STATE OF MICHIGAN

NURSE AIDE TRAINING

CURRICULUM MODEL

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
(Revised, 2014)

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Section A

Introduction

Background

In 1987, Congress included, in the Omnibus Budget Reconciliation Act (OBRA), legislation affecting the operation of nursing homes. A section of the legislation stated that all nurse aides employed in nursing facilities after October 1, 1990, must successfully complete a minimum 75 hours of training which includes classroom, laboratory, and clinical instruction in a State approved nurse aide training program. Nurse aides in nursing homes must also pass a competency evaluation test (written and clinical) and have their names entered on a State registry.

The State Department of Licensing and Regulatory Affairs is the agency in Michigan, which is charged with implementation of this legislation. As part of this implementation, the Michigan Nurse Aide Training Curriculum, 1989, was developed to be used by instructors in the Nurse Aide Training Program in a variety of ways: as a curriculum guide to be used in the development of a 75 hour training program, as a complete curriculum to be used as is, or adapted to fit specific facilities or training programs.

Adult Learning

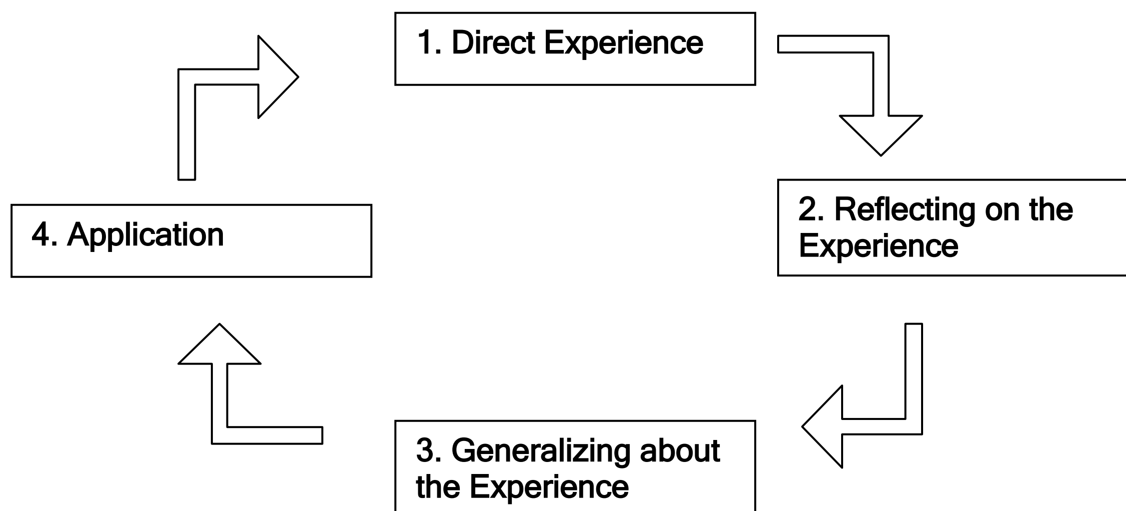
The approach to adult learning is based on the belief that adults learn differently from children, and thus should be taught differently. The American educator Malcolm Knowles coined the term andragogy to refer to "the art or science of helping adults to learn." The following principles of adult learning are based on Knowles's work:

Principles of Adult Learning

Adult learning occurs best when it:

- Is self-directed
- Fills an immediate need
- Is participatory
- Is experiential
- Is reflective
- Provides feedback
- Shows respect for the learner
- Provides a safe atmosphere
- Occurs in a comfortable environment

Many of these principles are applied and demonstrated in the "Adult Learning Cycle." The cycle begins with an experience that the adult can either learn from, or not. The next steps in learning are to reflect on the experience, then generalize about what happened, and then apply the new learning to other situations, to see if it holds true outside the learning environment.



The trainer can facilitate the adult learning cycle by designing appropriate activities for each step and asking questions to guide the adult learner. The following table outlines the tasks and role of the trainer:

Adult Learning Cycle			
Phase	**Activities**	**Trainer's Role**	Questions to ask
1. Direct Experience	Group tasks Case studies Role plays Skills practice Games	Structure the experience – present objectives, instructions, and time frame	What is the purpose of this activity? What else do you need to know to carry out this activity? How is it going? How much more time do you need?
2. Reflecting on the Experience	Small-group discussion Reporting from small groups Participant presentations Large-group discussion	Ask questions to help the learner to focus on key points and to share ideas and reactions with others	What happened? How did you feel when…? What did you notice about…? How do others feel about…? Why do you agree or disagree?
3. Generalizing about the Experience	Large-group discussion Lectures Demonstration Reading	Ask questions and provide key information to guide the learner to new insights based on experience and discussion	What did you learn from this? How does all that we're discussing fit together? What are some major themes we've seen here?

4. Application	Discussion Action planning Skills practice Field visits	Coach the learner by providing feedback, advice, and encouragement	How can you apply this in your own situation? What do you think will be most difficult when you use this? If you were to use this in your own situation, how would you do it differently? How can you overcome barriers to applying what you have learned?

Matching Training Methodologies to Learning Objectives

The activities listed in the "Adult Learning Cycle" table vary according to the phase of the learning cycle. This reflects the fact that different types of activities work better for different phases of learning. Another way of thinking about this is to consider the objectives of the learning event (or training). Objectives for job-related trainings are commonly grouped into three categories – knowledge, attitudes, and skills. This is based on the recognition that, in order to apply new learning on the job, trainees must not only know the information or tasks that they are to apply or carry out, but also must have the practical skills necessary to do so, plus the attitude that this is something they can and should do.

In general, trainers group the following methodologies with each type of learning objective:

- Knowledge: Lectures; findings; audiovisuals
- Skills: Demonstration, followed by practice with feedback; case studies (problem-solving); role plays; games
- Attitudes: Role plays; small-group discussion; case studies; games

In the 1970's, surveys of trainers to rank training methods for effectiveness indicated that experiential activities such as case studies, role playing, games, and discussion were considered more effective than formal lectures and films -- even for the knowledge-based objectives. However, lecturing is still considered one of the most cost-effective approaches to delivering new information in a short period of time. Thus, most trainers have developed an "interactive" approach to lecturing, which is described in more detail below.

In summary, trainers need to be able to conduct a variety of training methodologies, in order to achieve different learning objectives most effectively and efficiently. In general, applying the principles of adult learning and working with the experiential learning cycle means that trainers function more as facilitators and coaches, than as teachers. Therefore, the following tips for facilitation will apply to all

the training methodologies used in this curriculum (which are described in more detail in the next section).

Facilitation Skills

Non-verbal

- Maintain eye contact with everyone as you speak; don't appear to favor certain individuals.
- Move around the room without distracting the group (avoid pacing); make sure everyone can see you.
- Nod or smile to show people that you are listening when they speak.

Verbal

- Speak slowly and clearly.
- Be sure participants talk more than you do.
- Ask open-ended questions to encourage responses, e.g. "What do you think about…"; "What do you know about…" (Avoid asking, "Is this clear?" or "Do you understand?") If a participant responds with "yes" or "no," ask "Why do you say that?"
- Ask other participants if they agree or disagree with another participant's statement.
- Don't answer all questions yourself – participants can sometimes answer each other's questions.
- Paraphrase what a participant has said, to check understanding and make sure other participants have heard.
- Summarize the discussion; be sure everyone understands; draw conclusions.
- Reinforce statements, or encourage sharing by others, by sharing a relevant personal experience.

Training Methodologies

Methodologies have already been selected for each activity in this training to achieve the desired objectives and to best utilize the adult learning cycle. However, every training methodology has its strengths and weaknesses, and it is important to know how to maximize the strengths while minimizing the weaknesses. Also, at times the trainer will need to adapt an activity in the moment to accommodate changing conditions such as time constraints or smaller/larger group sizes. Therefore, the following tips are provided to help make the most of each activity and to achieve the learning objectives most effectively.

Large Group Exercise/Game

Purpose: To encourage more open sharing during subsequent activities, by establishing common ground with other participants (“breaking the ice”) in a fun and relaxed setting.

Tips:

- Large group exercises, and especially games, are generally meant to be fun. However, there is almost always a purpose related to learning and achieving training objectives. It is important to briefly share that purpose with participants, usually after the exercise, to let them know you are not wasting training time “just playing around.”
- Games and other exercises are not fun if participants get confused and aren’t able to follow the instructions. The trainer needs to give very clear instructions and then support people when they are not sure what to do.

Interactive Lecture

Purpose: To convey information, introduce a new topic, or provide an overview or synthesis.

Tips:

- Promote two-way communication during the presentation by asking open-ended questions, e.g. “What does this mean to you?” “What examples have you seen of this in your own life/work?”
- Begin a new topic by asking participants what they know about the topic already. This will help to identify lack of knowledge or areas of misinformation, or will help the trainer to tailor the presentation to a group that is already well informed.
- Use visual aids to reinforce points and focus attention.
- Be aware of the group’s energy. A presentation only works to convey information if the participants stay engaged and alert. To keep participants energized:
  - create quick discussion groups in pairs or triads on a particular question or topic,
  - use brainstorming (without flip charting to save time),
  - crush a piece of flip chart paper into a ball and throw it to a person to answer a question (and keep throwing around the room for more questions), or
  - take a quick stretch break.

Individual Exercises

Purpose: To reinforce learning by helping every individual participant to identify his or her own ideas, aspects of their lives, or experiences that relate to the care of others.

Tips:

- Individual exercises in this training are written worksheets or quizzes. Verbal instructions still need to be given by the trainer, along with an explanation of why participants are doing the exercise (to help connect the exercise to the learning cycle).

Small Group Exercises

<u>Purpose:</u> To allow participants to share experiences and ideas, or to work on a problem or task together; and to increase participation, particularly in large groups where individuals may be reluctant to speak in front of others but may have important ideas or experiences to contribute.

<u>Tips:</u>

- The purpose of the group work and instructions must be very clear. Write instructions on flip chart paper whenever feasible. Ask a participant to repeat back the instructions in their own words to confirm understanding.
- The trainer needs to check quickly with each group after they start work, to be sure that each group is clear on the purpose and instructions.
- The trainer needs to move from group to group during the exercise, to make sure they stay on task.
- The trainer needs to be clear about the timeframe for group work at the beginning, and give periodic reminders of how much time is left.
- When there are several small-group exercises, try to change group composition, to encourage participants to speak and interact with different members of the group.
- However, forming groups in itself can be time-consuming. To save time, you may sometimes form small groups (pairs or triads) where people are already sitting. Be aware, though, that people tend to sit next to others that they already know, which might limit the sharing of different ideas.
- The work of the small groups needs to be honored through sharing (reporting) and discussion in the large group. The trainer needs to guide the group reporting, to focus other participants on each small group's unique contribution and to help draw conclusions from what is shared. This is key to the "generalizing" phase of the adult learning cycle.

Role plays

<u>Purpose:</u> To demonstrate or practice skills; to simulate a realistic situation in which to explore a training topic; to "put yourself in another's shoes" and experience how you or others might feel in a given situation.

<u>Tips:</u>

- It may be necessary in some cases to ask for volunteers and prepare them ahead of time for their roles.
- The trainer needs to introduce the role play by explaining the situation to observers, so the role play will make sense.
- The trainer may need to guide or stop a role play if it strays off the topic too far.
- Discussion after a role play is important, both for reflection and for generalizing from the experience. Begin the discussion by thanking the role players and asking them how they feel about the role play.
- Asking what has been learned from the role play and how it applies to their own situations are key to making the role play a learning experience for all participants.

Large Group Discussion

Purpose: To share ideas and experiences, to clarify concepts, and to draw conclusions from other learning experiences.

Tips:

- Large group discussions follow nearly the entire training methodologies already listed – interactive lecture, small group exercises, and role plays. The trainer needs to be very clear about the learning objectives for each activity, and focus the large group discussion to make sure those objectives are met.
- Large group discussions can easily be dominated by a small number of vocal participants. The trainer needs to involve others in these discussions, possibly by asking open-ended questions directly to participants who are not speaking voluntarily.

Learning Circle

Purpose: To summarize or close an exercise (or the day) by asking each participant to make a comment about what he or she learned.

Tips:

- This methodology overcomes the drawback of large group discussions, by ensuring the each participant has a chance to speak. This is not a time for discussion – the trainer needs to ensure that one individual's remarks are not challenged or disputed, and do not lead to discussions that might cut into the time needed for other participants' sharing.
- Because each participant will need time to share what he or she is thinking or has learned, this exercise takes a lot of time. For that reason, it is often done at the end to allow for a sense of closure for the group, and to help start the transition from "generalizing" to "application" when they begin their new job responsibilities.

ADULT LEARNING STYLES

Learning Style	Characteristics	Teaching Strategies
Visual Learners	Process new information when it is visually illustrated or demonstrated	• Graphics, illustrations • Images • Demonstrations
Auditory Learners	Process new information best when its spoken	• Lectures • Discussions
Kinesthetic Learners	Process new information best when it can be touched or manipulated	• Written assignments, taking notes • Examination of objects • Participation in activities
Environmental Learners	Atmosphere / surroundings affect this learner	• Pay attention to: • Room temperature • Lighting • Seating • Etc.

Average learning retention rates:

Lecture = 5%
Reading = 10%
Audio Visual = 20%
Demonstration = 30%
Discussion Group = 50%
Practice by Doing = 75%
Teaching Others = 90%

(National Training Laboratories, Bethel, Maine)

Introduction to Culture Change

What is Culture Change?

Many long-term care communities are undergoing "culture change". It is a phrase you will undoubtedly hear from time to time on the floors of the long term care community or in staff meetings.

So, what is "culture change" and what is your role in this culture change? Very simply, culture change is the process an organization goes through to transform itself. The culture of the organization is what it believes, what it values, and how it operates on a day-to-day basis. Culture change is about changing how people treat each other, what they value as important, and how they structure their work. In many ways, culture change is big and broad. But it is also relevant and practical.

An organization undergoes culture change transformation in three main areas:

- Physical environment
- Organizational structure
- Personal/Social interactions

1. Physical environment: As culture change takes root in an organization, one can wander the halls and see many of these changes. Often times, nurses' stations are removed, smaller dining and community areas are created, long hallways are replaced with smaller units, 10-20 Elders residing on each. Many homes introduce plants, animals, and children as a means of enlivening the environment and responding to the plagues of loneliness, helplessness, and boredom.

2. Organizational structure: In addition to seeing the physical changes, you might observe these organizational changes. Resident-centered decision making. Residents are empowered to make decisions regarding their life. Perhaps it is a small decision, such as what one would like to wear each day, perhaps it is a bigger decision, such as when to get up in the morning, what to eat, what medications to take and how. Resident-centered decision-making occurs on an individual level and also collectively. Resident groups are encouraged to look for ways to be involved and make resident focused decisions. Perhaps the residents want raised flower gardens outside, or a later start to breakfast; that is resident-centered decision making. Other organizational changes include a change in the role and responsibility of staff. Universal workers, while primarily responsible for one main task or area, are cross-trained to provide additional services as needed for the residents. Permanent assignment is another example of an organizational change that impacts the residents and staff. Staff is specifically trained on teambuilding concepts and problem solving to empower them to work through any issues that may arise in the day-to-day happenings of the home.

3. Personal/Social Interactions: These changes are what you feel when you enter an organization. How staff are treated by leadership, how committed an organization is to caring for the whole person and not just treating their physical ailments, the permission and encouragement staff is given to develop relationships with one another and the residents are all examples of personal/social transformation.

Additionally, there are two factors that impact a home's culture change success:

1. Does this home embrace individuality? Are the individual and unique strengths and needs of the residents accounted for? Is each resident thought of in terms of their medical ailments or for their unique personality and talents? Is staff appreciated for the skills they bring to the organization?
2. Does this home encourage relationship development? Is staff encouraged to work together in teams, to help each other? Is staff encouraged to get to know the residents on a personal level beyond their treatment needs? Do the residents know their caregivers?

A home that embraces the uniqueness of the residents as well as the staff and seeks to create a caring community through the proactive support of relationships is well on its way to culture change success.

First Revision Curriculum Model, 1991

The Michigan Nurse Aide Training Curriculum, 1989, had been revised to build on the strengths of the model, to expand content in selected areas such as Dementia/Cognitive Impairment, and to include new content such as *Creating an Environment for Restraint Elimination, Reduction, and Appropriate Use*. The revised curriculum provided a lesson plan, which identifies learner objectives, content, teaching methodologies, and evaluation. Time allocation for class, lab, and clinical and a sample program schedule are also included.

The Michigan Nurse Aide Training Curriculum, 1991, was a 75-hour curriculum, which assisted an instructor to develop a classroom management system, which meets Federal Requirements for a Nurse Aide Training Program. This 75-hour program provides an overview of many areas and is not meant to be inclusive of all information needed by a nurse aide working in a long-term care facility. Many topics, such as cognitive impairment/dementia, will need to be given more emphasis and more in depth instruction via staff development programs once the training is completed. The curriculum provides a framework for ensuring minimal competency of nurse aides; when the training program is complete, nurse aides should continue to have support and instruction on an ongoing basis.

Performance guides and achievement indicators for each clinical skill were included as an appendix in the 1991 revised curriculum model. Nursing facilities may use their own procedures, the Michigan Model guide, or other sources for teaching clinical skills. The following information regarding clinical skills was located in an appendix.

Performance guides and achievement indicators for each clinical skill referenced in the Michigan Model, 1991, curriculum have been updated in the 2006 model. A Student Achievement Record which contains the task, criteria, date and instructor's signature is also included.

Other additions to the revised curriculum model included references for instructors, which are listed in selected units and a suggested Program Calendar.

It was intended by those involved with the development of the Michigan Nurse Aide Training Curriculum, 1991, to provide training which meets minimum Federal Requirements and prepare nurse aides to provide quality care to residents in long term care facilities.

Second Revision Curriculum Model, 2006

Asked by the State Agency, a group of dedicated professionals from the long term care industry, nurse aide training programs, and state agencies undertook improving and updating the model introduced in 1991. This group has been divided into two workgroups. Phase I workgroup reviewed and updated the model introduced in 1991. Phase II workgroup is looking at the longer overall improvements necessary for the quality service delivery required by nurse aides.

Those involved with development of the Michigan Nurse Aide Training Curriculum-2006 intend it to be used to teach minimum Federal requirements. It is also intended to provide nurse aides with task-based skills to deliver care to the residents in nursing homes and other long term care settings.

It is understood that the commitment to service by those developing this curriculum will be ongoing, as improvements are deemed necessary to maximize the quality of life for residents in long term care settings.

Federal Requirements

The Michigan Nurse Aide Training Curriculum Model, 2006, meets minimum Federal/State Requirements for Nurse Aide Training Programs.

The following are the Federal requirements, which are incorporated into the curriculum:

Program Objectives

The overall objective of this Nurse Aide Training Program is the provision of quality services to residents in long term care facilities by nurse aides who are able to:

- Form a relationship, communicate and interact competently on a one-to-one basis with the residents;
- Demonstrate sensitivity to residents' emotional, social, and mental health needs through skillfully directed interactions;
- Assist residents in attaining and maintaining functional independence;
- Exhibit behavior in support and promotion of residents' rights; and
- Demonstrate observational and documentation skills needed in the assessment of resident's health, physical condition and well-being.

The above are the program objectives, which reflect federal requirements.

Curriculum and Training Requirements

The curriculum must include the needs of various populations, i.e., persons with dementia, Alzheimer's, mental illness, developmental disability, and non-elderly persons with other disabilities that are peculiar to the population of an individual facility.

The program must be a minimum of 75 hours of training. At least 16 hours is required of classroom instruction in the core curriculum prior to a trainee's direct involvement with a nursing home resident – and another 16 or more hours devoted to skills training. The remaining hours can be used at the discretion of the designers of the training program.

Each Nurse Aide Training Program must have behaviorally stated objectives for each unit of instruction. Each objective must state measurable performance criteria, which serves as the basis for competency evaluation.

- Unit objectives must be reviewed with the trainees at the beginning of each unit, so the trainee knows what is expected of him/her in each part of the training program.
- The program must use the curriculum objectives for nurse aide training, and must adapt the content and skills training application to the industry's specific population.
- A performance record of major duties and skills must be developed for each nurse aide trainee and consist of the following (minimum requirements):
    - A listing of duties or skills expected to be learned in the program;
    - Space to record aide's performance of this duty or skill;
    - Space to note satisfactory or unsatisfactory performance;
    - Signature of instructor supervising the performance.

