ensure that skin or skin folds (ex: breasts) are not caught under the belt between the waist and the belt. (Note: Resident must have non-skid footwear on already and in a seated position)
- ___ 2 **FIRST** slip the belt end through the part of the buckle with teeth, **THEN** slide it through the other side of the buckle and tighten.
NOTE: A transfer belt may also have a plastic buckle that snaps together.
- ___ 3 Ensure the belt is snug but not too tight or restrictive. You should be able to slip no more than 2 fingers between the body and the belt.
- ___ 4 Face the resident and place each of your feet in front of the resident's feet to prevent them from slipping when they stand.
- ___ 5 Bend toward the resident, grasp the transfer belt securely at the back-side of the waist using both hands, palms and fingertips pointing up.
- ___ 6 If able, ask the resident to push themselves up from the bed on the count of 3 or if in w/c, ask them to push up on the arm rests.
- ___ 7 Assist with the transfer, then gently remove the transfer belt once the transfer is complete to avoid skin injury.

NOTE: It is NEVER acceptable to hold onto a client by the waistband of their pants or any other piece of clothing as a substitute for a gait belt.

*** ASSIST TO AMBULATE USING A GAIT OR TRANSFER BELT** NOTE: 3A is done for testing purposes.

- ___ 1 Preparation steps (SKWIPES) (Sanitize, Explain) PLUS...
 - Obtain a gait belt and gripper socks of the proper size.
 - **Obtain a wheelchair and position it out of the way with the brakes LOCKED so that the client can sit in it after ambulating 10 steps.** For state testing, the observer will position the wheelchair 10 steps away, but you are still responsible for locking the brakes.
 - Elevate the head of the bed to the high Fowler's position to PREPARE to ASSIST the client to a seated position on the bedside.
- ___ 2 BEFORE assisting the client to a standing position:
 - **Check and/or lock the bed brakes.**
 - Ensure the client is wearing non-skid footwear. (It is easiest to do this while the client is still lying down in bed.)
 - ASSIST the client to a seated position on the bedside. Ensure the bed is at a safe level so the client's feet are flat on the floor.
 - Ensure the client is "steady" before applying gait belt. Ask them if they are feeling dizzy or light-headed.
 - **PROPERLY apply the transfer belt securely at the waist over their clothing/gown AND CHECK THE BELT FOR TIGHTNESS (2 fingers).** Use your feet to prevent the client from slipping by angling them in front of the client's feet.
 - Grasp the transfer belt at the backside of the client's waist and provide instructions to enable the client to assist in standing, including a prearranged signal to alert the client to begin standing (Ex. "Let's stand on the count of 3 --- 1...2...3...").
- ___ 3A Ambulatory – (No assistive devices needed) Position yourself in front of the client. Get close to the client, bend your knees, if able, instruct the client push off the bed with their hands. Grasp the gait belt on both sides of the waist with your palms and fingertips up. Using proper body mechanics, direct the client to stand on the count of 3, PAUSE before ambulating to ensure the client feels steady.
- ___ 3B If using a walker, position and stabilize the walker in front of the client. Grasp the gait belt from the backside of the waist with your palm up and use the other hand to stabilize the walker. Direct the client to stand on the count of 3. Assist the client to a standing position, while stabilizing the walker. Ensure the client feels steady.
- ___ 3C If using a cane, bring it close to the bedside so that it is within reach. Assist the client to a standing position as if they were ambulatory. Once standing, provide the cane to the client. The cane should be held in the hand that is on the client's strong side.
- ___ 4 Position yourself slightly behind and on the client's weaker side. Prepare to start off walking on the same foot as the client.
- ___ 5 Hold the gait belt by the backside of the waist with one hand, palm up. Offer the client your other hand as a stabilizer (if the client falls, this prevents you from having to hold them dangling with one hand by the belt) and **safely ambulate the client at least 10 steps.**
- ___ 6 After ambulating, assist the client to pivot turn in front of the wheelchair. Assist the client into their wheelchair in a safe, controlled manner (have the client back up until their legs touch the seat of the wheelchair and have them feel for the armrests before assisting them to sit). Remove the transfer belt. NEVER pull a client down into a chair.
- ___ 7 Completion steps (CLOUDS). (Be Respectful, Provide Call Light, Sanitize your Hands)

REPOSITIONING A CLIENT IN A WHEELCHAIR – 1 CNA NOTE: NEVER pull a client back into a chair by the seat of their pants.

- ___ Option 1: If the client is able to stand, assist to a standing position. Pull the wheelchair up to the back of their legs and assist them to sit.
- ___ Option 2: Apply the brakes to the wheelchair, while also holding the handles (using your body to hold the wheelchair in place) and ask the client to plant their feet on the floor and push their bottom backward if able.

REPOSITIONING A CLIENT IN A WHEELCHAIR – 2 CNA's NOTE: NEVER pull a client back into a chair by the seat of their pants.

- ___ Option 1: If the client is able to stand, assist them to a standing position, pull the wheelchair toward the back of their legs and assist them to sit.
- ___ Option 2: If the client is UNABLE to stand, properly connect the mechanical lift, raise the client, and reposition the wheelchair before lowering them to sit.

*** PIVOT TRANSFER OF WEIGHT BEARING, NON-AMBULATORY CLIENT FROM BED TO W/C USING GAITBELT**

NOTE: You MUST ASSIST the client to a sitting position. You cannot ask them to sit up on the side of the bed.

- ___ 1 Preparation steps (SKWIPES). (Sanitize Hands, Explain, Gather Supplies: Gait belt & wheelchair)
- ___ 2 Remove the footrests and position the wheelchair (w/c) next to the foot of the bed on the client's stronger side so that the client is pivoting on their sturdier leg. The bed should be positioned so that when the resident gets out of the bed, they are pivoting on their stronger side.
- ___ 3 **Lock the brakes on the wheelchair to ensure the client's safety.**
- ___ 4 Position the bed at a safe level (even with the wheelchair) **and ensure the bed wheels are in the locked position.**
- ___ 5 Raise the head of the bed so the client is in a high Fowler's position. Put the client's shoes/gripper socks on while they are still in bed.
- ___ 6 Using proper body mechanics, **assist the client to a seated position. Lower the bed, so the feet are flat on the floor.** Ensure client is steady.
- ___ 7 Pull the w/c up to the client. The w/c armrest needs to touch the client's thigh. **The wheel of the w/c must touch the side of the bed.**
Ensure that the front of the wheelchair armrest is literally touching the client's thigh before assisting them to a standing position.
- ___ 8 Properly secure the gait belt at the client's waist over the clothing/gown. Ensure the gait belt is snug by slipping no more than 2 fingers between the belt and the client.
- ___ 9 Provide verbal instructions to enable the client to assist with standing. Include a prearranged signal to alert them when to start standing.
- ___ 10 Using proper body mechanics, **position yourself directly in front of the client.** Place your feet directly in front of the client's feet to prevent them from slipping forward when standing. **Properly grasp the gait belt with both hands** and your fingers in an upward position.
- ___ 11 Count to 3 to alert the client to begin standing. Have the client push off the bed with their hands as they stand.
- ___ 12 Ensure client maintains stability, on your signal, gradually **assist the client to a standing position.** Pause to ensure the client is steady.
- ___ 13 **In a controlled manner, ensuring the client's safety, assist the client to pivot.** Client should be standing directly in front of the wheelchair with the back of their legs against the seat. *(At NO time should the client be stepping backwards to the wheelchair.*
- ___ 14 Tell the client to feel for the armrest of the w/c. Then **lower the client into the wheelchair in a controlled manner ensuring client safety.**
- ___ 15 Position the client with their hips touching the back of the wheelchair. CAREFULLY **remove the gait belt.**
- ___ 16 Position the client's feet on the footrests and ensure the client is in a comfortable position with good body alignment.
- ___ 17 UNLOCK the wheelchair brakes and perform your completion steps (CLOWDS). **Maintain respectful, courteous, interpersonal interactions, provide the call light, and sanitize your hands)**