- Each Unit contains the instructor's information, the trainee's steps in successful completion, and detailed information for the performance of each task.
- A trainee must be clearly identified during all skills training portions. Identification must be recognizable to residents, family members, visitors and staff.
- The ratio of instructors to trainees in skills training must ensure that each trainee is provided with effective assistance and supervision.
- Program hours: Total of 75 hours with 16 hours of instruction prior to the trainee's direct involvement with nursing facility residents. It must include:
    - Communication and Interpersonal Skills (All Units)
    - Infection Control (Unit 6)
    - Safety/Emergency Procedures (Including the Heimlich Maneuver) (Unit 7)
    - Promoting Resident's Independence (Unit 3, All Units)
    - Respecting Resident's Rights (Unit 3, All Units)

In addition, the program must ensure that each nurse aide, at a minimum, demonstrates competency in the following areas:

- Basic Nursing Skills
- Personal Care Skills
- Mental Health and Social Services Needs
- Care of Cognitively Impaired Residents
- Basic Restorative Services
- Resident's Rights

<u>Requirements for Instructors in Nurse Aide Training Programs</u>

Instructor requirements for Nurse Aide Training Programs to be approved by the State of Michigan are the following:

<u>PROGRAM COORDINATOR</u>:

- RN licensed in the State of Michigan
- Train-the-Trainer Certificate

The Program Coordinator's responsibilities include:

- Overall administrative responsibility for the program

<u>PRIMARY INSTRUCTOR</u>:

- RN licensed in the State of Michigan
- Train-the-Trainer Certificate
- One year experience in care of the elderly in a long term care setting

The Primary Instructor's responsibilities include the following:

- Accountable for the entire program; i.e., classroom, laboratory, and clinical.
- Participates in the planning and evaluation of each segment of the curriculum.
- Monitors each new instructor in lecture, laboratory, or clinical, whenever that person is teaching something new for the first time.

- On-Site and available during entire clinical teaching time.
- On-Site and available at least 50% of the classroom and laboratory time.
- May delegate classroom, laboratory, and/or clinical teaching responsibilities to a Delegated Instructor (another registered nurse or a licensed practical nurse) within the legal scope of practice and assessed capabilities of those individuals.
- The Program Coordinator/Primary Instructor may be one or, at the most, two individual(s). If one person is assigned as the Program Coordinator/Primary Instructor, s/he may delegate teaching responsibilities to Delegated Instructors.
- Nursing facilities and non-nursing facilities may have one (1) or more Primary Instructors depending on the type of Nurse Aide Training Program they are conducting.

DELEGATED INSTRUCTOR:
- RN or LPN licensed in the State of Michigan

Delegated Instructor responsibilities include:
- Class, laboratory, and/or clinical teaching as delegated by Primary Instructor
- Must be supervised by Primary Instructor for at least 50% of class and laboratory time and 100% of clinical teaching time

GUEST INSTRUCTOR:
- Individuals with special knowledge such as physical therapists, occupational therapists, speech therapists, physicians, pharmacist, Ombudsman, and dietitians who may assist the Program Coordinator/Primary Instructor or Delegated Instructor in teaching related lecture and laboratory components of a Nurse Aide Training Program.

Guest Instructor responsibilities include:
- Teaching of content pertaining to area of expertise.

Those responsible for the Nurse Aide Training Program (the Program Coordinator/Primary Instructor/Delegated Instructor) are to verify demonstrated competency in a task/skill and sign the trainee's Student Achievement Record.

In a nursing facility based program, the training of nurse aides may be performed under the general supervision of the Director of Nursing for the facility, who is prohibited from performing the actual training. The Director of Nursing must delegate administrative duties to another member of the nursing leadership team while acting as Primary Instructor.

Equipment and Supplies for Nurse Aide Training Program

Resident Room

- ▢ Adequate space, lighting and ventilation
- ▢ A sink with hot and cold running water with hand faucets accessible in the room, or readily accessible to the room.
- ▢ Hospital bed with regular mattress (no air mattresses, etc.) (Electric or manual)
- ▢ Positioning rail
- ▢ Over-bed table
- ▢ Bedside table (night stand)
- ▢ Call light (may be simulated)
- ▢ Side chair or straight chair
- ▢ Soiled linen hamper
- ▢ Provisions for privacy: curtain or screen
- ▢ Commode or toilet
- ▢ Wheelchair with footrests and brakes
- ▢ Lamp
- ▢ Wastebasket

Toileting Supplies

- ▢ Bedpan and cover (fracture pan and full bedpan)
- ▢ Toilet tissue
- ▢ Catheter
- ▢ Incontinence briefs
- ▢ Urinary drainage bag (Drainage spout must be type that inserts into a pouch.)
- ▢ Alcohol wipes
- ▢ Leg band to secure catheter or tape
- ▢ Graduated container (Preferably clear plastic).
- ▢ Yellow food coloring or a substitute to color the water
- ▢ Funnel or irrigation syringe to fill the urinary drainage bag
- ▢ Urinal
- ▢ Air freshener
- ▢ Cotton balls
- ▢ Urine collection device

Measuring and Recording Supplies

- ▢ Digital thermometers
- ▢ Lubricant for rectal temperature
- ▢ Scale (non-digital stand-up scale)
- ▢ Device for measuring height (Measuring device that is attached to a stand-up scale)
- ▢ Watch or clock with second hand for vital signs
- ▢ Blood Pressure cuff (sphygmomanometer) multiple sizes
- ▢ Stethoscope (single and double earpiece)

Linens

- ▢ Sheets (flat and fitted)
- ▢ Blanket or bed spread
- ▢ Pillowcases
- ▢ Gowns and bedclothes
- ▢ Washcloths
- ▢ Towels
- ▢ Bath blankets
- ▢ Underpads (disposable, reusable, or comparable substitute)
- ▢ Covered pillows for positioning (minimum of 4)
- ▢ Lift Pad

Clothing: *normal and adaptive*

- ▢ Undershirt
- ▢ Pants (sweat suit or elastic waist pants)
- ▢ Button front shirt
- ▢ Socks
- ▢ Non-skid foot wear
- ▢ Slip or half slip
- ▢ Underpants
- ▢ Bra or camisole

Mouth Care Supplies

- ▢ Emesis basin for spitting
- ▢ Toothbrush
- ▢ Toothpaste
- ▢ Denture container
- ▢ Denture cleaner or toothpaste
- ▢ Full set of real dentures
- ▢ Mouthwash and swabs for oral care
- ▢ Drinking cups
- ▢ Water pitcher
- ▢ Dental floss
- ▢ Lubricant (lip balm)
- ▢ penlight

Bath Supplies

- ▢ Bathtub and shower (in clinical setting)
- ▢ Basin
- ▢ Soap, regular and/or rinse-less type
- ▢ Soap dish
- ▢ Bath thermometer
- ▢ Bath mat
- ▢ Robe

- ▢ Deodorant
- ▢ Shower chair
- ▢ Q-tips
- ▢ “Occupied” sign

Grooming Supplies

- ▢ Combs
- ▢ Brushes
- ▢ Curlers
- ▢ Skin care supplies – Lotion, oil, etc.
- ▢ Nail clippers
- ▢ Nail file or emery boards
- ▢ Orangewood sticks
- ▢ Razors
- ▢ Shaving cream/soap
- ▢ Shampoo
- ▢ Blow dryer
- ▢ Pail
- ▢ Water proof sheets or Rinsette
- ▢ Large pitcher
- ▢ Safety pin
- ▢ Mirror
- ▢ Hair accessories
- ▢ Aftershave
- ▢ Styptic pencil
- ▢ Electric shaver

Nutrition Supplies

- ▢ Dishes
- ▢ Dish covers
- ▢ Food trays
- ▢ Clothing protector
- ▢ Spoon, knife and fork, including common assistive devices
- ▢ Napkins
- ▢ Water pitcher
- ▢ Cups
- ▢ Standard measurements for fluid containers
- ▢ Sample menu’s
- ▢ Straws
- ▢ Diet Card
- ▢ Cereal and milk, or jell-o, or pudding

Ambulation/Transfer Supplies

- ▢ Cane
- ▢ Transfer belt or gait belt
- ▢ Crutches
- ▢ Mechanical lift
- ▢ Walker
- ▢ Trapeze

Miscellaneous

- ▢ Tape measure
- ▢ Facial tissues
- ▢ Pencil and paper for candidate's recording
- ▢ Paper towels and dispenser
- ▢ Disinfectant for cleaning supplies
- ▢ "No Smoking" signs
- ▢ Mannequin - jointed and anatomically correct.

Infection Control

- ▢ Disposable Gloves - assorted sizes
- ▢ Disinfectant for cleaning supplies
- ▢ Plastic bags
- ▢ Isolation gowns and masks
- ▢ Plastic isolation bags
- ▢ Isolation tags
- ▢ Plastic apron
- ▢ Goggles
- ▢ Gauze

Special Items

- ▢ Anti embolism stockings (TED)
- ▢ Foot board
- ▢ Foot stool or ottoman
- ▢ Hand rolls
- ▢ Heel and elbow protectors
- ▢ Over-bed cradle (optional)
- ▢ Positioning devices
- ▢ Pressure relieving mattress
- ▢ Stretcher (optional)
- ▢ Synthetic lambs wool
- ▢ Small calculator
- ▢ Waist restraint, lap buddy, bed/chair alarms

Teaching supplies

- ▢ Anatomical Chart

- Charts forms (e.g., ADL flow sheets, food acceptance records, intake and output records, graph and flow sheets for vital signs, blood pressure and weights.)
- Medical dictionary
- Weights and measures equivalence chart
- Incident / Accident Forms
- Turning schedule

Section B

Curriculum Matrix Nurse Aide Training Michigan Model Curriculum, 2006

Unit	Resident Rights	Restraints	Infection Control	Human Interaction	Safety And Emergency
Long Term Care Facility	X			X	
Long Term Care Resident	X			X	
Resident Rights	X			X	
Member Of Health Care Team	X			X	
Human Interaction Skills	X			X	
Basic Personal Skills	X		X	X	
Nutrition And Hydration	X			X	X
Elimination	X		X	X	
Resident Environment	X		X	X	
Vital Signs	X		X	X	
Death And Dying	X			X	
Rehab And Restorative Care	X	X		X	
Safety And Emergency	X		X	X	X
Infection Control	X		X	X	
Communicable Diseases	X		X	X	X
Development Disability	X			X	
Depression	X			X	
Restraint	X	X		X	X

Cognitive Impairment	X	X		X	

Recommended Hour Allocation Michigan Model Curriculum, 2006

Unit	Title	Class Hours	Lab Hours	Clinical Hours	Total Hours
1	Long Term Care Facility	1.0			1.0
2	Long Term Care Resident	1.0			1.0
3	Resident Rights	2.0			2.0
4	Member Of Health Care Team	2.0			2.0
5	Human Interaction Skills	2.0			2.0
6	Infection Control	2.0	2.0		4.0
7	Safety And Emergency	2.0	2.0		4.0
				Total Hours (Units 1-7)	16.0
8	Basic Personal Skills				
8-1	Introduction	0.5			0.5
8-2	Oral Hygiene	1.0	0.5		1.5
8-3	Skin Care	1.0			1.0
8-4	Hand and Foot Care	0.5	0.5		1.0
8-5	Hair Care and Shaving	0.5	1.5		2.0
8-6	Perineal Care	0.5	1.0		1.5
8-7	Bathing	0.5	1.0		1.5
8-8	Dressing and Appearance	0.5	0.5		1.0
	Total Hours (Units 8A-8H)			6.0	16.0
9	Care of Resident Environment	0.5	1.5	2.0	4.0
10	Care of Resident with Cognitive Impairment	3.0		1.0	4.0
11	Creating an Environment for Restraint Elimination, Reduction, Appropriate Use	3.0	0.5	0.5	4.0
12	Vital Signs, Height, Weight	1.0	1.0	2.0	4.0
13	Meeting Nutrition/Hydration Needs	2.0	1.0	1.0	4.0
14	Elimination	2.0	1.0	1.0	4.0
15	Restorative/Rehabilitative Care	2.0	2.0	4.0	8.0
16	Care of Resident with Developmental Disability	1.0			1.0
17	Depression	1.0			1.0
18	Death and Dying	0.5	0.5		1.0
19	Care of the Resident with Communicable Disease	1.0			1.0
20	Clinical Practicum – Integration of Clinical Skills			7.0	7.0
Total		34.0	16.5	24.5	75.0

Sample 75 Hour Program Schedule

Day	AM Unit	AM Topic	PM Unit	PM Topic
Day 1	Unit 1	The Long Term Care Facility	Unit 4	Nurse Aide as a Member of Health Care Team
	Unit 2	The Long Term Care Resident	Unit 5	Human Interaction
	Unit 3	Resident Rights		
Day 2	Unit 6	Infection Control	Unit 7	Safety/Emergency Procedures
Core Curriculum Completed after Unit 7				
Day 3	Unit 8-1	Introduction to Personal Care	Unit 8-5	Hair Care and Shaving
	Unit 8-2	Oral Hygiene	Unit 8-6	Perineal Care
	Unit 8-3	Skin Care	Unit 8-7	Bathing
	Unit 8-4	Hand and Foot Care	Unit 8-8	Dressing and Appearance
			Unit 9	Care of Resident Environment
Day 4	Unit 8 Clinical Skills		Unit 8 Clinical Skills	
Day 5	Unit 8 & 9 Clinical		Unit 10	Care of Resident with Cognitive Impairment
Day 6	Unit 11	Creating an Environment for Restraint Elimination/ Reduction/ Appropriate Use	Unit 12	Vital Signs/Height/Weight
Day 7	Unit 13	Meeting Nutrition/ Hydration Needs	Unit 14	Elimination
Day 8	Unit 15	Restorative/ Rehabilitative Care	Unit 16	Care of Resident with Developmental Disability
			Unit 17	Depression
			Unit 18	Death and Dying
			Unit 19	Care of Resident with Communicable Disease

Day 9	Unit 20 Clinical Practicum	Integration of Clinical Skills
Day 10	Final Test	

Section C:

<u>Lesson Plan</u>

In the Sample Lesson Plan, included are activities to provide the instructor with opportunity for active learning. These additional resources are located in Section D, Resources for Selected Units.

Unit 1: THE LONG-TERM CARE FACILITY

COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM

EVALUATION
Exams/Quizzes
75% accuracy

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

STUDENT OBJECTIVES	CONTENT	TEACHING METHOD
1. Describe three basic purposes of long-term care facilities	1. Purposes: a. to provide care based on identified needs such as rehabilitative care, personal care, services, etc. b. to provide services by a multidisciplinary team c. to promote function and independence	Class: Lecture/ Discussion Activity 1: “Picturing” the Health Care Setting
2. Name two types of long term facilities	2. a. Nursing Home/County Medical Care Facility b. Hospital Long Term Care Unit	
3. Identify a major legal responsibility of the long term care facility	3. Overview of concept of resident rights	Handout: Facility Bill of Rights
4. Give two examples of ethical issues faced by long term care facilities	4. a. Artificial feeding b. Do not resuscitate c. Living Wills	
5. Describe the basic organizational structure of a long care facility	5. Organizational Chart	Class: Lecture/Discussion
6. Describe the roles and relationships of workers in a long term care facility	6. Organizational Chart and brief job description: a. Administrator b. Director of Nursing (DON) c. Medical Director d. Charge Nurse e. Nurse aide f. Other (Physical Therapist/Occupational Therapist, Dietician, etc.)	Handouts: Organizational structure of long term care facility Brief job description of Director of Nursing, Charge Nurse, Administrator, and nurse aide

7. Give examples of standards for long term care facilities	7. Overview of regulations a. Medicare, Medicaid certification b. Role of regulatory agencies (Michigan Department of Public Health, etc.)

Unit 2. THE LONG TERM CARE RESIDENT	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes: 75% accuracy	Classroom: 1.0 Lab: Clinical: Total: 1.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Describe common physical changes of aging and their impact on function	1. Aging process/concept of functional impairment: vision, hearing, mobility	Class: Lecture/discussion	
2. Describe major life changes and losses experienced by residents of long term care facilities	2. Transitions and losses: a. relocation b. bereavement c. loss of health, independence, social support		
3. Describe common chronic illnesses of the long term care resident	3. Basic definitions of: a. Diabetes b. Parkinson's Disease c. Dementia d. Degenerative Joint Disease e. Hypertension f. Chronic Obstructive Pulmonary Disease g. Congestive Heart Failure h. Stroke	Handout: Basic definitions of common chronic illness	
4. Describe ways to meet long term care residents' psycho-social needs	4. Strategies and nurse aide role: a. Identify residents' individual needs and wishes b. Promote social interaction c. Promote involvement in activities	Class: Lecture/Discussion	
5. Identify the role of family members or significant others in identification of the resident's needs and development of care plan	5. a. Role of the care conference b. Involvement of resident/family/significant other in: 1) needs identification 2) care planning		

6. Discuss cultural and religious differences that may influence values and preferences	6. A. Ethnic/Racial groups: 1) Caucasian 2) Black-American 3) Hispanic 4) Asian 5) American Indian 6) Other b. Religious: 1) Protestant 2) Judaism 3) Catholic 4) Other

Unit 3: Resident Rights

	COMPTENCY IN ANY TASK WILL BE RECOGNIZED WHE THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 2.0 Lab: Clinical: Total: 2.0
STUDENT OBJECTIVES	**CONTENT**	**TEACHING METHOD**	
1. Describe the rights of the resident as specified in the Michigan Public Health Code	1. Michigan Public Health Code Sections: 333.20201 333.21771 a. Privacy and confidentiality b. Personal Choices c. Resolution of Grievances - function of the Resident Council d. Sexuality and expression of sexual needs e. Care and Security of Personal Possessions f. Minimization of use of physical and chemical restraints - see Unit 11 on restraints g. Other	Class: Lecture/Discussion Case Examples Handouts: 1. Michigan Public Health Code Sections 333.20201 and 333.21771 2. Omnibus Budget Reconciliation Act of 1987 (OBRA) Public Law 100-203	
2. Explain ways that the nurse aide can promote/protect resident rights	2. Strategies related to rights identified in objective #1		
3. Define and give an example of: a. Abuse b. Neglect c. Exploitation d. Endangerment	3. Definitions and examples of abuse, neglect, exploitation, and endangerment as stated in Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides, Michigan Department of Public Health, 1988, pp. 3-6		
4. Identify common situations that may cause abuse, neglect, endangerment, or exploitation	4. Common causes of abuse, neglect, endangerment, and exploitation stated in Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides p. 7	Reading Assignments: Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides - Student Section pp. 6-13; 14-21	
5. Explain the procedure and requirements for reporting abuse	5. Process and requirements for: a. Who must report b. To whom reports must be made c. Penalties incurred for failure to report		

6. Describe the nurse aide's responsibilities in an investigation of abuse	6. Process of investigating abuse and nurse aide responsibilities in investigation after a report is filed. Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides p.13	Reading Assignment: Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides - Student Section pp. 23-26
7. Identify penalties incurred for substantiated claims of abuse/neglect	7. Penalties for: a. Facility b. Perpetrator	Reading Assignment: Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides - Student Section p. 27

Unit 4: The Nurse Aide as a Member of the Health Care Team	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAMS	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 2.0 Lab: Clinical: Total: 2.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Describe the role and responsibility of the nurse aide in a long term care facility	1. a. Observation, reporting, recording changes in resident's condition b. Personal care services c. Assistance with activities of daily living d. Assist residents in attaining and maintaining functional independence e. Communicate and interact in a sensitive manner with residents f. Support and Promote Residents Rights g. Other	Class: Lecture/Discussion Activity 1, Part 2	
2. Identify ethical behaviors of the nurse aide	2. a. Definition of ethics/ethical behavior b. Examples of ethical behavior c. Examples of unethical behavior (accepting tips and gifts, eating resident's food, etc.)		
3. Explain legal responsibilities of the nurse aide	3. Functions that can and cannot legally be performed by a nurse aide a. Scope of job description b. Performance of tasks for which competency has been demonstrated c. Support resident rights	Handout: Michigan Public Health Code Section 222.20201	
4. Discuss qualities of an effective nurse aide	4. a. Hygiene b. Health (nutrition, stress management, exercises, etc.) c. Professional appearance d. Attitude		
5. Describe the roles of the nurse aide, Licensed Practical Nurse (LNP) and Registered Nurse (RN) in the planning and provision of resident care.	5. a. Purpose and use of resident care plan b. Delegation of duties c. Channels for reporting and recording d. Planning and organizing work (sequencing and prioritizing tasks)	Handout: - Facility job descriptions (NA, LPN, RN) - worksheets - Sample care plan	

Unit 5: Human Interaction Skills	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 2.0 Lab: Clinical: Total: 2.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Identify elements necessary for effective communication	1. a. Definition of communication (verbal and non-verbal) b. Concise c. Clear - words have same meaning for all parties d. Logical e. Communication that facilitates dignity and respect of individual 1) sensitivity/impact of values 2) attitudes	Class: Lecture/Discussion Activity 2: Mindful Caregiving	
2. Describe four (4) ways to facilitate communication with residents in long term care	2. a. Body language (social expression, gestures, etc) b. Active listening skills c. Use of touch d. Modification of nurse aide's behavior in response to resident's needs e. Reinforcement techniques (praise, etc)	Role playing Show magazine pictures depicting variety of emotion/body language Group discussion of interpretation	
3. Identify communication strategies to assist residents who have special needs	3. A. Visually impaired resident b. Hearing impaired resident c. Cognitively impaired resident d. Aphasia and dysarthria e. Other (language barrier, behavior problems) f. See Unit 11 on Restraints	Role playing Simulate vision and hearing impairment among students Picture boards Care and maintenance of hearing aides (guest speaker) Care and maintenance of eye glasses/contact lenses (guest speaker)	
4. Discuss strategies to resolve conflicts between: a. residents b. staff c. residents and staff	4. a. Basic conflict resolution strategies b. Resident Council c. Employer/employee grievance procedure d. Facility policy e. Resident grievance procedure	Role playing Handout: Interviewing Techniques	

Unit 6: Infection Control	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: 2.0 Lab: 2.0 Clinical: Total: 4.0

STUDENT OBJECTIVES	CONTENT	TEACHING METHOD
1. Define Infection	1. a. Concept of immune system (antibodies) b. Disease state - invasion and growth of microorganisms 1) Local 2) Systemic	Class: Lecture/Discussion
2. Identify common causes of infection	2. Definition and types of pathogens a. Bacteria b. Virus c. Other	
3. Describe ways that infection is spread among nursing home residents	3. a. Portals of entry for microorganisms 1) Respiratory (inhale) 2) Gastro-intestinal (ingest) 3) Blood 4) Breaks in skin b. Portals of exit for mircoorganisms 1) Respiratory (airborne droplets - coughing, sneezing) 2) Gastro-intestinal (urine, feces) 3) Blood 4) Wound drainage c. Methods of spreading microorganisms 1) Hands 2) Food, fluids 3) Dressings 4) Contaminated equipment/utensils 5) Insects 6) Animals	
4. Name the most common infectious organisms found in nursing home residents	4. a. Staphylococcus b. Streptococcus c. Infestation (scabies) d. Other	

5. Identify requirements needed for the growth of microorganisms	5. a. Host/reservoir b. Moisture c. Warmth d. Darkness e. Nourishment f. Oxygen (Differentiate between aerobic and anaerobic)
6. Explain why elderly people are susceptible to infection	6. a. Aging process/compromised immune system b. Common problems that predispose residents to infection 1) Chronic illness (diabetes) 2) Poor nutrition 3) dehydration 4) Stress/fatigue
7. Identify common signs and symptoms of infection	7. A. Classic signs and symptoms 1) Systemic a) Fever b) Anorexia c) Fatigue/lethargy 2) Local a) Erythema b) Purulent drainage c) Pain, tenderness, swelling B. Altered presentation of infection in nursing home residents 1) May have absence of (or very mild) classic systemic signs and symptoms 2) Confusion/agitation 3) Change in physiological functions and activities of daily living
8. Discuss the nurse aide's responsibility in reporting and recording observations of the resident who has an infection	8. a. Timeliness b. Written/oral reporting and recording c. Chain of command

9. Describe ways to prevent and control infection in the nursing home resident and health care worker	9. A. Definition of medical asepsis: prevent the spread of microorganisms through practices, which ensure cleanliness of hands and appropriate care and handling of equipment, food, etc. b. Examples of aseptic technique 1) Handwashing 2) Universal precautions 3) Isolation 4) Chemical disinfection 5) Appropriate handling of equipment, linen, food, waste products, body fluids c. Employee health 1) Employees who are ill or infected should not care for residents 2) Importance of reporting (self or family), breaks in skin, etc. 3) Health promotion practices	Guest Speaker/Resources: Local/State Health Department Local Hospital Medical supplier Center for Disease Control American Red Cross
10. Define Universal Precautions	10. Facility policy based on broad or narrow definition per Center for Disease Control guidelines	
11. Give examples of the appropriate use of Universal Precautions	11. Definition per facility policy	
12. Demonstrate Universal Precautions	12. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration
13. Demonstrate handwashing	13. Facility policy/procedure or see Appendix A	Demonstration/Return demonstration
14. Demonstrate isolation technique	14. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration

Unit 7: Safety/Emergency Procedures	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75%	Classroom: 2.0 Lab: 2.0 Clinical: Total: 4.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Identify common emergency situations which occur in a nursing home	1. A. Resident situations 1) Falls 2) Respiratory emergencies (choking, aspiration, airway obstruction) 3) Cardiac arrest 4) Seizures 5) Loss of consciousness 6) Burns 7) Laceration/Bleeding B. Facility situations 1) Fire 2) Power failure 3) Severe weather 4) Other	Class: Lecture/Discussion	
2. Identify common causes of resident falls	2. a. Knee joint instability b. Medication side effects (dizziness, drowsiness, etc.) c. Low blood pressure/postural hypotension d. Impaired coordination e. Visual impairment f. Cognitive impairment (poor judgment, misperception, etc) g. Environmental hazards (clutter, etc)		
3. Describe three ways to prevent falls in a nursing home resident	3. a. Assistance with ambulation b. Appropriate assistance/supervision c. Environment free of clutter d. Slow rising from bed/chair e. See Unit 11 or Restraints		
4. Demonstrate the appropriate response/action for a nurse aide when a resident falls	4. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	

5. Identify common causes for respiratory emergencies in the nursing home resident	5. a. Diseases b. Improper feeding technique c. Inadequate supervision while eating d. Improper position while eating	
6. List three ways to prevent respiratory emergencies in the nursing home resident	6. a. Proper feeding technique b. Appropriate supervision during mealtime c. Proper positioning for eating	
7. Describe the appropriate nurse aide response/action for a resident in respiratory distress/arrest	7. a. Recognition of signs of respiratory distress/arrest b. Action per facility policy	Resource: American Red Cross
8. Demonstrate the Heimlich Maneuver	8. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration
9. Identify the signs of cardiac arrest*	9. Signs of cardiac arrest	

*If the nurse aide trainee is expected to be competent in CPR (BCLS) - this must be taught in addition to the minimum 75 hour training program

10. Describe the appropriate nurse aide response/action when a resident is in cardiac arrest	10. Facility policy/procedure or see Appendix A	
11. Demonstrate the nurse aide's appropriate action for a resident experiencing a seizure	11. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration
12. List common reasons why a resident may lose consciousness	12. a. Hypoglycemia/hyperglycemia b. Transient ischemic attacks c. Low blood pressure d. Other	
13. Demonstrate the appropriate nurse aide response/action for the unconscious resident	13. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration

14. Identify common causes for burns in the nursing home resident	14. a. Unsupervised smoking b. Contact with hot objects/liquids 1) Bath water 2) Hot packs and heating pads 3) Food/beverages (spills, ingestion) 4) Metal near heat source/heater c. Electrical hazards	
15. Describe ways to prevent burns in a nursing home resident	15. a. Adequate supervision b. Monitoring/testing temperature of food and beverages c. Monitoring of environment (heat source, electrical hazards, etc)	
16. Demonstrate the appropriate action/response for a nurse aide when a resident is burned	16. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration
17. Identify common causes for bleeding/lacerations in the nursing home resident	17. a. Skin tears due to repositioning or transfer b. Falls c. Other	
18. Describe ways to prevent bleeding/lacerations in the nursing home resident	18. a. Care with resident while transferring, repositioning (consideration of skin fragility) b. Prevention of falls (see objective #3)	
19. Demonstrate the appropriate nurse aide action/response for the resident who is bleeding	19. a. Facility policy/procedure or see Appendix A b. Universal Precautions (see objective #10 - Unit on Infection Control)	Demonstration/Return Demonstration
20. Describe safety practices to prevent fires in the nursing home.	20. a. Supervised smoking b. Fire code/regulations per State Fire Marshal	Resource: State Fire Marshal Rules 1991
21. Demonstrate the appropriate action/response of a nurse aide if a fire occurs in the nursing home	21. Facility policy/procedure a. Resident Safety Procedure b. Fire extinguisher usage	Demonstration/Return Demonstration

22. Describe the appropriate action for the nurse aide during severe weather	22. Facility policy/procedure
23. Describe the appropriate action for the nurse aide during a power failure	23. Facility policy/procedure

Unit 8: BASIC PERSONAL CARE SKILLS 8-1: Introduction	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: .5 Lab: Clinical: 6.0 Total: 6.5* *Clinical hours for entire Unit 8-1 to 8-8
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Describe factors, which ensure the comfort, dignity, safety, cleanliness, and independence of the resident in the provision of personal care.	1. a. Knowledge, attitude, skills of staff b. Understanding of basic human needs c. Resident's Rights d. Importance of nurse aide's role: aide's knowledge of resident nurse aide as primary provider of personal care	Class: Lecture/Discussion	
2. Give three reasons why personal care is essential to a long term care resident	2. a. Basic human needs - comfort b. Resident's Rights c. Prevention of problems/poor outcomes	Resource: Maslow's Hierarchy of Needs	
3. Explain the components of personal care	3. a. Oral hygiene b. Skin care c. Perineal care d. Foot care e. Nail care f. Dressing g. Grooming h. Bathing		
4. Demonstrate basic personal care skills	4. Units 8-2 through 8-8 provides detailed instruction for personal care skills	Demonstration/Return Demonstration through individual Units 8-2 to 8-8	
5. Identify observations the nurse aide should make during the provision of personal care	5. a. Physical changes b. Behavioral changes c. Resident's concerns	Activity 3 Preparation for providing direct care	

6. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of personal care	6. A. Characteristics of observations: 1) Accuracy 2) Timeliness 3) Objectivity B. Types of observations 1) Resident 2) Environment a) Safety b) Equipment C. Written/oral reporting and recording D. Chain of command

Unit 8: BASIC PERSONAL CARE SKILLS Unit 8-2 Oral Hygiene	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 1.0 Lab: .5 Clinical: Total: 1.5
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	EVALUATION
1. Define oral hygiene	1. Definition: cleanliness and comfort of the oral cavity (mucous membranes, tongue, teeth/dentures); care of the mouth and teeth using techniques such as brushing, flossing, mouthwash, etc., as appropriate	Class: Lecture/Discussion	
2. Discuss the importance and frequency of oral hygiene	2. Effects of oral hygiene on: a. Comfort b. Prevention of problems c. Appetite d. Socialization	Guest Speaker: Dentist or Dental Hygienist to demonstrate techniques for oral hygiene	
3. Identify the levels of assistance required for oral hygiene	3. a. Non-assisted b. Partially assisted c. Totally assisted		
4. Identify safety precautions for the nurse aide providing oral hygiene	4. a. Universal Precautions b. Protection from biting, combativeness, etc		
5. Demonstrate oral hygiene for the resident with natural teeth	5. a. Facility policy/procedure or see Appendix A b. Non-assisted c. Partially assisted d. Totally assisted 1) Comatose resident 2) Paralyzed resident e. Care and proper storage of equipment/toothbrush	Demonstration/Return Demonstration	

6. Demonstrate oral hygiene for the resident with dentures	6. a. Facility policy/procedure or see Appendix A b. Non-assisted c. Partially assisted d. Totally assisted	Demonstration/Return Demonstration
7. Identify special precautions used in the care of dentures	7. a. Solutions b. Care and proper storage of equipment/dentures c. Safe handling (nurse aide and resident) d. Removal and insertion e. Identification f. Inspection for damage and fit	
8. Demonstrate oral hygiene for the resident without teeth or dentures	8. a. Facility policy/procedure or see Appendix A b. Non-assisted c. Partially assisted d. Totally assisted e. Care and proper storage of equipment	Demonstration/Return Demonstration
9. Demonstrate oral hygiene for the resident with special needs	9. A. Facility policy/procedure or see Appendix A b. Feeding tube c. Other (recent tooth extractions, cancer of tongue, tracheotomy, difficulty swallowing) d. Care of proper storage of equipment	Demonstration/Return Demonstration
10. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of oral hygiene	10. a. Type of observations 1) Inspection 2) Resident's concerns b. Types of observations to report c. Written/oral reporting and recording	

Unit 8: BASIC PERSONAL CARE SKILLS Unit 8-3: Skin Care	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: 1.0 Lab: Clinical: Total: 1.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Describe skin changes that occur with aging	1. a. Dryness b. Itching c. Fragility d. Decreased subcutaneous fat/"padding"	Class: Lecture/Discussion	
2. Explain the importance of skin care	2. a. Comfort b. Prevention of problems c. Maintenance of health skin		
3. Identify skin care needs	3. a. Cleanliness b. Lubrication c. Protection		
4. Identify methods to maintain healthy skin	4. a. Cleanliness 1) Frequency 2) Consideration of problems such as incontinence b. Lubrication 1) Types 2) Frequency c. Protection d. Nutrition/hydration e. Maintenance of circulation		
5. Demonstrate techniques for proper skin care	5. a. Facility policy/procedure or see Appendix A b. Massage c. Cleanliness d. Lubrication e. Protection	Demonstration/Return Demonstration	

6. Discuss the nurse aide's responsibility in recording and reporting observations noted during the provision of skin care	6. a. Types of observations 1) Inspection 2) Resident's concerns b. Types of observations to report c. Written/oral reporting and recording
7. Identify conditions that predispose a resident to skin problems	7. a. Incontinence b. Immobility/weakness/paralysis c. Circulatory impairment d. Diabetes e. Dehydration/malnutrition f. Gait instability/falls g. Decreased sensation h. Age-related changes i. Other

Unit 8: BASIC PERSONAL CARE SKILLS Unit 8-4: Hand and Foot Care	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: .5 Lab: .5 Clinical: Total: 1.0
STUDENT OBJECTIVES		TEACHING METHOD	
1. Describe the importance of hand and fingernail care for the nursing home resident	1. a. Comfort b. Hygiene c. Resident Rights	Class: Lecture/Discussion	
2. Identify observations the nurse aide should make during hand and fingernail care	2. a. Physical changes 1) Contracture 2) Thickened nails 3) Color of skin and nails 4) Hangnails b. Resident concerns	Guest Speaker: Beautician/manicurist to demonstrate nail care	
3. Discuss the nurse aide's responsibility in reporting and recording observations noted during hand and fingernail care	3. a. Timeliness b. Written/oral reporting and recording c. Chain of command		
4. Demonstrate cleaning, filing and trimming of resident's fingernails	4. a. Facility policy/procedure b. Nail care as a routine part of bathing	Demonstration/Return Demonstration	
5. Discuss the importance of foot and toenail care for the nursing home resident	5. a. Definition of foot care as the provision of: 1) Comfort 2) Hygiene b. Resident Rights c. Prevention of problems/maintenance of mobility d. Nurse aide performs toenail care/trimming if included in facility policy		

6. Identify observations the nurse aide should make during foot care	6. a. Physical changes 1) Thickness of nails 2) Color of skin and nails 3) Skin temperature 4) Abnormalities a) Ingrown toenail b) Fungal infection c) Corns, calluses, bunions d) Swelling/edema e) Lesions/ulcer f) Other b. Resident concerns	Guest Speaker: Geriatric Nurse Practitioner or Podiatrist
7. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of foot care	7. a. Timeliness b. Written/oral reporting and recording c. Chain of command d. Nurse aide as primary observer of resident's feet/nails	
8. Identify risk factors and problems that may require a nurse or a podiatrist to perform foot and toenail care	8. a. Diabetes b. Peripheral vascular disease c. Edema d. Excessively thick nails e. Abnormalities listed in # 6 f. Structural abnormalities (hammer toes, etd.) g. Other	
9. Give examples of problems and consequences that may result from toenail care or neglected nails	9. a. Examples of problems 1) Nails too short/too long 2) Inappropriate angle of trim 3) Nicks/cuts b. Consequences 1) Pain/immobility 2) Infection	Guest Speaker: Podiatrist to demonstrate routine foot care
10. Identify the importance of proper fit of shoes, socks, and slippers	10. a. Safety b. Comfort c. Prevention of problems such as corns, blisters d. Importance of inspecting footwear for fit, wear, structure, foreign objects	

11. Demonstrate foot care	11. a. Facility policy/procedure or see Appendix A b. Foot care as routine part of bath	Demonstration/Return Demonstration

Unit 8: BASIC PERSONAL CARE SKILLS Unit 8-5: Hair Care and Shaving	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: .5 Lab: 1.5 Clinical: Total: 2.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Discuss the importance of hair care and shaving	1. a. Comfort b. Hygiene c. Resident Rights	Class: Lecture/Discussion	
2. Identify observations the nurse aide should make during hair care and shaving	2. a. Physical characteristics 1) Changes 2) Lesions 3) Abnormal hair loss 4) Condition of scalp b. Resident's concerns	Guest Speaker: Beautician/Barber	
3. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of hair care and shaving	3. a. Timeliness b. Written/oral reporting and recording c. Chain of command		
4. Demonstrate hair care for a male and female using the appropriate level of assistance	4. a. Facility policy/procedure or see Appendix A b. Female 1) Resident preference a) Shampooing b) Styling - techniques for brushing, combing, appropriateness of style c) Ethnic/cultural considerations d. Appropriate use of beautician 2) Care of comb and brush a) Identification b) Cleaning/storage	Demonstration/Return Demonstration	

c. Male
1) Resident preference
a) Shampooing
b) Styling - brushing and combing
c) Ethnic/cultural considerations
d) Appropriate use of barber
2) Care of comb and brush
a) Identification
b) Cleaning/storage

5. Demonstrate shaving the male resident using the appropriate level of assistance	5. a. Facility policy/procedure or see Appendix A b. Types of razors 1) Electric 2) Safety razor c. Safety precautions d. Frequency e. Resident preferences f. Care of Equipment 1) Identification 2) Cleaning and storage 3) Proper disposal of safety razor	Demonstration/Return Demonstration
6. Demonstrate shaving/hair removal for a female resident using the appropriate level of assistance	6. a. Facility policy/procedure or see Appendix A b. Facial hair 1) Shaving 2) Tweezing 3) Resident preferences c. Leg and axillary hair 1) Shaving 2) Resident preference	Demonstration/Return Demonstration Simulate shaving using a balloon or inflated disposable glove

Unit 8: BASIC PERSONAL CARE SKILLS Unit 8-6: Perineal Care	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: .5 Lab: 1.0 Clinical: Total: 1.5
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Define perineal care.	1. Identify perineal area/perineum	Class: Lecture/Discussion	
2. Discuss the importance of perineal care.	2. a. Comfort b. Hygiene c. Resident Rights d. Prevention of problems 1) Infection in uncircumcised male 2) Vaginitis		
3. Identify observations the nurse aide should make during the provision of perineal care.	3. a. Physical characteristics 1) Lesions 2) Drainage/discharge 3) Odor 4) Cysts, abscesses, lumps, bruises 5) Other abnormalities b. Resident concerns (pain, itching, burning)		
4. Discuss the nurse aide's responsibility in reporting and recording observations made during the provision of perineal care.	4. a. Timeliness b. Written/oral reporting and recording c. Chain of command		
5. Give examples of resident problems/conditions that necessitate frequent perineal care	5. a. Incontinence (urinary and fecal) b. Foley catheter c. Vaginitis		

6. Demonstrate perineal care for male and female residents	6. a. Facility policy/procedure or see Appendix A b. Perineal care as routine part of a.m. and h.s. care and more frequently as needed c. Importance of privacy and dignity during the procedure d. Use of universal precautions in providing perineal care.	Demonstration/Return Demonstration

Unit 8: BASIC PERSONAL CARE SKILLS Unit 8-7: Bathing - Bed/Tub/Shower	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: .5 Lab: 1.0 Clinical: Total: 1.5

STUDENT OBJECTIVES	CONTENT	TEACHING METHOD
1. Discuss the importance of bathing	1. a. Comfort b. Hygiene c. Resident Rights d. Opportunity for communication/social interaction e. Opportunity of observations f. Integration and organization of other procedures	Class: Lecture/Discussion
2. Describe factors which ensure the comfort, dignity, safety, cleanliness and independence of a resident who is being bathed	2. a. Knowledge, skills, attitude of staff b. Understanding of basic human needs c. Resident Rights d. Importance of nurse aide's role e. Safety factors 1) Water and environmental temperature 2) Prevention of falls f. Infection control practices	
3. Identify types of baths	3. a. Bed b. Tub c. Shower d. Whirlpool e. Other	
4. Identify the levels of assistance that may be required for bathing	4. a. Non-assisted b. Partially assisted c. Totally assisted	
5. Identify observations the nurse aide should make while bathing a resident	5. a. Physical characteristics* b. Resident concerns* * See Units 8-1 through 8-6 (skin, hair, etc)	