DISCUSS DIFFERENCES IN TRANSFERRING FROM WC TO COMMUNE, RECLINER, TOILET, ETC

MOVING A CLIENT UP IN BED 1 CNA

- ___ 1 Preparation steps (SKWIPES) – Raise bed to the appropriate height.
- ___ 2 Ensure the head of the bed is as low as the client can tolerate, remove the pillow, and place it against the headboard. Adjust the linens.
- ___ 3 Facing the bed, position your feet so one foot is about 12 inches from the other. Bend your hips and knees so that your back is straight.
- ___ 4 Ask the person to bend their knees or assist them if needed. Place their feet firmly on the bed with their hands palm side down on the bed. If the client has a trapeze bar, instruct them to use it when ready.
- ___ 5 Place one arm under the client's shoulders and one under their buttocks. Ask the client to push against the bed with their hands and feet on the count of three.
- ___ 6 On three, shift your weight to foot nearest the headboard to assist the client to move upward in bed. Do NOT twist but move as one unit.
- ___ 7 Replace the pillow and recover the client.
- ___ 8 Completion steps (CLOWDS).

*** MOVING A CLIENT UP IN BED WITH A DRAW SHEET 2 CNA'S**

- ___ 1 Preparation steps (SKWIPES) PLUS ensure the head of the bed is as low as the client can tolerate. Remove the pillow and place it against headboard. Adjust the linens.
- ___ 2 Properly place the draw sheet under the client by rolling the client side-to-side.
- ___ 3 Both you and your partner should face the bed but on opposite sides. Both of you should position your feet so that they are about 12 inches apart, hips and knees bent so your backs remain straight.
- ___ 4 If able, ask the client to bend their knees & place their feet firmly on bed, cross their arms over their chest or use the trapeze if available.
- ___ 5 Both CNAs should roll their side of the draw sheet inward towards the client's shoulder and hip. Then firmly grasp it with both hands.
- ___ 6 Instruct the client to push up with their feet and/or pull up with the trapeze if available on the count of 3.
- ___ 7 On the count of 3, both the CNAs, should keep their elbows close to their body, lift and shift their weight to the foot that is near the headboard to move the client up in bed. Do NOT drag the client on the bed. Do NOT twist but move your whole body as one unit.
- ___ 8 Ensure the draw sheet is smooth and free of wrinkles, then tuck it under the mattress on both sides, replace the pillow, & cover the client.
- ___ 9 Ensure the client is in good body alignment. Completion steps (CLOWDS).

MOVING A CLIENT TO THE SIDE OF THE BED WITH A DRAWSHEET - 2 CNA'S

- ___ 1 Preparation steps (SKWIPES) PLUS ensure the head of the bed is as low as the client can tolerate. Remove the pillow and place it against headboard. Adjust the linens.
- ___ 2 Properly place the draw sheet under the client by rolling the client side-to-side.
- ___ 3 Both you and your partner should face the bed but on opposite sides. Both of you should position your feet so that they are about 12 inches apart, hips and knees bent so your backs remain straight.
- ___ 4 Ask the client to cross their arms over their chest and to place their legs flat on the bed.
- ___ 5 Roll the draw sheet inward towards the client's shoulder and hip and firmly grasp it with both hands.
- ___ 6 On the count of 3, both CNAs, keeping their elbows close to their bodies, lift and move the client to the desired side of the bed without dragging the client on the bed. One CNA will shift their weight from the back foot to the front foot while the other will shift their weight from the front foot to the back foot.

*NOTE: **NEVER** leave a client on the edge of the bed in an unsafe position. This skill is part of positioning a client onto their side. After using the drawsheet to move the client to the side of the bed, follow the steps in the "Positioning a Client on the Side" skills for proper positioning. If you must step away from a client in this position to move to the opposite side of the bed, you **MUST** raise the siderail so that they do not fall out of bed. A siderail is not needed if both you and your partner remain next to the client at bedside.*

LOGROLLING TECHNIQUE 2 CNA's - Used for positioning a client on their side or for providing cares.

- ___ 1 Preparation steps (SKWIPES) PLUS both CNAs positioned on the same side of the bed. The first CNA places their arms under the client's head and shoulders while the second CNA places their arms under client's hips and legs.
- ___ 2 Both CNAs bend their hips and knees, keeping their backs straight. On the count of 3, both rock backwards, transferring their weight from their front foot to their back foot, moving the client to the side of the bed they are standing on.
- ___ 3 Raise the side rail for safety and both CNA's move to the other side of bed to assist the client to roll to the center of the bed.
- ___ 4 Ask the client to cross their arms over their chest with the top arm indicating the direction to which they are rolling.
- ___ 5 The first CNA places their hands over person's shoulders and upper hip. The second CNA places their hands over the lower hip and calf. On the count of 3, roll client toward the CNAs with the head, back, and legs all in a straight line.
- ___ 6 Position the client to maintain straight alignment. Adjust pillows and linens as needed. Ensure client is not laying on their shoulder.
- ___ 7 Completion steps (CLOUDS). *NOTE: You must move or roll the client as one unit so that the upper and lower body are moved together.*

DISCUSS INSERTING AND REMOVING A HEARING AIDS – LEFT VS RIGHT EAR

DISCUSS EYE GLASS CARE – KEEPING THE RESIDENT'S GLASSES CLEAN?

DISCUSS HOW BACK RUBS INCREASE OVERALL CIRCULATION AND BENEFIT THE RESIDENTS

*** CLIENT ROOM ORDER**

- ___ 1 Treat client's personal items with same care as you give your own valued possessions.
- ___ 2 Maintain neat appearance by disposing of disposables and putting non-disposables away in proper places.
- ___ 3 Clean over-bed table and night stand when done with sanitizer wipes.
- ___ 4 Change and remove all soiled linens as soon as possible.
- ___ 5 Remove trash frequently.
- ___ 6 Dispose of food items left in room.
- ___ 7 Maintain neat appearance of bed.
- ___ 8 Make sure equipment is in good working order.

MOVING A CLIENT TO THE SIDE OF THE BED USING 3 STEP PROCESS - 1 CNA

NOT AN INDEPENDENT SKILL – THIS IS DONE AS PART OF THE POSITIONING A CLIENT ON THEIR SIDE SKILL PG 11

- ___ 1 Preparation steps (SKWIPES).
- ___ 2 Ensure the head of the bed is as low as the client can tolerate, remove the pillow, and place it against the headboard. Adjust the linens.
- ___ 3 Facing the bed, position your feet so one foot is about 12 inches in front of the other. Bend your hips & knees so your back is straight.
- ___ 4 Place your arms under the client's shoulders. Rock back on your feet, shifting your weight from your front foot to your back foot, lifting the client's upper body towards the side of the bed that you are standing on.
- ___ 5 Move toward the middle of the bed. Using the same stance, place your arms under the client's lower back and buttocks. Rock back on your feet to lift the client's midsection towards the side of the bed that you are standing on.
- ___ 6 Move toward the foot of the bed. Using the same stance, place your arms under the client's legs. Rock back on your feet to lift the client's lower body towards the side of the bed that you are standing on.
- ___ 7 Completion steps (CLOUDS).

*NOTE: **NEVER** leave a client on the edge of the bed in an unsafe position. This skill is part of positioning a client onto their side. If you must step away from a client in this position to move to the opposite side of the bed, you **MUST** raise the siderail so that they do not fall out of bed.*

* **POSITIONING A CLIENT ON THEIR SIDE – 1 CNA** Supplies: 4 pillows placed on bedside chair or overbed table

NOTE: LISTEN CAREFULLY - The Instructor/Observer will tell you which side to position the client on: L or R side.

- 1 Preparation Steps (SKWIPES). (Sanitize your Hands, Explain Procedure, Pull Privacy Curtain)
- 2 Raise the bed to a comfortable height then lay the client into a supine (flat) position.
- 3 Ask the client to lift their head or gently assist them to lift their head to remove the pillow. The pillow can remain but MUST be readjusted after the client is rolled.
- 4 **Raise the side rail on the side of the bed to which the client will be rolling.** *Note: When testing, you can ask the RN Test Observer to stand on the side of the bed the resident will be rolling towards in place of raising the siderail.*
- 5 After raising the siderail, go to the opposite side of the bed (called the "working" side of the bed).
- 6 Ask the client to cross their arms over their chest and cross their ankles toward the direction you are rolling them.
- 7 Using the "MOVING A CLIENT TO THE SIDE OF THE BED USING 3 STEP PROCESS" technique taught above, position client on the side of the bed that you are standing on.
- 8 Raise the second side rail to prevent the client from falling out of bed if you choose to leave the working side of bed. You can either roll the client away from you OR move to the other side of the bed and roll them towards you. Both are correct.
- 9 Instruct the client to reach out to grasp the siderail on the side of the bed they are rolling to **prevent them from rolling onto their face.**
- 10 Assist the client to bend their knee/leg that is on the opposite side they are rolling to assist you in turning them. Do NOT pull or tug on the hip/thigh area, this could cause a skin tear or damage the hip. Bending the knee allows you to use it as leverage when rolling them.
- 11 Roll the client on the side that was directed by the instructor or RN Test Observer ensuring the client is in the center of the bed.
 - a) **If rolling the client TOWARDS you:** Position yourself on the side of the bed to which the person is turning. Using proper body mechanics, place one hand on the client's far shoulder and the other on the bent knee. Roll the client toward you reminding the client to reach out to grasp the siderail as they are rolled. Remember to transfer your weight from your front foot to your back.
 - b) **Rolling the client AWAY from you:** Stay on the working side of the bed. Place a hand on the client's shoulder and the other on the client's knee. Carefully roll them away from you by transferring your weight from your back foot to your front foot.
- 12 Place a folded pillow/blanket or rolled towel along the client's back and tuck it snugly under the client to stop them from rolling back.
- 13 Assist the client to lift their head to replace or adjust the pillow to ensure their comfort-
- 14 Place a third pillow lengthwise between the client's lower legs with the bottom leg straight and the top leg slightly bent. The pillow should provide support at both the knee and the ankle to ensure the bony prominences are supported.
- 15 Place a fourth pillow under the client's top arm close to the underarm to prevent the skin from rubbing together and also supporting the bony prominence of the elbow and the hand.
- 16 Ensure the client is not lying on the bony prominence of the lower shoulder by pulling the shoulder forward slightly.
- 17 Ensure client is in the center of the bed in good body alignment before cleaning up.
- 18 Completion steps (CLOUDS). Leave the resident in a position of comfort, lower the bed, be respectful, call light, sanitize)

* **MOUTH CARE** Supplies: Paper towel, hand towel, Emesis basin, toothbrush, toothpaste, cup with mouthwash/water solution, gloves
*NOTE: When practicing this skill, your partner should be seated in a wheelchair in front of an overbed table. **DISCUSS TOOTHETTE USE***

- 1 Preparation Steps (SKWIPES) (Sanitize, Explain, Privacy, Gather Supplies) MINUS putting on gloves... See step 5.
- 2 Place a hand towel or paper towel on the over-bed table and arrange your supplies.
- 3 Get a cup of water (or water/mouthwash solution).
- 4 Place prepared over-bed table in front of the wheelchair and the resident.
- 5 AFTER your supplies are set up, put on gloves. Place a towel across the client's chest to protect their clothing.
- 6 Moisten the toothbrush by pouring water/mouthwash solution over it. **DO NOT DUNK THE TOOTHBRUSH IN THE CUP.**
- 7 Apply toothpaste to the moistened toothbrush.
- 8 **Clean the mouth by brushing the upper teeth and gums, the lower teeth and gums, AND THE TONGUE**, using gentle motions while **VERBALIZING** each surface you are cleaning (inner surfaces, outer surfaces, chewing surfaces, and tongue).
- 9 Maintain a clean technique with the placement of the toothbrush at all times (you can place it on the towel or paper towel).
- 10 Assist the client to rinse their mouth by holding the cup to mouth and assist them to take a drink with the water/mouthwash solution.
- 11 YOU must hold the emesis basin to the client's chin while the client rinses their mouth with the remaining water/mouthwash solution.
- 12 Break off about 18 inches of dental floss and gently floss all the teeth. Not done for testing.
- 13 Wipe the client's mouth and remove the chest barrier then place the towel in the hamper.
- 14 Ask the client if they would like to put on lip balm. Not done for testing.
- 15 Empty, rinse, and dry the emesis basin. Then rinse the toothbrush and place the used toothbrush in the basin.
- 16 Return the toothpaste, basin, and toothbrush back to the designated area.
- 17 Completion steps (CLOUDS). Remove Gloves, Position of Comfort, Call Light, Be Respectful, Sanitize Hands) Document and report.