6. Discuss the nurse aide's responsibility in reporting and recording observations made while bathing a resident	6. a. Timeliness b. Written/oral reporting and recording c. Chain of command	
7. Demonstrate: a. Bed bath b. Tub bath c. Shower	7. a. Facility policy/procedure or see Appendix A b. Bed bath 1) non-assisted 2) partially assisted 3) totally assisted c. Tub bath 1) non-assisted 2) partially assisted d. Shower 1) non-assisted 2) partially assisted 3) totally assisted e. Care and storage of equipment and resident's belongings	Demonstration/Return Demonstration

Unit 8: BASIC PERSONAL CARE SKILLS Unit 8-8: Dressing and Appearance	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: .5 Lab: .5 Clinical: Total: 1.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Identify the importance of clean, appropriate dress and appearance for the nursing home resident	1. a. Comfort b. Dignity c. Resident Rights d. Hygiene e. Social, psychological aspects of dressing and appearance	Class: Lecture/discussion	
2. Discuss ways to promote resident rights in relation to dress and appearance	2. a. Choices b. Resident preference c. Allowing resident self care are much as possible d. Consideration of past preferences and lifestyle e. Labeling and proper care of clothing and footwear f. Consideration of resident needs in accordance with care plan		
3. Identify observation the nurse aide should report while dressing a resident	3. a. Missing clothing items b. Fit of clothing c. Repair needs d. Need for modification of clothes to facilitate independence e. Appropriateness for season and temperature f. Change in self care ability		
4. Demonstrate dressing a resident using the appropriate level of assistance	4. a. Facility policy/procedure or see Appendix A b. Levels of assistance 1) non-assisted 2) partially assisted 3) totally assisted b. Guidelines to ensure resident dignity 1) Undergarments 2) Resident's own clothing 3) Correctly fastened and applied clothing 4) Matching (socks, shoes, etc) 5) Appropriate coverage c. Care and storage of resident's	Demonstration/Return Demonstration	

	belongings
5. Describe ways to enhance a resident's appearance according to resident's preference and/or past preference and lifestyle	5. a. Makeup b. Jewelry c. Nail polish d. Cologne, aftershave e. Other f. Care and storage of resident's belongings

Unit 9: Care of the Resident Environment	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: .5 Lab: 1.5 Clinical: 2.0 Total: 4.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Define resident environment	1. a. Physical 1) Temperature 2) Lighting 3) Ventilation 4) Equipment 5) Other b. Psychosocial 1) Stimulation 2) Personalization 3) Privacy c. Resident's possessions d. Relationship of environment to level of function	Class: Lecture/Discussion Guest Speaker: Resident's Council	
2. Discuss the importance of resident's personal space	2. a. Resident Rights b. Impact on dignity, self-esteem, individualization c. Personalization of environment/resident's possessions		
3. Identify unsafe conditions in the resident's environment	3. a. Clutter b. Spills c. Equipment 1) Poor repair 2) Improper use (wheelchair, unstable chairs, restraints) d. Poor lighting e. Inappropriate temperature/humidity f. Electrical hazards g. Unclean environment h. Unsafe substances within resident's reach	Resource: Facility Safety Committee	
4. Identify resident risks that may result from unsafe conditions	4. a. Falls b. Hypo/hyperthermia c. Infection d. Infestation (ants, cockroaches, etc.) e. Poisoning/toxicity		

5. Describe ways the nurse aide can maintain a safe environment for the nursing home resident	5. a. Adequate lighting and temperature b. Free of clutter c. Appropriate use of: 1) Side rails 2) Call lights 3) Wheelchair brakes d. Cleanliness 1) Adherence to routine cleaning schedules 2) Evaluation of cleanliness - routine inspection e. Consideration of resident's level of function	
6. Explain the nurse aide's role in reporting and recording conditions in the resident's environment	6. A. Timeliness b. Written/oral reporting and recording c. Chain of command 1) Nursing 2) Other (maintenance, dietary, etc)	
7. Define an occupied and an unoccupied bed	7. Definition of occupied and unoccupied bed	
8. Describe the importance of handling bed linen properly	8. a. Infection control b. Dust, lint	
9. Identify situations when a resident's be linen should be changed	9. a. Soiling b. Wetness c. Resident comfort d. routine changing per facility policy	
10. Identify special equipment that may be used on the bed	10. a. Egg crate mattress b. Air mattress c. Naso-gastric tube d. Oxygen e. Urinary drainage system f. Other	
11. Demonstrate operation of the bed	11. Per facility equipment (electric, manual, etc)	Demonstration/Return Demonstration
12. Demonstrate making an occupied and unoccupied bed	12. Facility policy/procedure	Demonstration/Return Demonstration

Unit 10: Care of the Resident with Cognitive Impairment (Dementia - Alzheimer's Disease and Related Disorders)	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 3.0 Lab: Clinical: 1.0 Total: 4.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Define cognitive impairment	1. Definition of cognitive impairment as diminished cognitive ability such as impaired memory, judgment, insight, capacity for logical thinking and abstract thought. Impairment of higher intellectual functions	Class: Lecture/Discussion	
2. Identify causes of cognitive impairment	2. a. Reversible causes 1) Medications 2) Malnutrition 3) Environmental 4) Dehydration 5) Other b. Irreversible causes 1) Dementia a) Alzheimer's Disease b) Multi-infarct dementia (strokes) c) Other 2) Brain injury		
3. Define dementia	3. Definition of dementia as irreversible loss of intellectual function due to a disease process		
4. Discuss the importance of understanding cognitive impairment and dementia and appropriate ways to care for the resident with cognitive impairment	4. a. More than half of nursing home residents have a dementing illness b. Impact of appropriate care and understanding 1) Preservation/Restoration quality of life 2) Minimal or no use of physical, chemical restraints 3) Maintenance of independence and function for as long as possible 4) Minimization of staff stress/frustration		

5. Describe the effects of cognitive impairment and implications for care	5. a. Impaired cognition/intellectual function (confusion) 1) Memory problems - especially short-term 2) Impaired judgment 3) Impaired insight 4) Impaired time orientation 5) Diminished attention span b. Altered behavior 1) Agitation 2) Combativeness 3) Nighttime wakefulness 4) Wandering 5) Delusions 6) Resistance to ADL
6. Discuss common causes of increased confusion and/or altered behavior in the resident with cognitive impairment	6. a. Concept of lowered stress threshold (See attachment) b. Inability to process information (See attachment) c. Causes of increased confusion and/or altered behavior 1) Fatigue 2) Physical illness/discomfort 3) Over-stimulating environment (sensory overload) 4) New situation - change in schedule or routine 5) Medications 6) Visual/hearing impairment - distortion of information 7) Unfamiliar environment (lack of familiar cues)
7. Describe ways to minimize confusion and prevent altered behavior in the resident with cognitive impairment	7. a. Communication 1) Clear 2) Slow 3) Simple, short sentences and instructions 4) Non-threatening, calm approach 5) Avoid reasoning and logic (person cannot think logically - increases frustration b. Environmental modification 1) Reduced stimulus environment 2) Familiarity/visual cues 3) Adequate lighting c. Facilitate sensory input (hearing aids, eyeglasses) d. Frequent rest periods e. Structure and routine

	f. Individualized care plan g. Capitalize on resident strengths/areas of intact intellect h. Techniques for encouragement/reinforcement i. Characteristics of Observations 1) Timeliness 2) Written/oral reporting and recording 3) Chain of command	
8. Discuss ways to deal with the resident behaviors	8. a. Introduce appropriate terms to describe behaviors b. Approach person slowly from front - make eye contact c. Calm, non-threatening approach d. Take resident to quiet area with stress reduction techniques (music, massage, etc) d. Validation, refocusing techniques	Role playing
9. Describe ways to prevent and eliminate the use of physical and chemical restraints in the resident with cognitive impairment	9. a. Methods as outlined in objective 7 and 8 b. See Unit 11 on Restraints	
10. Describe ways to promote resident rights for the person with cognitive impairment	10. a. Choice based on needs and individual's capacity to make decisions b. Maintenance of function, independence, encourage and support self care c. Respect for privacy and possessions d. Treat as an adult e. See unit on Resident Rights	
11. Describe feelings and attitudes a nurse aide may experience in caring for a resident with cognitive impairment	11. a. Importance of knowing the resident as an individual - use resident's personal history b. Positive feelings/attitudes 1) Fondness 2) Caring, nurturing 3) Satisfaction c. Negative feelings/attitudes 1) Fear 2) Avoidance 3) Frustration 4) Impatience 5) Devaluation of the person as an individual a) Minimizing or ignoring resident's statements, feeling, etc.	Video : “The Notebook”

	b) Treating the person as a child	
12. Discuss ways to use the resident's family/significant other as a source of information and support	12. a. Family/significant other as source of information 1) Resident's past preferences and lifestyle 2) Resident's personal history and interests - information to provide a view of the resident as an individual b. Family/significant other as source of support 1) Assistance with structure and routine 2) Other	Brief personal history – students write what they would like a nurse aide to know about them Activity: Gaining information from family members

Unit 11: Creating an Environment for Restraint Elimination, Reduction, Appropriate Use	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: 3.0 Lab: 0.5 Clinical: 0.5 Total: 4.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Identify strategies to reduce or eliminate the use of physical and chemical restraints	1. Strategies focusing on: a. Development of individualized care plans based on comprehensive assessment b. Communication c. Supervision/assistance d. Reduced stimulus environment e. Management of difficult behaviors 1) Wandering 2) Agitation/combativeness 3) Sleep disturbances 4) Hallucinations/delusions f. Falls risk reduction g. Rehabilitative/restorative care (increasing mobility, strength, activities of daily living performance) h. Meeting psychosocial needs	Class: Lecture/Discussion Handouts or Reading Assignment	
2. Define physical restraint	2. Definition of physical restraint per State Operations Manual, Survey Guidelines (See attached definition)		
3. Identify devices in a nursing facility that could meet the definition of physical restraint	3. a. Lap buddie b. Positioning device c. Alarms 1) Bed 2) Chair d. Low beds e. Mats f. Other		
4. Give examples for the use of physical restraints a. Appropriate b. Inappropriate	4. a. Criteria for appropriate use of restraints 1) Evidence of use of less restrictive measures that proved to be ineffective 2) Temporary (ongoing evaluation with goal of using less restrictive measures) 3) Consent by resident or legal representative 4) Medically justified/medical order 5) Part of treatment plan based on comprehensive assessment		

	A restraint may be used for various reasons. Differences in use are based on intent of use and whether justified, limited, supervised. For example: A vest restraint can be used to keep a resident upright in a chair; problems associated with the resident "slumping" or poor posture are greater than the problems associated with use of the device. b. Examples of appropriate use of physical restraints c. Examples of inappropriate use of physical restraints	
5. Demonstrate the application and removal of physical restraints	5. a. Importance of proper application (most injuries occur when restraints are improperly applied) b. Facility policy/procedure or see Appendix A c. Emphasis on appropriate application, removal, release, exercise every two (2) hours	Demonstration/Return Demonstration
6. Identify appropriate observations to make while a resident is physically restrained	6. A. Effectiveness of devices in context of care plan b. Frequency of observations c. Potential problems 1) Signs of impaired circulation 2) Evidence of skin irritation/injury 3) Effects on behavior (i.e., agitation, anxiety, fear) 4) Decline in physical function or condition (mobility, incontinence, pressure sores) d. Characteristics of observations 1) Timeliness 2) Written/oral reporting and recording 3) Chain of command	
7. Define chemical restraint	7. Definition of a chemical restraint per State Operations Manual/Survey Guidelines (See attached definition)	
8. Describe the possible effects of chemical restraints	8. Changes in mood, behavior, mobility, cognition	
9. Give examples for use of chemical restraints a. Appropriate b. Inappropriate	9. a. Examples of appropriate use of chemical restraints based on individualized care plans when other strategies are ineffective b. Examples of inappropriate use of chemical restraints	

10. Identify appropriate observations to be made for a resident who is chemically restrained	10. a. Effectiveness of chemical restraint in context of care plan b. Potential side effects - changes in behavior/status 1) Alteration in cognition 2) Sleepiness/lethargy 3) Impaired communication 4) Altered ability to perform activities of daily living 5) Gait disturbance 6) Dizziness c. Characteristics of observations 1) Timeliness 2) Written/oral reporting and recording 3) Chain of command
11. Discuss possible outcomes of restraint use (physical and chemical)	11. A. General - physical and psychological discomfort b. Physical 1) Increased muscle rigidity, weakness, unsteadiness - immobility, falls 2) Reduced or impaired circulation 3) Abrasions, skin tears 4) Pressure sores 5) Incontinence 6) Constipation/impaction 7) Ankylosed joints and contracted muscles 8) Bone resorption due to immobility and demineralization 9) Death - strangulation or impaired respiratory function 10) Safety to self, others 11) Maintenance/improvement of posture c. Psychological 1) Depression 2) Loss of will to live 3) Confusion 4) Change in mood and behavior (positive or negative)

UNIT 12: Vital signs, height, weight	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 1.0 Lab: 1.0 Clinical: 2.0 Total: 4.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Define body temperature	1. Definition of body temperature	Class: Lecture/Discussion	
2. Identify ways of taking a resident's temperature	2. a. Routes 1) Oral 2) Rectal 3) Axillary b. Methods 1) Glass 2) Electronic thermometer 3) Topical/temp strip c. Other routes and methods per facility policy		
3. Identify normal range for body temperature	3. a. Normal range 1) Oral 2) Rectal 3) Axillary b. Fever c. Hypothermia		
4. Describe factors and conditions that affect body temperature	4. a. Infection b. Environmental temperature		
5. Demonstrate taking and recording a resident's temperature a. Oral b. Rectal c. Axillary	5. Facility policy/procedure	Demonstration/Return Demonstration	
6. Define pulse	6. Overview of cardiovascular system		
7. Identify the method used by a nurse aide to take a resident's pulse	7. a. Radial b. Other methods/sites per facility policy		

8. Identify normal range for pulse	8. Normal pulse range	
9. Describe factors/conditions that affect pulse rate	9. a. Disease 1) Infection 2) Cardio-vascular disease b. Medications c. Emotional status (stress, etc) d. Activity level	
10. Demonstrate taking and recording a resident's pulse	10. Facility policy/procedure or see	Demonstration/Return Demonstration
11. Define respiration	11. Overview of respiratory system	
12. Identify normal range for respirations	12. Normal respiratory rate	
13. Describe factors/conditions that affect respiratory rate	13. a. Diseases 1) Infections 2) Cardio-vascular disease 3) Pulmonary disease b. Activity level	
14. Demonstrate taking and recording a resident's respiration	14. Facility policy/procedure or see	Demonstration/Return Demonstration
15. Define blood pressure	15. Overview of cardiovascular system	
16. Identify types of equipment for taking blood pressure	16. a. Types of sphygmomanometers b. Cuff sizes	
17. Identify factors that affect blood pressure	17. a. Diseases b. Emotional status c. Techniques and equipment d. Position e. Activity level f. Medication g. Diet (caffeine, sodium) h. Other	
18. Demonstrate taking and recording blood pressure	Facility policy/procedure	Demonstration/Return Demonstration

19. Describe importance of taking the resident's height and weight	19. a. Evaluation of nutritional status b. Basis for medication order c. Basis for diet orders	
20. Identify factors that affect a resident's height and weight	20. a. Aging changes b. Nutrition c. Activity level d. Diseases (osteoporosis, etc)	
21. Demonstrate taking and recording a resident's weight: a. Resident who is standing b. Resident who is unable to stand	21. a. Facility policy/procedure b. Equipment 1) Balance type scale 2) Bed scale 3) Chair scale	Demonstration/Return Demonstration
22. Demonstrate taking and recording a resident's height: a. Resident who is standing b. Resident who is unable to stand	22. Facility policy/procedure	Demonstration/Return Demonstration
23. Describe the nurse aide's responsibility in reporting and recording vital signs, height, and weight	23. a. Abnormal findings b. Timeliness c. Written/oral reporting and recording - flow sheets d. Chain of command	

UNIT 13: Meeting Nutrition/Hydration Needs of the Nursing Home Resident (Eating, Feeding, Hydration, I & O)	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 2.0 Lab: 1.0 Clinical: 1.0 Total: 4.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Define nutrition/hydration	1. a. Basic food groups b. Role of calories, nutrients, fluids	Class: Lecture/Discussion Guest Speaker: Dietician, County Extension Home Economist, Michigan Dairy Council Pamphlets: Michigan Dairy Council	
2. Identify nutrition/hydration needs of the nursing home resident	2. a. Nutrient/caloric requirements b. Fluid requirements c. Factors affecting nutritional needs: 1) Physical problems/diseases (diabetes, pressure sores, fever, etc) 2) Height/weight 3) Activity		
3. Identify the physical changes of aging that affect nutrition/hydration status of the nursing home resident	3. a. Taste b. Smell c. Dentition d. Thirst mechanism		
4. Describe psycho-social factors that affect nutrition/hydration status of the nursing home resident	4. a. Loneliness b. Depression c. Change in environment and routine d. Mental status (cognitive impairment)		
5. Describe changes that may occur with inadequate nutrition/hydration	5. a. Weight change b. Skin and mucous membrane changes (increased dryness) c. Lethargy d. Confusion e. Changes in elimination (constipation, oliguria)		
6. Discuss the nurse aide's responsibility in reporting/recording	6. a. Timeliness b. Written/oral reporting and recording		

observations related to nutrition/hydration	1) Flow sheets 2) Food acceptance record c. Accurate weight d. Chain of command	
7. Discuss the various types of special diets that may be used for a nursing home resident	7. a. Diabetic diet b. Sodium-restricted diet c. Liquid diet d. Soft diet e. Mechanical soft diet f. Nutritional supplements g. Force or restrict fluids h. Pureed i. Low cholesterol/low fat	
8. Name alternative nutrition/hydration therapies	8. a. Nasogastric tube feeding b. Hyperalimentation/Total Parenteral Nutrition (TPN) c. Intravenous (IV) d. Percutaneous Enterostomal Gastrostomy Tube (PEG Tube)	
9. Describe strategies to maintain/improve a resident's nutrition/hydration status	9. a. Resident choice/preferences b. Ethnic/cultural considerations c. Consideration of eating environment 1) Physical (noise, odors, cleanliness, etc) 2) Social (conversation, social interaction) d. Temperature and appearance of food e. Position of resident while eating f. Oral hygiene g. Dentures in place (fit) h. Handwashing for resident i. Adequate time for eating j. Timing of toileting	
10. Discuss ways to maintain/improve nutrition/hydration for the resident with special needs/problems	10. a. Methods to assist individuals with special needs: 1) Visual impairment 2) Dysphagia 3) Limited manual dexterity 4) Cognitive impairment 5) Agitation/combativeness b. Storing/hoarding food c. Non-compliance with diet	Guest Speaker: Occupational therapist Adaptive equipment utensils, plate guard, etc
11. Discuss the importance of a team approach in maintaining/improving a resident's	11. Role of: a. Dietician and dietary department b. Nursing c. Social work d. Nursing Aide	

nutrition/hydration status	e. Family	
12. Demonstrate feeding techniques using the appropriate level of assistance	12. A. Facility policy/procedure b. Levels of assistance 1) non-assisted 2) Partially assisted 3) Totally assisted c. Verify resident identity and appropriate tray d. Techniques for residents with special needs e. Protection of resident's clothing f. Removal of tray, food, and cleaning of eating area g. Signs indicating resident is having difficulty swallowing/choking h. Pre and post meal grooming	Demonstration/Return Demonstration
13. Define intake and output	13. Definition of: a. Intake (food and fluid) b. Output (feces, urine, emesis, wound drainage, perspiration)	
14. Discuss common reasons why intake and output is measured	14. Physical problems, chronic illness a. Dehydration b. Kidney failure c. Weight change d. Other	
15. Discuss the nurse aide's responsibility in reporting and recording intake and output	15. a. Timeliness b. Written/oral reporting and recording 1) Flow sheets c. Chain of command	
16. Demonstrate measuring and recording intake and output	16. A. Facility policy/procedure b. Intake (food, fluids per facility policy - I.e. oz. Or cc.) c. Output 1) Urine 2) Emesis 3) Feces	Demonstration/Return Demonstration
17. Demonstrate the Heimlich maneuver	17. Facility policy/procedure (see Unit 7 on Safety/Emergency Procedures)	Demonstration/Return Demonstration