- * CLEAN UPPER OR LOWER DENTURE** NOTE: The steps below prepare you for resident care at clinical. When practicing, the denture and denture cup will already be placed on the nightstand. SUPPLIES: Denture, denture cup, denture brush, toothpaste, washcloth, gloves
- 1 Preparation Steps (SKWIPES). (Sanitize, Explain what you are going to do when you pick the dentures up off the nightstand)
 - 2 Arrange your supplies by the sink. Prepare a water/mouthwash solution for the client to rinse their mouth if able.
 - 3 Assist the client to an upright seated position (75-90 degrees) and place a towel across their chest to protect their clothing.
 - 4 Put on clean gloves before CAREFULLY handling the dentures to avoid damage and contamination throughout the entire procedure.
 - 5 Have the client carefully remove their dentures or assist the client to remove their dentures and place them in the emesis basin. Take the dentures to the sink. When testing, the denture and denture cup is already placed on the nightstand.
 - 6 Line the bottom of the sink with a washcloth (or 3 paper towels) to prevent damage to the dentures in case they are dropped. Use a clean paper towel to turn on the cool water. Place a barrier on the side of the sink for placement of the denture cup and dentures.
 - 7 Dampen the toothbrush and apply denture toothpaste. Remove denture from the cup and hold in the hand with the toothbrush. Immediately rinse the denture cup and lid in cool running water. Then refill the denture cup with cool water. Place the cup and the lid on the paper towel. Then rinse the denture in cool water.
 - 8 Thoroughly brush all of the surfaces of the denture, the including inner, outer, and chewing surfaces, using a circular motion.
 - 9 Thoroughly rinse all the surfaces of the denture under cool water and place them in the rinsed denture cup. Cover the cup with the lid.
 - 10 Rinse the toothbrush and place it in the emesis basin, maintaining clean technique with the placement of the toothbrush.
 - 11 Turn off the water with a clean, dry paper towel. Return the supplies to the nightstand.
 - 12 If the client is putting the dentures back into their mouth, turn off the water with a clean, dry paper towel and take the dentures back to the bedside. Give the client a mouthful of the mouthwash mixture to rinse their mouth. Hold the emesis basin under the client's chin to catch the liquid and dry the client's mouth. IF NEEDED, help the client to clean the roof of their mouth, cheeks, gums, and tongue with a sponge brush (toothette) dipped in the water/mouthwash solution. If they have any natural teeth, help them to brush and floss them. Give the client another mouthful of the water/mouthwash solution to rinse. Hold the emesis basin under the client's chin to catch the liquid and dry the mouth. Give the dentures to the client to place in their mouth or assist the client to place them back in their mouth.
 - 13 Return to the sink to remove and properly dispose of the sink liner. Clean up the remaining work area.
 - 14 Completion steps (CLOUDS). (Be Respectful, Call light, Sanitize) Immediately report any damaged to the dentures or mouth sores.

- * ASSIST WITH A RESIDENT WITH A BEDPAN/FRACTURE PAN WITH HANDWASHING** DISCUSS USE OF URINAL
- NOTE: Patient in bed with gown on. The Instructor/Evaluator will specify whether you should place the client on a bedpan OR fracture pan. YOU select the correct pan from the supply table, then PROPERLY place the client on that SPECIFIC pan.
- 1 Prep Steps (SKWIPES). (Knock, Introduce, Sanitize, Explain, Privacy) Supplies: bedpan/fracture pan, TP/wipes. Place pan in the bottom drawer of the night stand, NOT on the overbed table, floor, or bed. When testing, TP is not needed but at clinical it is.
 - 2 Lower the head of the bed so the client is lying flat. Raise the side rail on the side of the bed to which the client will be rolling toward.
 - 3 Fan fold the top sheet so that it is just below the client's hips and adjust the nightgown as needed.
 - 4 Put on gloves and assist the client to roll towards the siderail. ONLY when testing, may you ASSIST the client to lift their hips.
 - 5 Place a barrier (towel, bed protector, waterproof pad, chux) under the client's buttocks.
 - 6 With a gloved hand, remove the correct pan from the drawer of the nightstand and using proper body mechanics, immediately position the bedpan or fracture pan correctly under the client's buttocks. To place the bedpan, the deeper portion should be directed toward the client's toes. To place the fracture pan, the handle should be directed toward the client's toes. Both should be centered beneath the client.
 - 7 Assist the client to roll back onto the bedpan. Cover the client with the top linens.
 - 8 Ask OR ASSIST the client to bend their knees and place feet flat on the bed to ensure urine flows into the pan and not down the thighs.
 - 9 Raise the head of the bed to a comfortable level and ensure the client's call light is within reach. Ask the client to signal when finished.
 - 10 Provide the client with privacy by stepping behind the curtain.
 - 11 Return to the bedside when called or directed by the client, instructor, or evaluator.
 - 12 Lower the head of the bed BEFORE removing the bedpan/fracture pan. Avoid over exposure by folding back the top sheet to the hips.
 - 13 Secure the pan with one hand and ask or assist the client to roll towards the siderail so you can slide the pan out and properly clean the client with toilet paper and/or wipes. (Not done while testing but done at clinical)
 - 14 AFTER completely removing the bedpan/fracture pan, hold that pan securely in one hand. With your other hand, guide or assist the client to roll back onto their back, cover the them up with their linens, and provide them with their call light. THEN hold the pan out so the instructor/observer can pour an unknown amount of liquid into the pan. Immediately empty the contents of the pan into the toilet.
 - 15 Rinse the pan and pour the rinse water into the toilet/commode. Return the pan to the designated storage area.
 - 16 Return to the client and remove the bed protector / waterproof pad and dispose of your gloves. (can be done while removing bedpan)
 - 17 Complete the HANDWASHING skill as outlined within that skill. Do NOT recontaminate your hands.
 - 18 Completion steps (CLOUDS). (Be Respectful, Provide Call Light) Document and report any skin issues.

DISCUSS USE OF COMMODE, HATS, ENEMA'S, AND SUPPOSITORIES

DISCUSS HAIR CARE - NO BED HEAD

DISCUSS COMPLETE BED BATH, SHOWER, OR BATH AT CLINICAL

DISCUSS SHAMPOOING A PERSON'S HAIR IN BED - Shampoo in a bag, dry shampoo, basin and water, etc.