Unit 14: Elimination	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 2.0 Lab: 1.0 Clinical: 1.0 Total: 4.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Identify routes of elimination	1. a. Urine b. Feces c. Skin (perspiration) d. Wound drainage e. Emesis	Class: Lecture/Discussion	
2. Describe aging changes that affect bowel and bladder elimination in the nursing home resident	2. a. Changes in bowel 1) Decreased motility, tone, sensation b. Changes in bladder 1) Decreased muscle tone, sensation 2) Decreased sphincter control		
3. Identify common elimination problems that may occur in a nursing home resident	3. a. Diarrhea b. Constipation/fecal impaction c. Urinary tract infections d. Incontinence		
4. Discuss the impact of restraint use on elimination patterns	4. a. Restraint use as a contributing factor to urinary and fecal incontinence, constipation		
5. Discuss ways to enhance elimination and prevent common elimination problems	5. a. Dietary considerations (food and fluid) b. Activity/exercise c. Frequency of toileting d. Knowledge of resident's elimination pattern e. Dignity, privacy during toileting		
6. Discuss the nurse aide's responsibility in reporting and recording observations related to elimination	6. a. Timeliness b. Verbal/oral reporting and recording c. Chain of command d. Appropriate observations to make: 1) Color 2) Odor 3) Amount 4) Character (blood, etc) 5) Frequency 6) Discomfort		

7. Discuss the nurse aide's role in bowel and bladder training	7. a. Definition of bowel and bladder training per facility procedures b. Nurse aide's role per facility policy c. Reporting and recording	
8. Define incontinence	8. Definition of: a. Urinary incontinence b. Fecal incontinence	
9. Describe factors that may cause incontinence	9. a. Infrequent toileting b. Urinary tract infection c. Diuretics d. Laxatives e. Neurologic disorders (CVA, etc) f. Restraint use	
10. Discuss the impact of incontinence on the nursing home resident	10. a. Physical 1) Skin breakdown 2) Discomfort b. Psycho-social 1) Shame, embarrassment 2) Social isolation 3) Negative attitude of staff	
11. Discuss ways to decrease/prevent incontinent episodes	11. a. Frequent toileting b. Accessibility of toilet/commode/bedpan/urinal c. Dietary considerations d. Bowel and bladder training	
12. Identify ways to manage incontinence	12. a. Appropriate use of absorbent products/pads b. Maintenance of resident's dignity and rights	
13. Demonstrate toileting using appropriate level of assistance for: a. Toilet b. Commode c. Bedpan d. Urinal	13. a. Facility policy/procedure b. Levels of assistance 1) Non-assisted 2) Partially assisted 3) Totally assisted c. Maintenance of privacy, dignity d. Universal precautions e. Care and storage of equipment	Demonstration/Return Demonstration

14. List reasons why urinary catheters are used	14. a. Intermittent vs. indwelling b. Urinary retention c. Skin breakdown d. Other	
15. Identify types of urinary catheters	15. a. Internal 1) Foley 2) Straight b. External 1) Condom drainage units c. Suprapubic catheters	
16. Discuss special considerations in caring for the resident with urinary catheter	16. a. Position of tubing b. Safety precautions when transferring or ambulating resident c. Observations to make d. Maintaining integrity of the system (patency)	Demonstration/Return Demonstration
17. Demonstrate catheter care	17. Facility policy/procedure	Demonstration/Return Demonstration
18. Demonstrate measuring and recording output	18. Facility policy/procedure	Demonstration/Return Demonstration
19. Demonstrate collecting urine and stool specimens	19. Facility policy/procedure a. Routine urine specimen b. Clean catch mid-stream c. Stool specimen for hemoccult d. Other	Demonstration/Return Demonstration

Unit 15: Rehabilitative Restorative Care	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 2.0 Lab: 2.0 Clinical: 4.0 Total: 8.00
STUDENT OBJECTIVES	**CONTENT**	**TEACHING METHOD**	
1. Define rehabilitative restorative care	1. Definition of rehabilitative/restorative care: a. Process by which people who have been disabled by injury or sickness are helped to recover as much as possible of their original abilities for the activities of daily living b. Activities to improve or maintain function	Class: Lecture/Discussion	
2. Identify the major goals of rehabilitative/restorative care	2. To help resident do as much as they can, as well as they can, for as long as they can a. prevention b. restoration c. maintenance		
3. List the components of rehabilitative restorative care	3. a. Mobility b. Range of motion c. Positioning/turning d. Transfer e. Assistive devices, i.e. wheelchair, walker		
4. Identify members of the rehabilitative restorative team	4. All health care team members: a. Occupational therapist b. Physical therapist c. Speech therapist d. Restorative aide e. Nursing staff f. Social worker g. Activities Director h. Physician i. Dietician j. Family	Guest Speaker: Rehabilitative Restorative Team Member	
5. Describe the role of the nurse aide in rehabilitative restorative care	5. a. Maintenance of safe environment b. Psychological support i.e. encouragement, praise c. Integration of rehabilitative/restorative care plan into daily care d. Characteristics of Observations 1) Timeliness		

	2) Written/oral reporting and recording 3) Chain of command e. Expectation of independence	
6. Explain the importance of proper body mechanics for the nurse aide and resident	6. Definition of body mechanics as special ways of standing and moving one's body to make the best use of strength and avoid fatigue or injury: a. Importance for nurse aide 1) Prevention of injury (especially back injury) 2) Safety 3) Enhancement of strength and stability b. Importance for resident 1) Prevention of injury and problems (contracture) 2) Safety	
7. Demonstrate the use of proper body mechanics when delivering care	7. a. Facility policy for specific activities such as transfer, lifting, moving, etc b. Incorporation of principles of body mechanics: 1) Broadened stance/wide base of support 2) Use of major muscle groups for lifting 3) Appropriate posture/body alignment	Demonstration/Return Demonstration
8. Describe the importance of maintaining a resident's mobility	8. Definition of mobility as ambulation and maintenance of joint function a. Prevention of problems related to immobility 1) Cardio-vascular deconditioning 2) Loss of muscle tone/strength 3) Pressure sores 4) Contractures 5) Constipation 6) Psychological effects 7) Joint stiffness "disuse syndrome" 8) Hypostatic pneumonia b. Benefits of maintaining mobility 1) Maintenance of physical function 2) Maintenance of psychological function	
9. Demonstrate proper ambulation	9. Facility policy/procedure or see Appendix A a. Ambulation without assistance b. Ambulation with assistance c. Ambulation with walker d. Ambulation with cane e. Use of wheelchair f. Use of artificial limb	Demonstration/Return Demonstration

10. Demonstrate transfer technique	10. Facility policy/procedure or see Appendix A a. Transfer to and from: chair, bed, wheelchair, commode, toilet, other b. Equipment: mechanical lifts, slide boards, transfer belt c. Other	Demonstration/Return Demonstration
11. Describe the benefits of proper turning and positioning	11. Prevent/minimize: a. Pressure sores b. Contractures c. Joint stiffness d. Discomfort/pain	
12. Discuss factors that determine the frequency of positioning/turning a resident	12. a. Resident's request b. Physician order c. Care Plan	
13. Demonstrate technique for positioning/turning a resident	13. Facility policy/procedure or see Appendix A for positioning/turning: a. Turning in bed b. Positioning in bed c. Positioning in chair	Demonstration/Return Demonstration
14. Discuss the nurse aide's responsibility in reporting, recording and observing related to positioning/turning of resident	14. a. Timeliness b. Written/oral reporting c. Chain of command	Demonstration/Return Demonstration
15. Demonstrate proper use of equipment for positioning/turning	15. Facility policy/procedure regarding: sandbags, pillows, etd	Demonstration/Return Demonstration
16. Identify the importance of range of motion exercises for nursing home residents	16. a. Exercise muscles and joints b. Maintenance of mobility and function	
17. Demonstrate active and passive range of motion	15. Facility policy/procedure	
18. Identify reasons for using Assistive devices	18. Maintenance of mobility, function and independence, improvement in function	
19. Give example of Assistive devices	19. Eating aids, plate guards, braces, splints and prosthetic devices	Guest Speaker: Occupational therapist

with demonstration of
use of Assistive
devices

Unit16:Care of the Resident with Developmental Disabilities	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: 1.0 Lab: Clinical: Total: 1.0

STUDENT OBJECTIVES	CONTENT	TEACHING METHOD
1. Discuss characteristics of the resident with mental retardation (developmental disabilities)	1. a. Cognitive/intellectual characteristics 1) Impaired memory 2) Impaired ability to learn 3) Decreased attention span 4) Poor impulse control 5) Impaired language/communication 6) May have limited ability to perform ADL's independently b. Psychological characteristics 1) Altered perceptions 2) Emotional liability 3) Inappropriate responses c. Chronological age will not match developmental age	Class: Lecture/Discussion
2. Identify the common causes of mental retardation (developmental disability)	2. a. Congenital disorders (ie. Down's Syndrome) b. Brain injury	
3. Describe the nurse aide's role in caring for the resident with mental retardation (developmental disabilities)	3. a. Maintenance of resident rights and dignity b. Physical needs 1) Safety 2) Supervision (ADL, activities) c. Psychological needs 1) Communication methods 2) Acceptance and support 3) Encouragement for self-help and independence 4) Assist other residents to be sensitive to the needs of the person with mental retardation	

Unit 17 Depression	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: 1.0 Lab: Clinical: Total: 1.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Identify symptoms of depression in the elderly	1. a. Sadness b. Withdrawal c. Fatigue d. Anorexia e. Weight loss f. Sleep disturbance g. Confusion h. Suicidal thoughts	Class: Lecture/Discussion Guest Speaker: Mental Health Professional Social Worker Physician Pharmacist	
2. Name two types/causes of depression in the elderly	2. a. Situational 1) Losses 2) Nursing home placement b. Chemical 1) Medication side effects 2) Altered brain chemicals (neurotransmitters)		
3. Identify possible outcomes of untreated depression	3. a. Suicide 1) Active 2) Passive (refusing meds, food) b. Increasing physical debilitation due to weight loss, etc.		
4. Identify methods used to treat depression	4. a. Counseling b. Medication		
5. Discuss the nurse aide's role in caring for a resident who is depressed	5. a. Observation and reporting of symptoms/behavior change b. Reassurance, support - convey individual's value and worth c. Listening d. Encouragement/participation in activities and socialization as appropriate		

Unit 18: Caring for the Resident at the end of life	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: 0.5 Lab: 0.5 Clinical: Total: 1.0

STUDENT OBJECTIVES	CONTENT	TEACHING METHOD
1. Describe common feelings that a nursing home resident may have about death and dying	1. a. Acceptance (may be a common response in nursing home residents) b. Fear c. Denial d. Anger	Class: Lecture/Discussion Guest Speaker: Social Worker/Mental Health Professional Physician Pharmacologist
2. Identify physical needs of the dying resident	2. a. Comfort/positioning b. Environment c. Hygiene/cleanliness	
3. Identify psychological needs of the dying resident	3. a. Dignity b. Resident preference regarding solitude or interaction c. Support/understanding d. Need for listening and touch e. Awareness of resident's sensitivity to what is being said/ability to hear when other senses diminished f. Spiritual needs	
4. Describe the feelings and responses the resident's family, friends, roommate may have during the dying process	4. a. Guilt b. Anger c. Sadness/depression d. Avoidance e. Denial f. Acceptance g. Relief	
5. Describe the nurse aide's role in caring for a dying resident	5. a. Physical care/comfort b. Support and caring c. Observations d. Reporting/recording appropriate information e. Knowledge of nursing care plan regarding advanced directives	
6. Describe the nurse aide's role in working with the family of a dying resident	6. a. Interaction and communication of appropriate information per facility policy b. Reporting/recording - appropriate	

	information c. Understanding/support d. Comfort (information about meals, coffee, etc) e. Special visiting policy f. Cultural issues/variations g. Myths	
7. Identify ways to support other nursing home residents when a resident dies	7. a. Listening b. Caring, interested attitude c. Appropriate observations (signs of depression, etc) d. Reporting/recording appropriate information	Small group discussion or short written assignment Guest Speaker: Funeral Director Pastoral Care Counselor
8. Identify one's own feelings about death/dying	8. a. Self-examination of feelings (loss, sadness, etc) b. Nurse aide's relationship with resident	
9. Describe ways to cope with one's own feelings when a resident dies	9. a. Talking with peers b. Talking with professional staff c. Other	Case study using an actual resident
10. Demonstrate post-mortem care	10. Facility policy/procedure	Demonstration/Return Demonstration

Unit 19: Caring for the Resident with Acquired Immune Deficiency Syndrome	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	<u>EVALUATION</u> Exams/Quizzes with 75% accuracy	Classroom: 1.0 Lab: Clinical: Total: 1.0

STUDENT OBJECTIVES	CONTENT	TEACHING METHOD
1. Define Acquired Immune Deficiency Syndrome	1. Definition of Acquired Immune Deficiency Syndrome	Class: Lecture/Discussion
2. Define Human Immunodeficiency Virus (HIV)	2. Definition of HIV	Resources: State Health Department - Office of AIDS Prevention Local Health Department American Red Cross American Health Care Association - The Nursing Home Resident with AIDS
3. Identify sources of the AIDS virus (HIV) and methods of transmission	3. a. Sources of HIV 1) HIV positive blood 2) HIV positive body fluids b. Methods of transmission of HIV - Direct contact of blood with HIV positive blood, body fluids 1) Transfusions 2) Puncture wounds/needle sticks/breaks in skin 3) Mucous membranes "splashed" with contaminated body fluids 4) Sexual contact	
4. Describe symptoms and problems of the nursing home resident with AIDS	4. a. Physical 1) Physical debilitation 2) Susceptibility to infection 3) Cognitive impairment (dementia syndrome) b. Psychological 1) Age (younger than typical nursing home resident) 2) Depression 3) Fear 4) Guilt 5) Death, dying issues	

5. Discuss one's own feeling and attitudes about caring for the resident with AIDS	5. a. Self-examination of feelings b. Importance of accurate knowledge	Group discussion Written assignment
6. Describe the nurse aide's role in caring for the resident with AIDS	6. a. Resident rights/confidentiality b. Physical needs 1) Comfort 2) Hygiene 3) Use of Standard Precautions - see Unit 6 4) Nutrition c. Psychological needs 1) Support 2) Listening 3) Maintenance of dignity d. Reporting/recording appropriate information	

Unit 20: Clinical Practicum	COMPETENCY IN ANY TASK WILL BE RECOGNIZED WHEN THE STUDENT PERFORMS IT ACCORDING TO THE PROCEDURES OF THE TRAINING PROGRAM	EVALUATION Exams/Quizzes with 75% accuracy	Classroom: Lab: Clinical: 7.0 Total: 7.0
STUDENT OBJECTIVES	CONTENT	TEACHING METHOD	
1. Demonstrate beginning ability to function as a nurse aide in a long term care facility	1. Resident care which integrates knowledge and skills of nurse aide	Observation, supervision and evaluation of trainee by the Primary Instructor (PI) or Delegated Instructor (DI) * * DI must be supervised by PI	

Section D:

Resources For Selected Units

Unit 2 – Long-Term Care
"Diseases"
Intermed Communications, Inc.
132 Welsh Road
Horsham, PA 19044

Duke University Center for Geriatric Education
Box 3003
Durham, NC 27710
(919) 684-2248

Unit 3 – Resident Rights
Michigan Public Health Code
Sections 333.20201 and 333.21771

Identification and Reporting of Abuse: A Manual for Nursing Home Aides, Michigan Department of Public Health, 1988

Geriatrics, October 1979. "The Need for Personal Space in Institutions for the Elderly," pp. 42-50.

Unit 4 – Health Team Member
"The Health Care Worker and Ethics"
Video Associates
P.O. Box 1656
Kalamazoo, Michigan 49081
A 25 minute video on ethical and legal responsibilities for beginning health care workers. $49.95

Unit 5 – Human Interaction Skills
Nursing Life, July/August, 1986. "Communicating Better With the Elderly," pp 25-27

Nursing 80, February, 1980. "Pseudo Communication With Patients," pp 105-108

3. Communication Skills Building, "Experiencing Aphasia"
   P.O. Box 42050
   Tucson, AZ 85733 $24.95 (workbook and 2 audio tapes)

Unit 7 – Safety/Emergency Procedures
American Heart Association Publications
Heart Saver Manual
Health Care Providers Manual for BLS
Basic Life Support

American Red Cross
Adult CPR
Standard First Aid

Unit 8 – Basic Personal Care
Gannon, E., Kadezabeh, E. March 1990. "Meticulous Mouth Care," Nursing 80, pp 70-75.

Unit 10 – Cognitive-Impairment
See resources attached to unit

Unit 11 – Restraint Elimination
Journal of Gerontological Nursing, 1991, 17 (2) Special issue of restraints.

Unit 12 – Vital Signs
American Red Cross
How to Measure Blood Pressure (manual)

Unit 13 – Meeting Nutrition/Hydration Needs
Dairy Council of Michigan, 2163 Jolly Road, Okemos, MI 48864 (800) 548-8097

Robison, G., Weigley, E. (1984) Basic Nutrition and Diet Therapy (6th ed.), New York, MacMilliam Publishing Co.

Unit 15 – Restorative Care
Hoeman, S. (1990) Rehabilitation/Restorative Care In the Community, St. Lousi, C.V. Mosby Co.

Unit 19 – AIDS
AIDS Hotline – (800) 872-2437

Section E:

References

Allen, J., April/May 1986. Health Care Worker and the Risk of HIV Transmission, Hastings Center Report.

American Health Care Association, 1987. AIDS and the Nursing Home Resident.

Michigan Department of Public Health, Office of AIDS Prevention, (517) 335-8468.

Additional Resources and References

Hall, G.R. and Buckwalter, K.C. (1987) Progressively Lowered Stress Threshold; A Conceptual Model for Adults with Alzheimer's Disease. Archives of Psychiatric Nursing, 1: 399-406.

Rader, J. (1991) Modifying the Environment to Decrease the Use of Restraints. Journal of Gerontological Nursing, 17 (2) 9-13.

Beck, C. and Heacock, P. (1988) Nursing Interventions for Patients with Alzheimer's Disease. Nursing Clinics of North America, 23 (1) 95-124.

Cohen, D. and Eisdorfer, C. (1986) The Loss of Self: A Family Resource for the Care of Alzheimer's Disease and Related Disorders, New York, W.W. Norton.

Cohen, U. and Weisman, G.D. (1991) Holding on to Home, Baltimore, John Hopkins University Press.

Coons, D.H. and Metzelaar, L. (1990) A Manual for Trainers of Direct Service Staff in Special Dementia Units, Ann Arbor, University of Michigan.

Edelson, J.S. and Lyons, W.H. (1985) Institutional Care of the Mentally Impaired Elderly, New York, Van Nostrand Reinhold.

Feil, Naomi (1984) Communicating with the Confused Elderly Patient. Geriatrics, 39 (3) page 131.

Feil, Naomi, Validation Therapy (Manual used with film "Looking for Yesterday". Available for Edward Feil Productions, Cleveland, Ohio.

Gwyther, L.P. (1985) Care of Alzheimer's Patients: A Manual for Nursing Home Staff, Washington, D.C., Alzheimer's Disease and Related Disorders Association and American Health Care Association.

Hall, G., et all (1986) Sheltered Freedom: The Creation of a Special Care Alzheimer's Unit in an ICF. Geriatric Nursing, 7 (3) 132-137.

Hall, G.H. (1988) Alterration in Thought Process. Journal of Gerontological Nursing, 14 30-37.

Maas, M. (1988) Management of Patients with Alzheimer's Disease in Long Term Care Facilities. The Nursing Clinics of North America, 23 (1) 57-64.

Mace, N.L. (1990) Dementia Care: Patient, Family and Community, Baltimore, John Hopkins University Press.

Mace, N.L. and Rabins, P.V., MD (1991) The 36-Hour Day, Baltimore, John Hopkins University Press, Revised Edition.

Robinson, A, Spencer, B., and White, L. (1988) Understanding Difficult Behaviors: Some Practical Suggestions for Coping With Alzheimer's Disease and Related Illness, Ypsilanti, Geriatric Education Center of Michigan, Eastern Michigan University.

Zgola, V. (1987) Doing Things: A Guide to Programs and Organized Activities for Persons with Alzheimer's Disease and Related Disorders, Baltimore, John Hopkins University Press.

OBRA Subtitle C, Nursing Home Reform PL 100-203, 1987, National Citizens Coalition for Nursing Home Reform.

State Operations Manual, April 1989, Department of Health and Human Services, Health Care Financing Administration.

Section 6901. Medicare and Medicaid Technical Corrections Relating to Nursing Home Reform, December 19, 1989.

Omnibus Budget Reconciliation Act of 1989 PL 101-239.

Omnibus Budget Reconciliation Act of 1990 PL 101-508.

Federal Register Vol. 56, No. 187, Thursday, September 26, 1991.

Michigan Public Health Code, Act 368 of 1978 as amended, Article 15 – Occupational Regulations.

Omnibus Budget Reconciliation Act of 1987, PL 100-203.
Federal Register Vol. 56, No. 187, Thursday, September 26, 1991.

State Operations Manual (Revised September 1990) Transmittal No. 232. P51, F203, F204

Filmstrips/Audio-Visual Materials
“Experiencing Aphasia”
Nevland, G., Jones, R.
Communications Skills Builder
3830 E. Bellevue
P.O. Box 42050
Tucson, AZ 85733
(602) 323-7500

“Sounds Heard When Taking Blood Pressure and Pulse”
Smith, Kine & French
1500 Spring Garden Street
Philadelphia, PA 19101

Helping People with Dementia in Activities of Daily Living, 1987, Terra Nova Films, Inc., 9848 S. Winchester Avenue, Chicago, IL 60643.(Videotapes)

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Albany, NY, Delmar Publishers.

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(5th ed.) Albany, NY, Delmar Publishers.

Hogan, J., Sorrention, S. (1988) Mosby’s Textbook for Long-Term Care Assistants, St. Louis, The C.V. Mosby Company.

Matteson, M., McConnell, E. (1988) Gerontological Nursing Concepts and Practice Philadelphia, W.B. Saunders Company.

Menezes, K. (1989) Nursing Assistant Course Guide Big Rapids, Michigan, Matthew Scott Publishers.

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Sorrentino, S. (1987) Mosby’s Textbook for Nursing Assistants St. Louis, The C.V. Mosby Company.

Will, C., Eighmy, J., (1991) Being a Long-Term Care Nursing Assistant, Robert J. Brady Co.

“Diseases”
Intermed Communications, Inc.
132 Welsh Road
Horsham, PA 19044

Section F:

Glossary

Abuse Manual:
(The Identification and Reporting of Abuse, A Training Manual for Nursing Home Aides, 1988) A training manual prepared by the Michigan Department of Public Health

Achievement Indicators:
Summary of performance guides – necessary behaviors demonstrated for a student to successfully complete a task.

Adult Learning Theory
Adult learning theory involves an active approach to learning as referred to by Malcolm Knowles as "andragogy". Adults learn differently then children. Adult learning involves self directed learning, is participatory, utilizes experiential learning, provides feedback and occurs in a comfortable safe environment.

Behavioral Objective:
Measurable outcomes of student performance which indicate the behavior a student will demonstrate upon successful completion of a learning experience. Behavioral/Learner objectives can be cognitive, affective, or psychomotor.
Cognitive – Intellectual learning
Affective – Emotional/Social/Value learning
Psychomotor – Task/Skill learning

Classroom Instruction:
Instruction provided by Program Coordinator/Primary Instructor, Primary Instructor, Delegated Instructor or guest lecturer in a classroom setting. It includes but is not limited to lecture, discussion, programmed instruction, interactive exercises and media presentations.

Clinical Skills Instruction:
Instruction provided to nurse aide trainees under the direct supervision of Program Coordinator/Primary Instructor, Primary Instructor, or Delegated Instructor in an actual care giving environment in which actual residents are involved.

Clinical Practicum:
This is an actual clinical experience for nurse aide trainees, which occurs during the Nurse Aide Training Program under the supervision of an instructor with the Nurse Aide Training Program. The purpose of the practicum is to evaluate and supervise nurse aide trainees as they integrate and apply the knowledge and skills learned in the class and laboratory. This portion of the curriculum is indicated after classroom and laboratory sections are completed.

Competency Based Education:

The education program that utilizes the student's achievement of program specific knowledge, skills, or judgment, at a pre-specified level of proficiency, as the criteria for determining successful completion of the instructional program.
Content:
Material/information that is specific to unit objectives that are presented to the class, via various teaching methods.

Core Curriculum:
It is a minimum of sixteen hours of instruction, which students are taught prior to direct involvement with a resident. The core curriculum must include:

- communication and interpersonal skills
- infection control
- safety and emergency procedures
- promotion of resident's independence
- residents' rights.

Criteria:
The standards upon which judgment can be based. The minimum level of performance that is accepted as evidence of achievement of the objectives.

Curriculum:
The course of study necessary to achieve learner objectives. This includes: program objectives/program goals; behavioral/learner objectives for lecture, laboratory, and clinical skills training; teaching methods; evaluation measurements; student policies; program schedule; and faculty schedule.
The course of study necessary to achieve learner objectives which includes all of the above except student policies, faculty schedule, and program schedule. Such curricula are independent of a particular Nurse Aide training programs but program may purchase the "package". Examples include ProCare, Medcom, and VideoLink.

Evaluation Measurements:
The methods used to assess whether a student has met the objectives of the program.
Criterion referenced – based on individual program guidelines
Learner performance is measured against predetermined criteria built into the objectives. Used for evaluation of skills performance.
Norm referenced – percent of acceptable passing grade
Compares an individual's performance to the performances of others, the class, the group, i.e., percentile, rank. Used with classroom testing.

Grading Criteria:
Standards, cut scores or percentage, which determine a students' grade and can also refer to a percentage or grade, which determines pass/fail.

Laboratory Instruction:
Instruction provided to nurse aide trainees by Program Coordinator/Primary Instructor, Primary Instructor, or Delegated Instructor in a simulated setting where students practice clinical skills without using actual residents.

Lesson Plan:
A format for structuring unit specific objectives, content, teaching methods, and evaluation criteria into columns to assist the instructor in organizing, planning and presenting instructional material to students.

Michigan Model:
Michigan Nurse Aide Training Curriculum, Revise 2006 (Revised) A task based curriculum model for a 75 hour Nurse Aide Training Program which provides examples of program objectives and behavioral objectives for lecture, laboratory, and clinical skills training.

OBRA Act:
Public Law 100-203 (the Nursing Home Reform Act, Subtitle C of the Omnibus Budget and Reconciliation Act) of December 22, 1987.

Performance Guides:
Series of steps required for the performance of a task arranged in the sequence ordinarily followed.

Physical Restraint:
Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access.

Program Objective/Federal Program Objective:
Defines, identifies the purpose, desired outcomes, or goal of a program of instructional content. The Federal Program objective of the Nurse Aide Training Program is to provide quality services to residents by nurse aides who are able to:
Form a relationship, communicate and interact competently on a one-to-one basis with the residents;
Demonstrate sensitivity to residents' emotional, social, and mental health needs through skillful, directed interactions;
Assist residents in attaining and maintaining independence;
Exhibit behavior in support and promotion of residents' rights; and
Demonstrate observational and documenting skills needed in the assessment of resident's health, physical condition and well-being.

Psychoactive Drugs (chemical restraints):
Drugs prescribed to control mood, mental status, or behavior.

Resident Rights:
Michigan Public Health Code Act Number 368 P.A. of 1978 statutory mandate whereby a health facility of agency which provides services directly to patients or residents and which is licensed shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. A Nurse Aide Training Program must contain objectives and content addressing Resident Rights. This includes content from the following:
Section 333.20201 of the Michigan Public Health Code

Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discrimination against patient exercising protected right; exercise of rights by nursing home patient's representative; informing patient or resident of policies; designation of person to exercise rights and responsibilities.
Section 333.21771 of the Michigan Public Health Code
Policy describing abusing, mistreating, or neglecting patient; reports; investigation; retaliation prohibited.
OBRA and Social Security Act:
The Omnibus Budget Reconciliation Act of 1987 (PL 100-203), 1989 (PL 101-239), 1990 (PL 101-508) and Sections 1819(f) Medicare and 1919(f) Medicaid of the Social Security Act created federal requirements for Nursing Home Reform. This parallels and expands many Michigan requirements in the content area of Resident Rights.

Student Achievement Record (S.A.R.):
Ongoing and summative record of major skills to be learned in the program and the trainee's performance of each. The record consists of four (4) components: skill, criteria, date of performance, and signature of instructor.

Syllabus:
A statement of the main course components including the administrative elements and the curriculum components.

Teaching Methods/Methodology:
Selection of instructional methods, materials and approaches to meet the needs and abilities of individual learners in meeting the objectives.

Unit Objective:
Behavioral learner objectives given to the learner at the beginning of each unit of instruction.

Section G:

Students Achievement Record (SAR)

NURSE AIDE TRAINING PROGRAM

STUDENT: ________________________ CLASS SITE: _______________________

CLASS DATE: ____________________ TO: _______________________________

INSTRUCTIONS:
Mark each student's level of competence according to the following guide:

S = Satisfactory (Student performs skill correctly without assistance)
U = Unsatisfactory (Student needs assistance to perform skill)
SIM = Simulate [acceptable only for asterisk (*) items]
NATP = NURSE AIDE TRAINING PROGRAM

NATP SKILL DEMONSTRATED	LAB **(DATE)**		**Instructor's Initials**	CLINICAL **(DATE)**		**Instructor's Initials**
	S	**U**	**LAB**	**S**	**U**	CLINICAL
1. Handwashing, Using Protective Clothing & Handling a Plastic Trash Bag						
2. First Aid for Choking (Airway Obstruction*), Bleeding, Burns, Falls/Seizure, and Unconscious, Sudden Illness or Injury						
3. Taking and Recording a Person's Axillary Temperature						
4. Taking a Person's Rectal Temperature (**LECTURE**)						
5. Taking and Recording a Person's Oral Temperature						
6. Reading, Cleaning, and Handling Thermometer						
7. Using an Electronic Thermometer						
8. Counting and Recording a Person's Pulse						
9. Counting and Recording a Person's Respirations						
10. Taking and Recording a Person's Blood Pressure						
11. Moving a Person Around in Bed						
12. Positioning a Person in a Supine Position						

13. Positioning a Person in a Fowler’s Position						
14. Positioning a Person in a Modified Side-Lying Position						
15. Positioning a Person in a Prone Position (**lecture**)						
16. Transferring a Person from the Bed to the Chair						
17. Repositioning a Person in a Chair (Two Nurse Aides)						
18. Using a Mechanical Lift to Transfer a Person from the Bed to a Chair (Two Nurse Aides) (**lecture)**						**(observe)**
19. Turning a Person Using a Log-Rolling Technique						
20. Making an Unoccupied Bed/Bed Operation						
21. Making an Occupied Bed						
22. Brushing & Flossing a Person’s Teeth						
23. Providing Denture Care						
24. Providing Mouth Care for an Unconscious Person						
25. Shampooing, Brushing, and Combing a Person’s Hair						
26. Helping a Man Shave with an Electric and/or Safety Razor						
27. Cleaning & Trimming a Person’s Fingernails						
28. Providing Foot Care & Cleaning a Person’s Toenails						
29. Helping a Person Dress						
30. Helping a Person Undress						
31. Helping a Person with Bathing in a Tub/Shower/Bed Bath/Skin Care Inspection						
32. Measuring a Person’s Height and Weight						
33. Helping a Person Eat						
34. Measuring & Recording Intake & Output						
35. Maintaining Gastric Suctioning **(Lecture)**						
36. Helping a Person Use the Bathroom Toilet						
37. Helping a Person Use a Portable						

Commode						
38. Helping a Person Use a Bedpan or Urinal						
39. Providing Perineal Care for a Person (male/female) with/without a Urinary Catheter						
40. Cleaning Around Tubes & Catheters						
41. Changing an Ostomy Appliance (**MANKIN**)						
42. Emptying a Urinary Drainage Bag						
43. Applying an External Urinary Catheter to a Male – simulate in clinical if facility does not use this item*						
44. Collecting Urine Specimens						
45. Collecting Stool Specimens						
46. Helping a Person Walk, or use a Walker/Cane/Wheelchair						
47. Helping a Person with Passive ROM Exercises						
48. Collecting Sputum Specimens **(Lecture**)						
49. Postmortem Care (Simulated)*						

SIGNATURE	TITLE	INITIALS		DATE
1.				
2.				
3.				
4.				

Student Name: ___________________________

TASK 6-1: Handwashing

STANDARD:
Hands, wrist and fingernails must be dry and free of pathogenic microorganisms.

TOOLS AND EQUIPMENT:

Dispenser – soap	Paper towels	Water
Liquid soap/bar soap	Sink	
Orange stick or nail brush	Wastepaper basket	

Competencies:	**Date**	**Instructors Initials**
1. Approach sink		
2. Turn on water		
3. Adjust water temperature to warm		
4. Wet wrist and hands thoroughly with water holding hands downward		
5. Apply soap		
6. Lather hands well by rubbing palms together		
7. Wash hands using friction and rotating motion for a minimum of 20-30 seconds a) Wash palms and back of hands		
b) Wash fingers in rotary motion, wash between fingers		
c) Wash wrists in circular motion		
8. Clean fingernails with orange stick or nail brush; if fingernails are very short, rub on opposite palm		
9. Rinse wrists and hands well		
10. Pat wrists and hands dry		
11. Turn water off using a DRY paper towel		
12. Discard all paper towels into wastepaper basket		

Competence in the task will be recognized when hands are cleaned according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 6-2: Standard Precautions

STANDARD:
The Center for Disease Control recommendations for preventing transmission of pathogens such as the human immunodeficiency virus (HIV) and Hepatitis B virus (HBV), will be used to minimize the risk of exposure to blood and body fluids. Standard Precautions are to be carried out by all health care workers to prevent the spread of microorganisms among residents, personnel, and visitors.

TOOLS AND EQUIPMENT:

Face masks	Gowns	Gloves	Plastic bags
Paper Towel	Watch		

Competencies:	Date	Instructors Initials
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Putting on and taking off a disposable paper face mask a) Adjust mask over your nose and mouth. Be careful not to touch your face with your hands		
b) First tie top strings of the mask behind your head. Then tie the bottom strings securely.		
c) Replace mask if it becomes moist during procedure		
d) Untie bottom strings first. Untie top strings second		
e) Remove the mask by holding the top strings. Discard in appropriate infectious waste receptacle		
f) Wash hands		
5. Putting on a gown a) Remove your wristwatch and place on the clean side of an open paper towel. (NOTE: The watch will be placed on the paper towel so it can be referred to without being touched.)		
b) Put on gown by slipping arms into sleeves.		
c) Slip fingers under inside neckband and grasp ties in the back. Secure neckband with a simple bow, or fasten Velcro strips		
d) Reach behind and overlap the edges of the gown so that your uniform is completely covered. Secure waist ties with a simple bow, or fasten Velcro strips.		

e) Wash hands		
6. Put on clean gloves. If wearing gown, be sure cuffs of gloves overlap gown.		
7. Removing contaminated gown, gloves, and mask a) Remove gloves. Use preferred hand to pull off opposite glove without touching inside of opposite glove. Discard glove. Remove second glove by reaching inside the glove with ungloved hand and pull glove off. Discard glove.		
b) Undo waist ties of gown.		
c) Holding a clean paper towel, turn faucets on. Discard towel.		
d) Wash your hands. Dry with paper towel.		
e) Using a dry paper towel, turn off faucets.		
f) Undo mask (bottom ties first, then top ties). Holding by ties only, dispose of mask.		
g) Undo the neck ties and loosen gown at shoulders.		
h) Slip fingers of the right hand inside the left cuff without touching the outside of the gown. Pull gown down over the left hand.		
i) With the gown-covered left hand, pull the gown down over the right hand.		
j) Fold gown with contaminated side inward. Roll and dispose of in appropriate receptacle.		
k) Wash hands		
l) Remove watch from clean side of paper towel. Holding clean side of paper towel, dispose of towel in wastepaper receptacle.		

Criteria: Competency will be recognized when gowning, gloving and mask application are followed to prevent the spread of microorganisms according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 7-1: Assisting the resident who falls

STANDARD:
While ambulating a resident, the resident begins to fall. Resident must be lowered to the floor without injury to resident or self and an appropriate report made.

TOOLS AND EQUIPMENT:
Gait belt Incident/Accident report form

Competencies:	**Date**	**Instructors Initials**
1. Stand with your feet apart. Keep your back straight.		
2. Bring the resident close to your body as quickly as possible. Use the gait belt on the resident if one is worn. If the resident is not wearing a gait belt, wrap your arms around the resident's waist or hold the resident under his or her arms.		
3. Move your leg so the resident's buttocks rest on your leg. Move the leg nearest to the resident.		
4. Lower the resident to the floor. Allow him or her to slide down your leg to the floor. Bend at your hips and knees as you do this.		
5. Call a nurse to check the resident.		
6. After the nurse has checked the resident, help the nurse return the resident to bed. Get other co-workers to help if necessary.		
7. Report the following to the nurse: a) What time the resident got up b) How far the resident walked c) How the resident tolerated the activity prior to the fall d) Any resident complaints prior to the fall e) The amount of assistance needed by the resident while walking f) Sign the appropriate Incident/Incident/Accident report form		
8. Ensure resident's comfort and safety, leave call light within reach		
9. Wash hands		
10. Use appropriate physical and verbal contact		

Criteria: Competency in the task will be recognized when the resident has been safely lowered to the floor according to the procedure of the training program and the achievement indicators listed.

Student Name: ____________________________

ASK 7-2: Assisting the resident having a seizure

STANDARD:
Injury will be prevented and an airway will be maintained. The resident should not be left alone.

TOOLS AND EQUIPMENT:
Pillow

Competencies:	**Date**	**Instructors Initials**
1. When a resident is observed having a seizure. Ring/call for assistance		
2. Do not leave the resident		
3. Assist the resident to lie down on side, if possible, to allow for saliva/vomitus drainage		
4. Do not attempt to restrain the resident		
5. Move objects that might injure the resident		
6. Loosen clothing, particularly around the neck		
7. Place pillow or soft padding under the resident's head if available		
8. Observe the resident during and following the seizure		
9. Ensure resident's comfort and safety		
10. Wash hands		
11. Report observations to nurse		
12. Use appropriate physical and verbal contact		

CRITERIA: Competence in the task will be recognized when the resident having a seizure is protected from injury and an open airway is maintained according to the procedure of the training program and the achievement indicators listed. Note: when indicated, preserve resident privacy and dignity.

Student Name: ____________________________

TASK 7-3: Assisting an unconscious resident

STANDARD:
Appropriate assistance will be given to the unconscious resident

TOOLS AND EQUIPMENT:
None

Competencies:	**Date**	**Instructors Initials**
1. Call for assistance from nurse		
2. Check for pulse		
3. Check for breathing		
4. Begin CPR if trained and per facility policy		
5. Observe for specific signs and symptoms		
6. Assist the nurse in any way possible		
7. Wash hands		
8. Report observations to nurse		
9. Use appropriate physical and verbal contact		

CRITERIA: Competence in the task will be recognized when appropriate assistance is given to an unconscious resident according to the procedure of the training program and the achievement indicators listed.

Student Name: ______________________

TASK 7-4: Assisting the resident who is burned

STANDARD:
Provide first aid for a burn

TOOLS AND EQUIPMENT:
Cool water
Basin or washcloth
Incident/Accident report forms

Competencies:	**Date**	**Instructors Initials**
1. Remove the source of heat		
2. Call for assistance		
3. Wash hands		
4. When possible, report the degree of the burn		
5. Cool area with cool water until pain subsides		
6. Assist as necessary when help arrives		
7. Ensure resident's comfort and safety, leave call light within reach		
8. Wash hands		
9. Report abnormal findings and irregularities to nurse, sign Incident/Accident report		
10. Use appropriate physical and verbal contact		

CRITERIA: Competence in the task will be recognized when the resident is provided with first aid assistance for a burn according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 7-5: Assisting the resident who is bleeding

STANDARD:
First aid will be provided to control bleeding and prevent infection.

TOOLS AND EQUIPMENT:
Gloves
Gauze or clean cloth
Incident/Accident report form

Competencies:	**Date**	**Instructors Initials**
1. Ring/call for assistance		
2. Put on gloves		
3. Apply pressure directly to the wound with your hand over a gauze, tissue or cloths for 5-10 minutes		
4. Elevate injured part above the level of the resident's heart. Continue using direct pressure		
5. Do not remove the dressing. This will disturb the clots already formed.		
6. Assist as necessary when help arrives		
7. Dispose of soiled dressing		
8. Clean work area		
9. Ensure resident's comfort and safety, leave call light within reach		
10. Remove gloves		
11. Wash hands		
12. Report abnormal findings and irregularities to nurse and sign Incident/Accident report		
13. Use appropriate physical and verbal contact		

CRITERIA: Competence in the task will be recognized when the resident is provided with first aid assistance for bleeding according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 7-6: Heimlich Maneuver

STANDARD:
Procedure performed using all steps in appropriate sequence and with appropriate technique.