DISCUSS SHOWERS, BATHS, AND FULL BED BATHS – FREQUENCY, REFUSALS, OPTIONS

*** GIVE MODIFIED BED BATH (FACE AND ONE ARM, HAND, AND UNDERARM)**

Supplies: Washbasin, soap, 2 wash clothes, 2 towels, bath blanket, clean gown, gloves

- 1 Preparation steps (SKWIPES). (Sanitize your Hands, Explain Procedure, Pull Privacy Curtain) AND RAISE THE BED HEIGHT.
- 2 Fill a wash basin with water. Check the water temperature for safety and comfort THEN ask the client to verify the comfort of the water.
- 3 Lower the head of the bed as low as the client can tolerate and put on clean gloves.
- 4 Cover the client with a bath blanket and fan-fold the top sheet to the client's waist. Remove the client's gown and place it into the soiled linen container without exposing the client.
- 5 Wash BOTH of the clients' eyes with a wet washcloth (NO SOAP), using a different area of the washcloth for each stroke. Wash from the inner aspect of the eye to the outer aspect and then proceed to wash the entire face using a clean area of the washcloth.
- 6 Pat dry the client's eyes and face with the towel.
- 7 Expose one arm and place a towel underneath the arm.
- 8 Apply soap to the wet washcloth that you used on the face.
- 9 When washing the arm, move the client's body gently and naturally, avoiding force and over-extension of the limbs and joints.
- 10 Wash the arm, hand, and underarm. Start at the shoulder, then down the arm to the hand, then back up to finish with the underarm.
- 11 Using a clean washcloth, rinse the entire arm the same way you washed it, then pat dry the entire arm the same way. Repeat with the client's other side and apply lotion if needed or requested (not done during testing).
- 12 Put a clean gown on the client. Lay the gown over the top of the bath blanket. Slide the client's arms into the arm holes. Secure the gown at the neck. Carefully remove the bath blanket from under the client's gown and cover the client with the linens.
- 13 Dispose of your dirty linens into the soiled linen container, avoiding contact with your clothing.
- 14 Empty, rinse, and dry the basin. Return the basin to the designated storage area.
- 15 Remove and dispose of your gloves. Sanitize your hands.
- 16 Completion steps (CLOUDS). (Lower the Bed, Be Respectful, Call Light, Sanitize your Hands) Document and report any skin issues.

*** PROVIDE FOOT CARE** Supplies: washbasin, soap, 1 washcloth, 2 towels, lotion, gloves **Instructor/Observer will choose L or R foot.**

NOTE: Your partner should be sitting in a chair next to the bed. The shaving skill is done at the same time. DISCUSS HAND CARE

- 1 Preparation steps (SKWIPES). (Sanitize your Hands, Explain the Procedure)
- 2 Place a large towel on the floor in front of the client and arrange your supplies.
- 3 Fill a foot basin with warm water. Check the water temperature. Ask the client to verify the water temperature for safety and comfort.
- 4 Position the wash basin on the towel and put on gloves.
- 5 Remove the client's sock and shoe on the proper foot. Remember the Instructor/Observer will choose the L or R foot.
- 6 Place the client's bare foot into the water. During testing, you MUST verbalized that you would soak the foot for 5 to 20 min.
- 7 Apply soap to a wet washcloth. Support the foot and ankle, lift the foot from the water, and wash the foot, including between the toes.
- 8 Push back the cuticles on the toenails gently with the washcloth.
- 9 Using the same washcloth, rinse the foot including between the toes. The soapy foot can be placed back into the basin, BUT this doesn't count toward rinsing. You MUST rinse with the washcloth and use it to run water over the foot including between the toes.
- 10 Use a clean towel to dry the foot, including between the toes.
- 11 Inspect the condition of the skin, including the toenails.
- 12 Apply lotion to your gloved hands and rub it between your hands to warm it. Lotion the entire foot, removing the excess lotion with a towel. Lotion MUST be applied when practicing/testing. Do NOT massage the client's calf area. Avoid getting lotion between the toes.
- 13 Put on the client's socks and replace their shoe. GIVE the client their call light.
- 14 Empty, rinse, and dry the basin and return it to the designated storage area.
- 15 Dispose of your used linens into the soiled linen container and put away all your supplies.
- 16 Completion steps (CLOUDS). (Position of comfort, call light, sanitize) Document and report any skin issues.

*** ASSISTING WITH SHAVING - NOTE: In class you will be shaving each other's legs during foot care.**

- 1 Preparation steps (SKWIPES).
- 2 Cover the over-bed table, counter, or floor area with a paper towel and arrange your supplies. Fill the wash basin with warm water and have the client check the water temperature.
- 3 Place the client in a high Fowlers position and place a towel over their chest or in a seated position for shaving legs. Put on gloves.
- 4 Inspect the skin for moles, birthmarks, or sores. Assist the client to wash their face with soap and warm water. Hold a warm wash cloth on the face for a couple of minutes to soften the hair on the client's face. Also do this on the legs when shaving the legs.
- 5a Rinse the safety razor and apply shaving cream to the skin. Hold the skin of one cheek tight with the fingers of the opposite hand and draw the razor downward in short strokes in the direction that the hair grows. Repeat over the other cheek, chin, lips, and neck. Rinse the razor often. Ask client to tilt their head or puff their cheeks as needed. For legs, also shave in the direction the hair grows.
- 5b If using an electric razor, pre-shave lotion may be used. Hold the skin tight while moving the razor across the client's face according to the instructions, usually in a circular motion. Continue shaving in a circular motion until you have covered all areas of the face and neck. Clean the razor head after use by opening the head of the razor and gently tapping it against your palm over a garbage can.
- 6 Rinse the face or legs with warm water and pat it dry. Place the cloth and the towel into the hamper.
- 7 Apply aftershave, if used. Provide the client with a mirror to check the shaved area and finish with your completion steps (CLOUDS). Document and report any skin issues. Plug in the client's electric razor if necessary.

*** APPLIES ONE KNEE-HIGH ANTI-EMBOLIC STOCKING** NOTE: You MUST HAND WASH and hang the stocking to dry at the end of each class AND while on the job. Do NOT send them to laundry. Machine laundering/drying will ruin the elastic.

- 1 Preparation Steps (SKWIPES). (Sanitize, Explain, Privacy) Raise the Bed to a good working height. Supplies: Compression Sock
- 2 Expose ONLY one leg. ***LISTEN CAREFULLY, the Instructor/Observer will choose the left or right leg.***
- 3 Roll, gather, OR turn the stocking inside-out to the heel.
- 4 Hold the stocking so that when you place it on the foot, the toe and heel will be in the correct position.
- 5 Move the foot and leg gently and naturally, avoiding force and over-extension of the limb and joints during the entire procedure.
- 6 Slide the stocking over the toes, foot, and heel, then roll or pull the stocking up the leg. Ensure proper positioning, adjust if needed.
- 7 **Smooth out the stocking to be sure there are NO twists or wrinkles present** and that the heel of the stocking (if present) is over the heel and the opening in the toe (if present) is either over or under the toe area.
- 8 Check the client's toes for proper circulation and adjust if needed (look for a cold or bluish color and ask if they have any numbness or tingling in their feet).
- 9 Move to the other side of the bed and repeat for the opposite leg when providing client care. Not done during testing.
- 10 Completion steps (CLOUDS). (Lower the Bed, Be Respectful, Call Light, Sanitize) Document and report any skin issues.

*** DRESSING A BEDRIDDEN CLIENT WITH AN AFFECTED "WEAK" SIDE** Supplies: gripper socks, pants, Button-Up shirt, gloves)

NOTE: Listen carefully, the Instructor/Observer will choose the weak side: L or R. Both socks AND gripper socks are used.

- 1 Preparation steps (SKWIPES) (Sanitize, Explain, Privacy) and RAISE THE BED HEIGHT.
 - 2 Ask the client what they would like to wear. Show them a couple of options and dress the client in the clothing of their choice.
 - 3 Lay the client flat in bed. Cover the client with a bath blanket or sheet to avoid over exposure and raise the side rails. Apply gloves.
- DRESSING BOTTOM CLOTHING** NOTE: Undergarments are not used when practicing or testing, but you will use them during clinical.
- 4 Underwear & **Pants** – Gathering the leg openings to the waist band. **Help the client place their WEAK leg into the opening FIRST, then the other.** Inch them up the legs as far as possible. Assist the client to roll side-to-side until their pants are pulled all the way up.
 - 5 Socks AND Nonskid footwear – Gather the opening of the sock and place it over the toes. Guide it onto the foot, adjusting as needed ensuring no wrinkles. Repeat with the other side. Next **put on the client's non-skid socks.** Draw the socks up the client's feet until they are smooth. If using shoes, loosen the laces and guide the foot into the shoe, adjust the fit, and then secure the laces/fasteners.

UNDRESSING THE UPPER:

- 6 Elevate the head of the bed. Have the client lean forward when removing, applying, or adjusting the clothing behind the client's back.
- 7 Without exposing the client, remove the strong arm from the gown first so the client can assist by moving the arm. Then remove the affected weak side from the gown. Dispose of the gown into the soiled linen container keeping the client covered with a blanket/sheet.

DRESSING TOP CLOTHING NOTE: Bras and undershirts are not used when practicing or testing, but you will use them during clinical.

- 8 Place the client's arms through the bra straps. Adjust the straps and cups of the bra. If using an undershirt, gather the shirt from the hem to the neck opening. Place the client's arms into the armholes and slip it over client's head, lean the client forward and pull the shirt down in the back. Place your hand through the wrist of the client's shirt, and hold the client's hand to **slip the sleeve onto client's WEAK arm FIRST.** Assist the client to sit forward so that you can bring the top around the back and then assist with the stronger arm. Some clients will need to lift their arm up towards the shoulder to put their arm into the sleeve, some will need the shirt positioned down towards their waist to put their good arm into the sleeve. Finish by adjusting the shirt as necessary and then buttoning it up.
- 9 Completion steps (CLOUDS). (Comfortable and safe position, Lower Bed, Be Respectful, Call light, Sanitize, PROPERLY DRESSED!)

*** EMPTYING & MEASURING URINARY DRAINAGE BAG** (Complete Contact Precaution PPE & Handwashing when testing.)

- 1 Sanitize your hands. **Obtain a PPE gown and put it on as directed within that skill.** Secure the ties at the neck and waist, covering as much of your clothing as possible. Do not allow the gown to touch the floor.
- 2 Obtain gloves and inspect them closely for rips/defects before putting them on. Ensure the gloves are covering the cuffs of the gown.
- 3 Preparation Steps (SKWIPES). (Knock, Introduce, Explain) **PLUS TO MAINTAIN CLEAN CONTACT** – Ensure client is in a position of comfort and provide them with their call light BEFORE contaminating your gloves by touching the urinary drainage bag.
- 4 Place a clean barrier (paper towel) on the floor under the drainage bag. Open the alcohol wipe so that it is ready to be used.
- 5 Place the graduate on the barrier. If needed, elevate the bed so the bag can be emptied without touching the graduate.
- 6 Remove the drainage tube from the protective sleeve and open the drain to allow the urine to flow into the graduate until it is empty.
- 7 Avoid touching the graduate with the tip of the tubing (do NOT tap the tube against the graduate). Then close the clamp securely.
- 8 After emptying the bag and closing the clamp, wipe the drain tube with an alcohol wipe and return the tube to the drain holder.
- 9 Carefully place the graduate on a flat surface on top of a paper towel to read the urinary output.
- 10 At eye level, obtain the output in mLs and remember the measurement. Note the characteristics (i.e., color, clarity, sediment, or unusual odor) of the urine.
- 11 Empty the graduate into the commode/toilet, rinse it, and empty the rinse water into the commode/toilet (Do NOT dry). Return your equipment to the storage area.
- 12 Discard your barrier into the garbage. Completion Steps (CLOUDS). (Position of Comfort and Safety, Call light, Be Respectful)
- 13 Properly remove your PPE as directed within that skill without contaminating yourself and dispose into the appropriate container.
- 14 Properly perform the complete HANDWASHING skill as directed within that skill. **Do NOT recontaminate your hands.**
- 15 Record the urine output in mLs on your signed recording sheet. You must be within +/- 25 mLs of the Evaluator/Instructor.

ADDITIONAL TOPICS TO DISCUSS IN DOWN TIME:

- WHAT WILL MORNING CARES AND A NORMAL CLINICAL DAY LOOK LIKE????**
- COLLECTING A ROUTINE URINE OR STOOL SPECIMAN INCLUDING CLEAN CATCH URINE**
- APPLYING TOPICAL MEDICATIONS – WHEN AND WHAT TYPES ARE ALLOWED AS A CNA**
- ASSISTING WITH DEEP BREATHING AND COUGHING EXERCISES – INCENTIVE SPIROMETRY**

CATHETER TUBING SAFETY (This skill is done at the same time as catheter care.) **DISCUSS CHANGING A CATHETER BAG**

- 1 Make sure that tubing is secured to the inner thigh with catheter stabilization device (Ex. Velcro/elastic strap or sticker).
- 2 Keep the tubing lower than the bladder and the drainage bag lower than the tubing.
- 3 Keep the tubing free of kinks, bends, creases, and dependent loops (areas where urine will sit and can grow bacteria).
- 4 Avoid pulling on the tubing.
- 5 Don't allow the tubing to touch the floor. A clamp can be used to help secure the tubing to the fitted sheet of the bed.
- 6 Do NOT disconnect the tubing from drainage bag unless you are assisting to change the bag.
- 7 Always take the tubing and bag placement into consideration when moving/rolling the client to prevent discomfort/injury.
- 8 The bag and tubing must be fed through the pant leg before putting on a new pair of pants for the client.
- 9 If the drainage bag is not covered by clothing, cover the bag with some type of privacy covering to maintain the client's dignity.
- 10 Leg straps should regularly be rotated from side to side to prevent skin breakdown.