TOOLS: None

Competencies:	**Date**	**Instructors Initials**
Note: During the practice of these skills, do not actually perform thrusts on your partner. Rather, simulate these skills on your partner.		
1. Assessment a) Determine airway obstruction. Ask, "Are you choking?" Determine if victim can speak, cough, or breathe		
b) Situation: Victim cannot speak, cough, or breathe Call for help or Shout "Help!"		
2. Heimlich maneuver. Perform back blows and abdominal thrusts per updated CPR guidelines a) Stand behind the resident		
b) Wrap arms around resident's waist		
c) Make a fist with your one hand and place thumb side of your fist against resident's abdomen in the midline slightly above the navel and well below the tip of the xiphoid		
d) Grasp fist with your other hand		
e) Press into the victim's abdomen with quick upward thrusts		
f) Each thrust should be distinct and delivered with the intent of relieving the airway obstruction		
e) Repeat thrusts until object is expelled or the resident becomes unconscious		
f) No pressure should be exerted against the resident's rib cage with the rescuer's forearms.		
3. Ensure resident's comfort and safety, leave call light within reach		
4. Wash hands		
5. Report abnormal findings and irregularities to nurse		
6. Use appropriate physical and verbal contact		

CRITERIA: Competence in task will be recognized when Heimlich Maneuver is performed according to the procedure of the training program and achievement indicators listed.

Student Name________________________

TASK 7-7: Fire preparedness

STANDARD:
Fire preparedness is a responsibility for all employees. Fire drills are held on each shift at least once a quarter.

TOOLS AND EQUIPMENT:
Per Facility Policy Incident/Accident Report Form

Competencies:	**Date**	**Instructors Initials**
1. Stop and quickly assess the situation		
2. Yell for help and/or sound the alarm		
3. Immediately remove all residents from the area		
4. Do not open windows		
5. Close the door to the rooms		
6. Evacuate residents in rooms on both sides of the affected room		
7. Move residents at immediate risk to the end of the wing farthest from the fire or off the wing or unit entirely if instructed to do so.		
8. Fight the fire with extinguisher only if it is very small and contained. **Do not fight any larger fire.**		
9 **If an evacuation is ordered to evacuate, use following order:** a) Those nearest the fire b) Ambulatory residents c) Ambulatory residents who need assistance d) Residents who use wheelchairs e) Residents with severe medical complications f) All charts and medication charts.		
10. **Fire Alarm Sounds** a. Clear residents out of the halls into their rooms and close the door b. If several residents are in a gathering area, close the doors to that large room unless the fire is in the immediate area c. Make sure the halls are free from obstructions		
11. Wait for further instructions from a supervisor		

CRITERIA: Competence in the task will be recognized when the fire preparedness protocols are followed according to the procedure of the training program and the achievement indicators listed.

Student Name________________________

TASK 8-1: Denture care

STANDARD:
Dentures must be clean and in place in the resident's mouth.

TOOLS AND EQUIPMENT:

Dentures	Denture Cup	Towels	Emesis Basin
Toothpaste (or denture cleaner)		Tooth brush	
Mouthwash (diluted)		Gloves	Pen/pencil/paper

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Provide privacy		
6. Put on gloves		
7. Remove upper dentures first (slide finger along gum line and pull down to break seal or grasp front teeth and thumb and index finger. Move dentures up and down to break vacuum) and place in emesis basin		
8. Remove lower dentures (turn resident slightly to prevent discomfort) and place dentures in emesis basins		
9. Take dentures to sink, in denture cup or emesis basin. Cover bottom of sink with towels and fill sink with cool water.		
10. Apply toothpaste to brush and clean dentures thoroughly over sink full of water.		
11. Rinse in cool water and place on paper towel or in emesis basin.		
12. Rinse out emesis basin. Place dentures in emesis basin and take back to resident.		
13. Perform mouth care per condition of resident, using a tooth brush/toothette/swab to massage gums, freshen mouth and remove food residue from gum pockets.		
14. Offer resident opportunity to rinse mouth and spit into emesis basin.		
15. Replace dentures (bottom first)		

Competencies:	**Date**	**Instructors Initials**
16. Clean and put away supplies and equipment		
17. Remove gloves and wash hands.		
18. Ensure resident's comfort and safety leave call light within reach.		
19. Report any abnormal or unusual observations to the nurse		
20. Use appropriate verbal and non-verbal communication		

CRITERIA: Competence in the task will be recognized when the resident's dentures are cleaned according to the procedure of the training program and the achievement indicators listed.

Student Name________________________

TASK 8-2: Oral hygiene (minimal and total assistance)

STANDARD:
Resident's teeth must be cleaned and flossed resulting in no food particles in mouth or between teeth. If resident does not have teeth or dentures the inside of the mouth must be clean and without residual food particles.

TOOLS AND EQUIPMENT:

Dental Floss	Denture Cup (optional)	Toothbrush	Emesis Basin
Toothpaste	Mouthwash (diluted)	Towels	Gloves
Lip Balm	Paper and plastic bags for soiled linen and equipment		

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Provide privacy		
6. Position resident as appropriate for level of consciousness (i.e. seat in a chair or if in bed in semi-fowlers to fowlers position or raise head of bed a minimum of 45 degrees.		
7. Put on gloves		
8. Place towel across chest of resident and emesis basin under resident chin		
9. Moisten toothbrush and apply toothpaste		
Conscious resident – minimal assistance required		
10. Allow resident to brush teeth/clean inside mouth if condition permits		
11. Give resident mouthwash solution or water to rinse mouth, and offer opportunity to spit into emesis basin as needed. Dry area around mouth.		
12. Remove about 18 inch strand of dental floss for resident		
13. Provide additional floss as needed. Discard soiled floss.		
14. Offer opportunity to rinse mouth and spit into emesis basin		
15. Provide lip balm for lips		

Competencies:	**Date**	**Instructors Initials**
Conscious resident- total assistance required		
16. Move brush back and forth using short strokes cleaning two-three teeth at a time		
17. Brush entire surface of mouth, if resident does not have teeth; also gently brush gums and tongue.		
18. If resident is able to, have resident rinse mouth with mouthwash solution, and offer opportunity to spit into emesis basin as needed.		
19. Dry area around resident's mouth		
20. If resident is able, offer opportunity to rinse mouth with diluted mouthwash and spit into emesis basin		
21. Dry area around resident's mouth		
22. Apply lip balm for lips		
25. Clean and put away supplies and equipment		
26. Remove gloves and wash hands.		
27. Ensure resident's comfort and safety, leave call light within reach		
28. Report any abnormal or unusual observations to the nurse		
29. Use appropriate verbal and non-verbal communication		

Note: If resident is wearing dentures refer to procedure for removing dentures in denture care.

CRITERIA: Competence in the task will be recognized when the resident is given oral hygiene according to the procedure of the training program and the achievement indicators listed.

Student Name________________________

TASK 8-3: Oral hygiene/ unconscious resident with teeth or without teeth or dentures

STANDARD:
Resident's teeth must be cleaned and flossed resulting in no food particles in mouth or between teeth.

TOOLS AND EQUIPMENT:

Denture Cup	Toothbrush/Toothettes	Emesis Basin	Padded tongue blade
Toothpaste	Mouthwash (diluted)	Towels	Mouth swabs
Lip Balm	Gloves	Paper/Pen/Pencil	

Paper and plastic bags for soiled linen and equipment

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Provide privacy		
6. Elevate head and bed, position resident on side facing nurse assistant		
7. Place a towel under resident's head and across his chest		
8. Position emesis basin under resident's chin		
9. Put on gloves		
10. Gently separate the resident's upper and lower teeth (use padded tongue blade to help keep mouth open if needed)		
11. Clean inside of mouth with toothette using a massaging motion at the gum line, also brush tongue.		
12. Use a soft toothbrush moistened with diluted mouthwash to clean resident's teeth.		
13. Wipe area around mouth as needed		
14.		
15. Apply lip balm to lips.		
16. Wash hands		

Competencies:	**Date**	**Instructors Initials**
17. Clean and return equipment to storage		
18. Ensure resident's comfort and safety, leave call light within reach		
19. Report any abnormal or unusual observations to the nurse		
20. Use appropriate verbal and non-verbal communication		

Note: If dentures are in-place, also provide denture care per procedure and condition of resident.

CRITERIA: Competence in the task will be recognized when the resident is given oral hygiene according to the procedure of the training program and the achievement indicators listed.

Student Name________________________

TASK 8-4: Fingernails/cleaning and trimming

STANDARD:
Resident's fingernails must be cleaned without damaging the skin or nails and trimmed without rough edges or breaking of skin. Procedure must be recorded on resident's flow sheet.

TOOLS AND EQUIPMENT:

Basin	Nail clipper	Soap	Orange Stick
Protection for bed linens		Emery- board Towel	Washcloth
Gloves		Plastic trash bag	Laundry bag

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Provide privacy		
6. Protect bed linen		
7. Position resident in comfortable position (sitting position if possible)		
8. Fill wash basin with warm water and place it on clean surface		
9. Let resident soak hands in water for about 5 minutes.		
10. Put on gloves		
11. Remove residue under nails with an orange stick, using the flat end.		
12. Gently push back cuticle with washcloth		
13. Dry resident's hands with towel		
14. Trim nails with nail clipper		
15. Then shape and smooth rough edges with emery board, check for jagged edges		
16. Apply hand lotion to resident's hands, using a massaging motion		

Competencies:	**Date**	**Instructors Initials**
17. Empty basin, clean and put away, and tidy work area		
18. Ensure resident's comfort and safety, leave call light within reach		
19. Report any abnormal or unusual observations to the nurse		
20. Use appropriate verbal and non-verbal communication		

CRITERIA: Competence in the task will be recognized when the fingernails of the resident are cleaned and trimmed according to the procedure of the training program and the achievement indicators listed.

Student Name________________________

TASK 8-5: Foot care

STANDARD:
The skin on the resident's feet will be clean, dry, intact and free of any signs of redness or irritation. Procedure must be recorded on the resident's flow chart

TOOLS AND EQUIPMENT:

Basin Soap Protection for bed linens Orange stick
Towel Washcloth Laundry bag Plastic bag Gloves

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Provide privacy		
6. Protect bed linen		
7. Assist resident to sit in chair		
8. Place basin of warm water on disposable pad/towel on floor		
9. Soak foot for 10-20 minutes, then lather with soap and rinse thoroughly		
10. Remove residue under nails with an orange stick, using the flat end.		
11. Scrub calloused areas on feet with washcloth		
12. If using a non-rinse cleaning product, remove feet from basin and dry thoroughly		
13. Apply lotion, inspect toenails and skin on feet, check for jagged edges		
14. Ensure resident's comfort and safety, leave call light within reach		
15. Empty basin, clean and put away		
16. Wash hands		

Competencies:	**Date**	**Instructors Initials**
17. Report any abnormal or unusual observations to the nurse		
18. Use appropriate verbal and non-verbal communication		

CRITERIA: Competence in the task will be recognized when foot care is provided according to the procedure of the training program and the achievement indicators listed.

NOTE: If feet are very soiled, disposable gloves may be worn.

Student Name________________________

TASK 8-6: Shampoo in bed

STANDARD:
The resident's hair must be clean. Bed linens and resident's bedclothes must be kept dry. Procedure must be recorded.

TOOLS AND EQUIPMENT: Shampoo in bed

Bath Blanket	Towels Safety pin	Blow Dryer
Shampoo Conditioner(optional)	Chair	Waterproof/plastic sheets or rinsette
Small pitcher of cool water	Large pitcher of warm water	Basin

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Adjust head of bed to lowest position		
6. Provide privacy, close doors and windows		
7. Protect bed linen, with plastic waterproof sheet		
8. Remove any pins or clips from the hair, brush or comb hair to remove tangles		
9. Place the waterproof chair close to the head of bed and place waterproof sheet over chair		
10. Remove pillow from resident's head.		
11. Remove top sheet and replace with bath blanket		
12. Place a waterproof sheet under the resident's head to cover the bottom sheet or place rinsette.		
13. Pin bath towel around resident's neck		
14. Place washbasin in chair, roll waterproof sheet so that the water drains into the washbasin.		
15. Pour warm water over hair		
16. Apply a small amount of shampoo to hair and massage into hair and scalp with fingertips, not fingernails, being careful not to scratch the resident		

Competencies:	Date	Instructors Initials
17. Start at hairline and work toward back of head.		
18. Rinse hair with warm water		
19. Repeat steps 16-17		
20. Rinse hair until all shampoo is removed.		
21. Squeeze excess water from hair		
22. Remove waterproof sheet from pillow		
23. Dry resident's hair with towel		
24. Dry hair with blow dryer if needed (leave dry towel under resident's head until hair is completely dry)		
25. Comb and brush resident's hair		
26. Ensure resident comfort and safety leave call light within reach		
27. Tidy the area, clean and return equipment		
28. Wash hands		
29. Use appropriate verbal and non-verbal communication		
30. Record and report observations as required.		

CRITERIA: Competence in the task will be recognized when the shampoo is provided according to the procedure of the training program and the achievement indicators listed.

Student Name________________________

TASK 8-7: Hair Care- styling (comb and brush)

STANDARD:
The resident's hair must be combed and brush according to the resident's request. Completion of the procedure must be recorded.

TOOLS AND EQUIPMENT:
Brush Mirror Comb Towel Hair Accessories
Laundry bag Plastic bag

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Provide privacy		
6. If able, assist resident to sit in chair		
7. Place a towel around the resident's shoulders		
8. Remove eyeglasses and hair accessories		
9. Brush the hair gently, beginning at the ends, and work up in sections to the scalp.		
10. Style the resident's hair according to preference		
11. Show resident hair in mirror		
12. Tidy area, clean, discard and put away materials		
13. Wash hands		
14. Report any abnormal or unusual observations to the nurse		
15. Ensure resident's comfort and safety, leave call light within reach		
16. Use appropriate verbal and non-verbal communication		

CRITERIA: Competence in the task will be recognized when hair care is provided according to the procedure of the training program and the achievement indicators listed.

Student Name________________________

TASK 8-8: Shaving- blade or electric razor

STANDARD:
The resident must be shaved with minimum skin irritation. Any nicks must be reported. Procedure must be recorded on the resident's flow chart

TOOLS AND EQUIPMENT:

Shaving cream	Razor	Aftershave	Mirror
Towel	Basin of warm water		Washcloth
Laundry bag	Plastic bag	Styptic Pen	Gloves

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment at bedside		
5. Provide privacy		
6. Adjust lighting		
7. Raise head of bed (if preferred by resident, assist resident to sit in chair)		
8. Place a towel under the resident's chin		
9. Put on gloves		
10. Soften beard with warm water for 3-5 minutes by applying warm washcloth to face		
11. Inspect the resident's face for moles, birthmarks or sores		
12. Apply shaving cream to face		
13. Hold skin taut and shave in direction of hair growth (downward). If using an electric razor follow the manufacturer's instructions.		
14. Rinse razor often in basin of water, change water as needed		

Competencies:	Date	Instructors Initials
15. Wash resident's face when shave is finished		
16. Pat dry		
17. Apply after shave if available		
18. Offer mirror to resident		
19. Ensure resident's comfort and safety, leave call light within reach		
20. Tidy area, clean, discard used razor in sharps container, and return equipment as needed. For electric razor, open and clean the razor head, apply electric razor cleaner if available.		
21. Wash hands		
22. Report any abnormal or unusual observations to the nurse		
23. Use appropriate verbal and non-verbal communication		

CRITERIA: Competence in the task will be recognized when the shave is provided according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 8-9: Perineal care – male

STANDARD:
Ensure resident privacy and dignity while providing perineal care. The perineal area must be clean and dry.

TOOLS AND EQUIPMENT:

Soap dish and soap | Incontinent pad | Bath towel
Disposable bag | Bath blanket | Gloves
Washcloth (or disposable washcloths or cotton balls if available)

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Raise the height of the bed to the appropriate level for proper body mechanics		
6. Remove soiled or wet linen from the bed		
7. Cover the resident with a bath blanket. Move top linens to the foot of the bed.		
8. Position the resident on his back. Place an incontinent pad under his buttocks		
9. Drape the resident: a) Position the bath blanket with one corner between the resident's legs. There should be a corner on each side of the bed and a corner at the neck		
b) Wrap the bath blanket around his far leg by bringing the corner around the leg and tucking it under the hip		
c) Drape the near leg in the same manner		
10. Fill the wash basin with water 105 to 109 degree F (41 to 43 degree C)		
11. Place the wash basin on the overbed table on top of the paper towels		

Competencies:	Date	Instructors Initials
12. Put the washcloths in the wash basin		
13. Help the resident flex his knees and spread his legs, if he is able. Otherwise, help him spread his legs as much as possible with his knees straight		
14. Put on the gloves		
15. Fold the corner of the bath blanket between the resident's legs onto his abdomen		
16. Apply soap to a washcloth		
17. Gently grasp the penis		
18. Retract the foreskin if the resident is uncircumcised		
19. Clean the tip of the penis using a circular motion. Start at the urethral opening and work outward. Use fresh side of washcloth for each stroke. Repeat this step as necessary.		
20. Rinse the area with another washcloth		
21. Return the foreskin to its natural position if the resident is uncircumcised		
22. Clean the shaft of the penis with firm downward strokes and rinse well		
23. Cleanse the scrotum and rinse well		
24. Pat dry the penis and scrotum		
25. Fold the center corner of the blanket back between the resident's legs		
26. Help the resident lower his legs and turn onto his side away from you		
27. Clean the anal area by cleaning from scrotum to anus. Rinse the anal area with a washcloth and dry well. Discard the washcloth		
28. Remove the gloves and discard into the bag		
29. Position the resident so that he is comfortable		
30. Return the bed linens to their proper position and remove the bath blanket		
31. Lower the height of the bed to its lowest horizontal position		

Competencies:	**Date**	**Instructors Initials**
32. Empty and clean the washbasin. Return it and other supplies to their proper place		
33. Wipe off the overbed table with the paper towels and then discard them		
34. Unscreen the resident		
35. Take soiled linen and the disposable bag to the soiled utility room		
36. Ensure resident's comfort and safety, leave call light within reach		
37. Wash hands		
38. Report abnormal findings and irregularities to nurse a. Odors b. Redness, swelling, discharge, or irritation c. Resident complaints of pain, burning or other discomfort		
39. Use appropriate physical and verbal contact		

Criteria: Competence in the task will be recognized when pericare of the male has been performed according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 8-10: Perineal care – female

STANDARD:
Ensure resident privacy and dignity while providing perineal care. The perineal area must be clean and dry.

TOOLS AND EQUIPMENT:

Soap dish and soap | Incontinent pad | Bath towel
Disposable bag | Bath blanket | Gloves
Washcloth (or disposable washcloths or cotton balls if available)

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment and supplies at bedside		
5. Raise the height of the bed to the appropriate level for proper body mechanics		
6. Remove soiled or wet linen from the bed		
7. Cover the resident with a bath blanket. Move top linens to the foot of the bed.		
8. Position the resident on her back. Place an incontinent pad under her buttocks		
9. Drape the resident: Position the bath blanket with one corner between the resident's legs. There should be a corner on each side of the bed and a corner at the neck		
a) Wrap the bath blanket around her far leg by bringing the corner around the leg and tucking it under the hip		
b) Drape the near leg in the same manner		
10. Fill the was basin with water 105 to 109 degree F (41 to 43 degree C)		
11. Place the wash basin on the overbed table on top of the paper towels		
12. Put a washcloth in the wash basin		
13. Help the resident flex her knees and spread her legs, if she is able. Otherwise, help her spread her legs as much as possible with her knees straight		

Competencies:	Date	Instructors Initials
14. Put on the gloves		
15. Fold the corner of the bath blanket between the resident's legs onto her abdomen		
16. Apply soap to a washcloth		
17. Separate the labia. Clean downward from front to back with one stroke. Discard the washcloth, if heavily soiled, repeat steps until the area is clean		
18. Rinse the perineum with a washcloth. Separate the labia. Stroke downward from front to back. Use fresh side of washcloth for each stroke and repeat this step as necessary.		
19. Pat the area dry with the towel		
20. Fold the center corner of the blanket back between the resident's legs		
21. Help the resident lower her legs and turn onto her side away from you		
22. Apply soap to a washcloth		
23. Clean anal area by cleaning from the vagina to the anus with one stroke.		
24. Dispose of the washcloth as appropriate		
25. Rinse the anal area with a washcloth. Stroke from the vagina to the anus. Discard the washcloth. Repeat the steps as necessary		
26. Pat the area dry with the towel		
27. Remove the gloves and discard into the bag		
28. Position the resident so that she is comfortable		
29. Return the bed linens to their proper position and remove the bath blanket		
30. Lower the height of the bed to its lowest horizontal position		
31. Empty and clean the washbasin. Return it and other supplies to their proper place		
32. Wipe off the overbed table with the paper towels and then discard them		
33. Unscreen the resident		
33. Take soiled linen and the disposable bag to the soiled utility room		

Competencies:	**Date**	**Instructors Initials**
34. Ensure resident’s comfort and safety, leave call light within reach		
35. Wash hands		
36. Report abnormal findings and irregularities to nurse a) Odors b) Redness, swelling, discharge, or irritation c) Resident complaints of pain, burning or other discomfort		
37. Use appropriate physical and verbal contact		

CRITERIA: Competence in the task will be recognized when it is performed according to the procedure of the training program and the achievement indicators listed.