*** FEMALE CATHETER CARE & HANDWASHING** *SET-UP: Female manikin is lying in a bed with a gown on, covered with a sheet.*
NOTE: Perineal care and catheter care are done together on the job. **DISCUSS ENHANCED BARRIER PRECAUTION'S**

- 1 Prep steps (SKWIPES). (Knock, Introduce, Sanitize, Explain, Privacy)
- 2 Fill the basin with warm water and check the water temperature. Ask the client to verify the water temperature.
- 3 Put on clean gloves.
- 4 Lower the head of the bed as tolerated. If needed, place a bed protector under the perineal area before washing.
- 5 Expose the area surrounding the catheter by raising the gown just above the pubic hair area and lower the top sheet just below the hips to avoid-over-exposure throughout the entire procedure.
- 6 Check to see that urine can flow unrestricted into the drainage bag. VERBALIZE that there are no kinks, twists, or creases in the tubing and that the tubing is attached at the thigh and bed properly.
- 7 DO NOT TUG/PULL THE CATH TUBING AT ANY TIME DURING THE PROCEDURE. ENSURE PRIVACY AT ALL TIMES.
- 8 Apply soap to a clean, wet washcloth. Wash the area around the catheter where it exits the body. Wipe around the tube at least 2 times using a clean area of the washcloth. With one hand, gently secure the catheter firmly at the meatus with 2 fingers to prevent tugging. Using a clean area of the washcloth, clean at least 4 inches of the tube. Wrap the washcloth around the tube and wipe only in one direction, moving away from the meatus. You must use a clean area of the washcloth for every stroke. Repeat this wiping motion on the tube at least two times.
- 9 Using a clean, wet washcloth. RINSE the area around the catheter where it exits the body. Wipe around the tube at least 2 times using a clean area of the washcloth. With one hand, gently secure the catheter firmly at the meatus with 2 fingers to prevent tugging. Using a clean area of the washcloth, RINSE at least 4 inches of the tube. Wrap the washcloth around the tube and wipe only in one direction, moving away from the meatus. You must use a clean area of the washcloth for every stroke. Repeat this wiping motion on the tube at least two times.
- 10 Using a hand towel AND without tugging, pat dry the catheter tubing the same way you washed and rinsed it.
- 11 Recover the client with their gown and linens. Dispose of your used linens into soiled linen container. Avoid contact with your clothing.
- 12 Remove the bed protector if needed. Empty, rinse, and dry the basin and place it in the designated storage area.
- 13 Completion steps (CLOWDS). (Place Resident in a Position of Comfort, Provide Call Light, Be Respectful)
- 14 Complete the Handwashing Skill as directed within that skill. Document and report any skin issues.

DISCUSS USE OF THE PUREWICK SYSTEM and CONDOM CATHETER'S

CHANGING INCONTINENCE BRIEF

- 1 Preparation steps (SKWIPES). Plus, if the client is in bed, raise one side rail.
- 2 Fan fold the linens down to expose the incontinence brief. Remove or move any clothing as needed. Undo the Velcro tabs or tear the side seams of the brief and tuck the sides of the brief under the client.
- 3 Assist the client to roll away from you or move to the opposite side of the bed and assist the client to roll toward the side rail.
- 4 Completely clean the client's perineal area with TP/wipes and remove the soiled brief.
- 5 Place a new brief under the client's buttocks and center it. Gently tuck the tabs so that they are easy to pull out once the client rolls back.
- 6 Assist the client to roll onto their back. Position the brief over the front of the client and secure the brief with the tabs.
- 7 Re-cover the client with their clothing/gown and sheets/blankets.
- 8 Completion steps (CLOWDS). Document and report any skin issues
- 9 Remember to take the client's garbage with the soiled brief out of the room when you leave.

*** PERINEAL CARE** *SET-UP...Female manikin is lying in bed, gown on, covered with a sheet.*

- 1 Preparation steps (SKWIPES). (Knock, Introduce, Sanitize, Explain Procedure...to the manikin, Provide Privacy, Raise the Bed Height)
- 2 Lay out a clean towel on the over-bed table. Fill the wash basin with warm water (105 – 115 degrees).
- 3 Ask the client to verify that the water temperature is comfortable and then place the basin on the clean towel.
- 4 Raise the siderail on the side of the bed to which the client will be rolling OR ask your partner/observer to stand on that side of the bed.
- 5 Lower the head of the bed as low as the client can tolerate and **RAISE THE BED HEIGHT**.
- 6 Put on clean gloves.
- 7 **ROLL** the client to the side to place a linen protector/chux under the perineal area before washing.
- 8 Ask or ASSIST the client to bend their knee(s) and/or spread their leg(s) as much as possible to comfortably access the perineal area.
- 9 Raise the gown just above the pubic hair area. Pull the sheet just below the hips to **expose only the perineal area**. Avoiding overexposure.
- 10 Wet the washcloth and apply soap.
- 11 Wash the pubic hair on lower abdomen area, then wash the groin areas on each side, using a clean area of the washcloth for each stroke.
- 12 Use a clean washcloth to rinse the soap from these same areas, using the same steps used when washing.
- 13 Towel dry the area, using the same steps as with washing and rinsing. *Steps 10- 13 are not done while testing to save time.*
- 14 Verbalize and **PERFORM** separation of the labia, while washing, rinsing, and drying the vaginal area of a FEMALE while testing.
- 15A FEMALE: Use a clean soapy washcloth to wash from the top of the labia to bottom (towards the rectum) with each swipe. Wash the left labia, then the right, then the **center of the vaginal area using both a clean area of the cloth AND** gentle motion for each stroke.
- 15B MALE: Retract the foreskin if uncircumcised. Wash around the urinary meatus in a circular motion using a clean surface of the washcloth for each stroke. Wash the head of the penis in the same fashion, then wash the shaft of the penis towards the thighs. Finally, wash the scrotum and groin area. Use the same technique to rinse and dry. Replace the foreskin to its natural position when finished.
- 16 Use a clean washcloth to rinse the soap from genital area, using the same technique as with washing.
- 17 With a clean area of the towel, pat dry the genital area. Ensure the client is covered with their gown and the sheet to avoid exposure.
- 18 After cleaning the genital area, ask or ASSIST the “client” to roll toward the siderail. **Using a clean washcloth**, wash both butt cheeks using a clean area of the washcloth for each swipe. Always wash upward toward the tailbone. Then **wash the rectal area moving from the rectum toward the tailbone for each stroke**. Use a clean washcloth to rinse the area the same way and then pat dry.
- 19 Roll the client to **remove the linen protector** and position the client on their back in a comfortable position. Use proper body mechanics.
- 20 Properly **dispose of your used linens into the hamper** avoiding contact with your clothing.
- 21 Empty, rinse, and dry the basin. Place the basin in the designated storage area.
- 22 Completion steps (CLOWDS). (Remove Gloves, Lower the Bed, Be Respectful, Call Light) Document and report any skin issues.
- 23 Complete **HANDWASHING** as directed within that skill. **Avoid re-contaminating your hands**.

DISCUSS PERICARE FOR RESIDENTS WITH A CATHETER

*** USING A SIT TO STAND MECHANICAL LIFT FOR TRANSFERS – 1 or 2 CNA’s**

- 1 Preparation steps (SKWIPES), including gathering the lift, sling, and chair to which the client will be transferred.
- 2 Assist the client to a seated position if lying down in bed, or assist the client to lean forward in their wheelchair or chair to slide the sling behind their back. Lock the brakes of both the wheelchair and bed BEFORE transferring the client to and/or from either location.
- 3 Bring the lift to the client, spread the legs of the lift, position it in front of them. Assist them to lift their feet (with non-skid footwear on) onto the platform. Ensure that the arms of the lift do not hit the client’s head, arms, or legs. Ensure that their legs are properly positioned against the pad in front of the knees/shins. Secure the legs in place by using the strap that goes across the back of the calves if present.
- 4 Place the sling under the client’s arms and secure the sling around the client’s waist like a gait belt. Check the sling for tightness.
- 5 Properly attach the sling to the lift and have the client hold onto the lift handles at the designated place.
- 6 Alert the client that you will begin to lift them and instruct them to pull up on the handles and straighten their legs to stand as they are lifted to support their weight. Use the controls to lift the client from a seated to standing position. Do not raise the client higher than they can comfortably tolerate. Stop raising the lift if the client vocalizes or shows signs of pain or discomfort.
- 7 Unlock the brakes and move the client to the wheelchair, bed, chair, toilet, etc. to which they are transferring. Widen the legs of the lift if they were closed during transport. **DO NOT LOCK** the brakes on the lift once the destination is reached. If the brakes are locked while the client is lifted, the weight of the client can tip the lift over or pin the client’s legs between the lift and wheelchair.
- 8 Alert the client that you will begin to lower them, then slowly lower them into a seated position. If transferring them into a chair/wheelchair, ensure that their hips are against the back of the chair.
- 9 Remove the sling from the lift and remove the strap from behind the client’s legs if used. Unlock the brakes of the wheelchair and assist to move the client’s feet off the platform of the lift as it is moved away from the client. Finish removing the sling by unfastening it at the client’s waist and carefully removing from behind their back. Adjust clothing if necessary.
- 10 Leave the client in a position of comfort (put feet on footrests if needed, elevate footrest of recliner, etc.).
- 11 Completion steps (CLOWDS), including cleaning/disinfecting the lift/sling per facility policy and return it to its proper storage place.

*** USING A TOTAL DEPENDENT MECHANICAL LIFT FOR TRANSFERS – 2 CNA's**

- ___ 1 Preparation steps (SKWIPES), including gathering the lift, sling, and wheelchair to which the client will be transferred.
- ___ 2 To place the sling, roll the person side to side. Ensure the top of the sling is under the shoulders and that the bottom is at the knees. Always follow the manufacturer's instructions for placement of the sling and how to properly attach the straps to the lift to ensure client safety. Manufacturers recommend that total dependent mechanical lifts be used by 2 CNAs.
- ___ 3 Position the lift over the client ensuring it doesn't come in contact with any part of the client. Spread the legs of the lift to the widest position and lock the brakes.
- ___ 4 Raise the head of the bed to avoid pulling on the sling when connecting it to the lift. Have the client cross their arms over their chest. Attach the sling to the lift, first the top loops, then the bottom loops ensuring the loops are the same length on each side. Explain to the client that you are going to start lifting them and will be moving them to the chair. Using the controls, lift the client off the bed, and release the brakes. Always ensure the client's safety throughout the transfer by making sure that they are not injured by bumping into the lift or any other obstacles.
- ___ 5 Move the lift to the chair as a co-worker guides the client over their chair. After the client is positioned over the chair, slowly lower the client into their chair, making sure their hips are against the back of the chair. **DO NOT LOCK** the brakes on the lift. If the brakes are locked while the client is lifted, the weight of the client can tip over the lift if they begin to swing or sway. If the brakes are unlocked and the client begins to swing or sway; the lift will move via the wheels without tipping over.
- ___ 6 Unhook the sling from the lift and move the lift away. Attach the footrests to the wheelchair and place the client's feet on the footrests.
- ___ 7 Remove the sling or keep it in place according to the facility policy. If not removed, ensure the sling is wrinkle free, not rubbing the skin, and that the loops are discreetly tucked in.
- ___ 8 Completion steps (CLOUDS), including cleaning/disinfecting the lift/sling per facility policy and return it to its proper storage place.

PROVIDING POSTMORTEM CARE

- ___ 1 Ensure with the nurse that cares are ready to be completed.
- ___ 2 If family is present, greet them sympathetically, ask if they have any requests for the preparation or viewing of the body (such as position of the body, special clothing, jewelry, etc.) If they express any religious or cultural preferences, accommodate them as much as possible.
- ___ 3 If the family wishes to be present or assist with care, explain/talk them through each step of the procedure/process.
- ___ 4 Perform preparation steps (SKWIPES), including gathering extra PPE for family members if needed.
- ___ 5 Cover the over-bed table with a towel and fill the wash basin with warm water. Place the basin and supplies on the table.
- ___ 6 Put on gloves and/or gown per facility policy. Lower the bed and place the client into the supine position.
- ___ 7 Place a bath blanket over the body and remove client's soiled clothing.
- ___ 8 If needed, change the fitted sheet. Place an absorbent pad under the client's buttocks. Urine/feces is often expelled as the client is moved.
- ___ 9 IF APPROPRIATE per facility policy, remove indwelling devices (e.g., urinary catheter, endotracheal tube), If an autopsy is to be performed, **DO NOT** remove any indwelling devices.
- ___ 10 If needed, gently close the client's eyes by pulling the eyelids down over the eyes. Also gently close the mouth if open. A rolled towel can be placed under the chin to stabilize the jaw.
- ___ 11 If the client has dentures that are not in his or her mouth, place them there. If the dentures do not stay securely in the mouth, place them in a labeled denture cup and ensure that they are transported with the client's body to the mortuary.
- ___ 12 Remove or place jewelry ensuring that you are following facility policy (wedding and engagement rings are typically left on) and per family wishes. Place remaining jewelry in an envelope or small plastic bag. Record each item on an inventory sheet as it's removed.
- ___ 13 Provide client with a COMPLETE bed bath. Dress the client in a clean gown or the preferred clothing. Urine/feces is also often expelled when the client is moved for transport, so a clean incontinence brief should be placed after the bath is completed.
- ___ 14 Place a clean sheet over the client's body up to the chin area. Position the client's hands on top of the abdomen so one hand is placed on top of the other hand.
- ___ 15 Brush or comb the client's hair. Remove any hair clips, hairpins, or rubber bands.
- ___ 16 Check facility policy for applying an identification bracelet.
- ___ 17 If the client's family requests a viewing, prepare the client's body and room in a culturally sensitive manner per facility policy.
 - a) Remove unneeded medical equipment from the room.
 - b) Provide soft lighting and chairs for the family.
 - c) Put a chair at the bedside for a family member who may collapse.
 - d) Provide tissues, a pitcher of water, and cups for the family.
- ___ 18 Discard your supplies, remove personal protective equipment (PPE), and perform hand hygiene.
- ___ 19 Identify which of the client's belongings are to stay with his or her body and which are to be given to the family.
- ___ 20 Completion Steps (CLOUDS).
- ___ 21 Ensure the work area is clean before inviting the family back into the room. Provide privacy and leave the room.
- ___ 22 Allow the family time alone with the client's body.
 - a) Encourage the family to say good-bye with religious rituals and in their culturally accepted manner.
 - b) Do not rush the grieving process. Allow the family as much time as they need to say goodbye.
 - c) Do not force family members to view the client.
 - d) Remain accessible to address needs and answer questions.
- ___ 23 Check frequently with the family to see if there is any further care is needed.

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***HIGHLIGHTED SKILLS INCLUDE HANDWASHING**