Student Name: ____________________________

TASK 8-11: Bathing/ tub – shower

STANDARD:
Water must be warm, bath mat must be in place and resident must demonstrate understanding of faucets, safety handles, and shower chair. At the end of the procedure the resident must be clean and dry and the bathing area must be left clean and ready for use. Procedure must be recorded.

TOOLS AND EQUIPMENT:

Bath mat	Robe	Call light	Shower chair	Soap
Deodorant	OCCUPIED sign	Washcloth	Towel	
Shower or bathtub	Lotion	Supplies to clean the bathing area after the bath		

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble supplies		
5. Provide privacy		
6. Assist resident to remove clothes and put on robe		
7. Accompany resident to bathing room		
8. Explain use of equipment: a) Faucets b) Safety handles or grab bars c) Shower chair d) Call light		
9. Place OCCUPIED sign on shower room door		
10. Place bath mat in front of tub or shower		
11. Check to insure that area is clean		
12. For a tub bath, fill tub halfway with warm water. For a shower, adjust flow and temperature of water		
13. Inquire about allergies and supply required non-allergenic soap		

Competencies:	**Date**	**Instructors Initials**
14. Provide privacy		
15. Assist resident to bathe if condition so dictates per facility procedure. Note: Do not leave resident unattended if condition dictates close observation		
16. Instruct resident to call when ready. Note: Return periodically if not called.		
17. Assist resident with drying skin, observe for reddened skin, dry skin and open areas		
18. Assist resident in applying deodorant and lotion as needed		
19. Assist resident in dressing		
20. Accompany resident to room		
21. Ensure resident's comfort and safety, leave call light within reach		
22. Wash hands		
23. Clean bathing area		
24. Remove OCCUPIED sign		
25. Wash hands		
26. Report abnormal findings and irregularities to nurse		
27. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident has been bathed according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 8-12: Bathing – bed-bath

STANDARD:
Medical asepsis must be maintained during bed bath. At the end of the procedure the resident must be clean and dry. Procedure must be recorded.

TOOLS AND EQUIPMENT:

Bath blanket	Orange stick	Soap and water
Q-tips	Bed linen	Lotion
Towels	Washcloths	Gloves
Bedpan or urinal	Wash basin	Gown/pajamas

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Close windows and doors (check temperature of room)		
5. Assemble equipment and supplies		
6. Provide privacy		
7. Offer bedpan or urinal per procedure		
8. Wash hands		
9. Drape resident with bath blanket. Don't expose resident unnecessarily. Keep resident warm and dry during procedure		
10. Make resident comfortable		
11. Fill wash basin 2/3 full with warm water (check temperature)		
12. Apply gloves		
13. Place a towel under resident's chin (lengthwise across chest)		
14. Wash face (use soap per resident preference)		

Competencies:	**Date**	**Instructors Initials**
15. Rinse and dry face		
16. Remove resident's gown or pajamas. Note: Resident may wish to bathe independently		
17. Expose far arm and hand, place towel under arm and hand		
18. Bathe resident's far arm and axillae (use soap sparingly)		
19. Rinse and dry arm and axillae (cover shoulder with blanket)		
20. Soak far hand in basin and clean nails		
21. Rinse and dry hand		
22. Cover far arm and hand with blanket		
23. Expose near arm and hand, place towel under arm and hand		
24. Repeat procedure for near arm, axillae and hand (Steps 15-20)		
25. Fold bath blanket down and place towel lengthwise across resident's chest		
26. Bathe chest (use soap sparingly)		
27. Rinse and dry chest		
28. Apply lotion to resident as condition dictates		
29. Bathe abdomen using washclothe/Q-tip for navel (use soap sparingly)		
30. Rinse and dry abdomen		
31. Cover chest and abdomen with bath blanket		
32. Fold bath blanket back and expose far thigh, leg and foot		
33. Place towel beneath far thigh, leg and foot		
34. Bathe leg and thigh (use soap sparingly)		
35. Rinse and dry thigh and leg		

Competencies:	**Date**	**Instructors Initials**
36. Cover far thigh and leg with bath blanket		
37. Soak far foot in basin		
38. Check condition of toenails and skin		
39. Rinse and dry foot thoroughly		
40. Cover foot with bath blanket		
41. Expose near thigh, leg and foot		
42. Place towel beneath resident's near thigh, leg and foot		
43. Repeat procedure for near thigh, leg and foot		
44. Change bath water. Note: Change bath water if it is too dirty, too soapy, or too cold		
45. Position resident facing away (turn resident on side)		
46. Place towel close to resident's back		
47. Bathe resident's back (use soap sparingly)		
48. Rinse, dry, and powder/lotion as condition dictates		
49. Cover resident's back with bath blanket		
50. Expose perineal area (turn resident on back)		
51. Place towel beneath buttocks		
52. Perform perineal and anal care per procedure. Note: Resident may wish to complete this part		
53. Discard soiled gown in proper receptacle. Remove gloves.		
54. Assist resident to redress in clean gown/pajamas		
55. Tidy work area. Clean and return equipment to storage		
55. Ensure resident's comfort and safety, leave call light within reach		

Competencies:	**Date**	**Instructors Initials**
56. Wash hands		
57. Report abnormal findings and irregularities to nurse		
58. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when a resident's skin is cleansed according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 8-13: Skin care/inspection

STANDARD:
Resident’s skin must be clean and dry with any abnormalities or reddened areas on shoulders, elbows, hips, coccyx and heels noted and reported.

TOOLS AND EQUIPMENT:
Bath blanket Lotion

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident’s identity and explain procedure		
3. Wash hands		
4. Provide privacy		
5. Cover resident with bath blanket		
6. Remove clothing as necessary		
7. Inspect resident’s skin, particularly the bony prominences of shoulders, elbows, hips, coccyx, heels, and under breast and skin folds		
8. Apply lotion as needed		
9. Replace clothing		
10. Ensure resident’s comfort and safety, leave call light within reach		
11. Wash hands		
12. Report abnormal findings and irregularities to nurse		
13. Use appropriate physical and verbal contact		

CRITERIA: Competence in the task will be recognized when any abnormal conditions of a resident’s skin are detected according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 8-14: Dressing

STANDARD:
Resident must be provided with privacy. Resident must be dressed neatly and appropriately. Procedure must be recorded.

TOOLS AND EQUIPMENT:
Resident's clothing to include undergarments, top clothing and socks or hospital gown

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4.Provide privacy		
5.Offer resident choice/preference for clothing as appropriate		
6.Remove soiled garments, draping resident appropriately to avoid exposure		
7.Put on undergarments or assist as needed		
8.Assist resident to put on clean clothing or gown, per resident preference as appropriate. Note: If resident has a one-sided weakness dress weaken side first/undress strong side first		
9.Assist resident to put on socks		
10. Collect soiled garments and dispose of accordingly		
11. Ensure resident's comfort and safety, leave call light within reach		
12. Wash hands		
13. Report abnormal findings and irregularities to nurse		
14. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident is assisted to dress according to the procedure of the training program and the achievement indicators listed.

Student Name: ____________________________

TASK 9-1: Bed Operation

STANDARD:
The nursing assistant will appropriately operate a bed for height and/or position.

TOOLS AND EQUIPMENT:
Electric bed Manual bed

Competencies:	**Date**	**Instructors Initials**
1. Wash hands		
2. Manual bed a) Locate cranks		
b) Use cranks to adjust bed height		
c) Use cranks to position the bed in Fowler's position		
3. Electric bed a) Locate control unit		
b) Use control unit to adjust bed height		
c) Use control unit to position the bed in Fowler's position		
4. Safety considerations a) Adjust bed to comfortable working height for nursing assistant		
b) Always return bed to low position for resident safety and comfort		
c) Check with charge nurse on use of knee gatch		
d) Return cranks to down position		
5. Wash hands		

CRITERIA: Competency in the task will be recognized when the bed can be adjusted for height and position safely according to the procedure of the training program and proper body mechanics are observed and the achievement indicators listed.

Student Name: ___________________________

TASK 9-2: Making an unoccupied bed

STANDARD:
Linens must be smooth, neat and without wrinkles; corners must be mitered. Pillow must be at head of bed with open end of pillowcase away from door.

TOOLS AND EQUIPMENT:

Bed	Mattress pad (optional)	Bedspread	Pillow
Pillowcase	Mattress	One flat sheet	One fitted sheet
Linen bag or hamper	Gloves (optional)		

Competencies:	**Date**	**Instructors Initials**
1. Wash hands		
2. Assemble linens		
3. Place linens on clean surface		
4. Adjust bed to comfortable work height		
5. Remove soiled linen from bed according to facility policy		
6. Placed soiled linen in linen bag and close bag		
7. Slide mattress toward head of bed		
8. Secure mattress pad on bed with absorbent side up		
9. Removes and place bottom sheet on bed with fold down center of mattress and seams toward mattress		
10. Adjust bottom sheet and secure all four corners		
11. Tuck sides of sheet under mattress along one side		
12. Place top sheet on bed with fold down center		
13. Adjust top sheet so that top hem is even with top edge of mattress		
14. Place bedspread on bed with fold down center so that top hem is even with top edge of mattress		
15. Tuck linens under bottom of mattress		

Competencies:	**Date**	**Instructors Initials**
16. Miter corner of top linens at foot of bed		
17. Repeat procedure on other side of bed		
18. Fanfold top linens to bottom of bed for an open bed or fold sheet and bedspread down about three inches for a closed bed.		
19. Insert pillow in pillowcase		
20. Position pillow at head of bed with open end of pillowcase away from door		
21. Adjust bed to height to receive resident a) Adjust to lowest position to receive ambulatory resident b) Adjust to highest position to receive resident from stretcher		
22. Remove linen bag or hamper to area designated for soiled linen		
23. Wash hands		
24. Report abnormal observations and irregularities to nurse		

CRITERIA: Competency in the task will be recognized when the bed is changed according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 9-3: Making an occupied bed

STANDARD:
Linens on resident's bed must be clean and neat; corners must be mitered. Pillow must be at head of bed with open end of pillowcase away from door.

TOOLS AND EQUIPMENT:

Bedspread	Mattress	Draw sheet	Mattress pad(Optional)	
Flat sheets	Pillow	Linen bag	Pillowcase	Gloves (optional)

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble linens on clean surface near bed		
5. Adjust bed to comfortable work height		
6. Remove bedspread		
7. Loosen top sheet at foot of bed		
8. Remove pillow		
9. Assist resident to far side of bed, facing away from you		
10. Loosen bottom linens on side opposite resident		
11. Slide mattress toward head of bed		
12. Tighten mattress pad or replace soiled pad		
13. Fanfold soiled linen close to resident's body		
14. Fanfold half of bottom sheet lengthwise		

Competencies:	**Date**	**Instructors Initials**
15. Place fan folded length of bottom sheet along side of fan folded soiled linen		
16. Note for flat bottom sheet: Lower hem of sheet should be even with bottom of mattress. Seams should be facing toward mattress. a) Tuck sheet under mattress at head of bed		
b) Miter corner at head of bed		
Note for fitted bottom sheet: secure corners of the sheet at the top and the bottom of the mattress		
17. Note if draw sheet is used: a) Fold draw sheet b) Fanfold draw sheet and place fanfold on top of fanfold bottom sheet c) Tuck side of draw sheet and side of bottom sheet together under mattress		
18. Turn resident over linen mound toward clean side of bed		
19. Move to opposite side of bed		
20. Remove soiled bottom linen from bed, place in linen bag		
21. Pull all clean linen toward you		
22. Miter corner of bottom sheet at head of bed		
23. Tuck bottom sheet and draw sheet smoothing out wrinkles		
24. Remove soiled pillowcase from pillow and replace with clean pillowcase		
25. Assist resident to comfortable position		
26. Place pillow under resident's head, with open end of pillowcase away from door		
27. Spread clean top sheet over resident		
28. Pull soiled top linen out toward foot of bed, remove and place in bag. Close bag.		
29. Tuck top linens at foot of bed if condition dictates (make toe pleat)		

Competencies:	**Date**	**Instructors Initials**
30. Fold top sheet back over top edge of bedspread		
31. Remove linen bag to area designated for soiled linen		
32. Ensure resident's comfort and safety, lower bed to lowest horizontal position and leave call light within reach		
33. Wash hands		
34. Report abnormal findings and irregularities to nurse		
35. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident bed is changed according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 11-1: Application of restraint alternatives and a waist restraint

STANDARD:
The physician must order a waist restraint. Protective devices must not interfere with treatment or health problems. Application of protective devices must be recorded and resident must be released, exercised and checked every two hours.

TOOLS AND EQUIPMENT:
Waist restraint Bed alarm Chair alarm

PERFORMANCE
Note: Applying protective devices has serious implications and safety procedures must be followed.

Competencies:	**Date**	**Instructors Initials**
1. Check care plan regarding use of restraints		
2. Introduce self		
3. Verify resident's identity and explain procedure		
4. Ensure resident and support person/family that protective devices are temporary and used only for resident safety		
5. Wash hands		
6. Provide privacy		
7. Apply bed alarm a) Make sure resident is comfortable and in good body alignment in the bed		
b) Place bed alarm tab on resident		
c) Place call bell within resident's reach		
8. Apply chair alarm a) Make sure resident is comfortable in chair		
b) Place chair alarm on resident per manufacturers instructions		
9. Apply waist restraint		
a) Obtain a waist restraint in a size appropriate for the resident		
b) Make sure resident is comfortable in chair		

Competencies:	Date	Instructors Initials
c) Place the belt around the front of the resident's waist, bring the ties to the back of the resident		
d) Make sure the restraint is smooth and free from wrinkles		
e) Lay restraint across resident's lap, bring ties down between the side of the resident and seat of wheelchair, crisscross behind wheelchair		
f) Complete application of the restraint by securing the restraint to a non-movable part of the wheel chair according to manufacturer's instructions, using a quick release knot, and observe resident per facility procedure/policy		
10. Check and remove restraints every 2 hours and reposition the resident. Provide proper skin care; perform a set of range of motion exercises; offer toileting and provide resident a drink. Reapply the restraint.		
11. Ensure resident's comfort and safety, leave call light within reach		
12. Wash hands		
13. Report abnormal findings and irregularities to nurse		
14. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when restraint alternatives and a waist restraint are applied according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 12-1: Measure and record temperature – oral – axillary – rectal – aural (tympanic or ear)

STANDARD:
Glass thermometers are only used when an electronic thermometer is not available. Manufacturer's instructions must be followed for each thermometer used. Resident's temperature must be recorded.

TOOLS AND EQUIPMENT:

Lubricant (if necessary)
Electronic Thermometer
Alcohol wipes
Paper to record results
Probe covers
Pencil/pen
Gloves

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Write resident's name and room number on paper		
6. Remove electronic thermometer from the charger. Select the thermometer or probe for oral or rectal temperatures.		
7. Measure the resident's temperature		
Oral Temperature a. Check that the probe is for oral temperatures		
b. Remove the probe from the storage well		
c. Insert the probe into the probe protective cover		
d. Place under the resident's tongue and ask resident to close lips around the probe		
e. The thermometer will indicate, usually with a beep, when it has reached the reading.		
Axillary temperature a. Check that the probe is for oral temperatures		
b. Cleanse and dry underarm area		
c. Remove the probe from the storage well		
d. Insert the prove under the resident's arm pit		
e. Hold the resident's arm tightly against their chest		
f. The thermometer will indicate, usually with a beep, when it has reached the reading.		

Competencies:	Date	Instructors Initials
Rectal temperature a. Place the resident in the Sim's (side-lying position)		
b. Apply gloves		
c. Check that the probe is for rectal temperatures		
d. Remove the probe from the storage well and apply lubricant		
e. Insert the probe into the probe protective cover		
f. Insert the probe into the rectum 1 to 1½ inch.		
g. Hold the probe in place until it has reached its reading		
h. The thermometer will indicate, usually with a beep, when it has reached the reading.		
i. Wipe excess lubricant from rectal area when thermometer is removed		
j. Remove gloves and wash hands		
Aural (tympanic) temperature a. Check that the probe is for aural (tympanic) temperatures		
b. Remove the probe from the storage well		
c. Insert the probe into the probe protective cover		
d. Place the probe into the residents ear canal		
e. The thermometer will indicate, usually with a beep, when it has reached the reading.		
7. Read the thermometer		
8. Remove and discard probe cover into trash, remove gloves		
9. Cleanse probe with alcohol wipe and return probe to storage well.		
10. Record temperature on paper		
11. Ensure resident's comfort and safety, leave call light within reach		
12. Wash hands		
13. Report abnormal reading to nurse		
14. Record temperature on paper		
15. Return thermometer to charging base		
16. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the temperature of a resident is obtained according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 12-2: Take/record pulse

STANDARD:
Regular pulsation must be counted for 60 seconds. All findings must be recorded.

TOOLS AND EQUIPMENT:
Pencil/pen	Paper to record results	Watch/clock with second hand

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Support forearm while taking pulse		
6. Locate radial artery		
7. Place two fingers over radial artery		
8. Count pulsations for 60 seconds (one full minute) using watch with second hand		
9. Note regularity and strength of beat		
10. Record pulse rate on paper		
11. Ensure resident's comfort and safety, leave call light within reach		
12. Wash hands		
13. Report abnormal findings and irregularities to nurse		
14. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the pulse rate of a resident is obtained according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 12-3: Take/Record Respiration

STANDARD:
Respiration must be counted for 60 seconds. All findings must be recorded.

TOOLS AND EQUIPMENT:
Pencil/pen Paper to record results Watch/clock with second hand

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Conceal counting of respirations by not telling resident, (i.e. keeping fingers on resident's wrist while counting respirations)		
6. Count resident's respirations for 60 seconds (one full minute) using watch with second hand		
7. Note depth and rhythm of respirations		
8. Record respirations on paper		
9. Ensure resident's comfort and safety, leave call light within reach		
10. Wash hands		
11. Report abnormal findings and irregularities to nurse		
12. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the respirations of a resident are obtained according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 12-4:Take/Record Blood Pressure (one-step method)

STANDARD:
Earpieces and diaphragm of stethoscope must be cleaned before and after blood pressure is taken. Sphygmomanometer cuff must be placed at least one inch above elbow. All findings must be recorded.

TOOLS AND EQUIPMENT:

Alcohol wipe	Paper to record results Pencil/Pen
Stethoscope	Sphygmomanometer

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment – select appropriate size cuff		
5. Clean earpieces and diaphragm of stethoscope with alcohol wipe		
6. Expose anticubital areas		
7. Wrap deflated cuff smoothly and snugly around resident's upper arm and fasten		
- Place cuff at least one inch above elbow		
- Center over brachial artery		
8. Locate brachial artery at inner aspect of elbow by: - Positioning arm with palm up and elbow at level of heart		
- Feeling for pulse at brachial artery with fingers		
9. Place earpieces of stethoscope in your ear, adjust for comfort and placement		
10. Place diaphragm of stethoscope over brachial artery where pulse last felt		
11. Close valve on air pump		
12. Pump air bulb to inflate cuff according to program policy and specific resident's history		
13. Deflate cuff slowly and at consistent rate (2-4 mm per second)		
14. Watch numerical line or needle of Sphygmomanometer as it falls		

Competencies:	**Date**	**Instructors Initials**
15. Listen for first thumping sound in stethoscope		
16. Note needle reading where first thump (systolic pressure) is heard		
17. Note needle reading where last thump (diastolic pressure) is heard		
18. Open valve to let remaining air out		
19. Repeat steps 7-18 if necessary, pausing 30 second between attempts		
20. Record reading on paper		
21. Remove cuff		
22. Ensure resident's comfort and safety, leave call light within reach		
23. Wash hands		
24. Clean and return equipment to storage - Clean stethoscope earpieces and diaphragm with alcohol wipes		
25. Report abnormal findings and irregularities to nurse		
26. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the blood pressure of a resident is obtained according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 12-5: Take/record height and weight

STANDARD:
Scales must be balanced and must be stationary before resident is on the platform. Measurements must be recorded. Discuss wheelchair scales and scales on mechanical lifts.

TOOLS AND EQUIPMENT:
Pencil/pen Paper to record results Scale Paper towel

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Provide for privacy		
6. Weight a. Ensure scale is in stationary position		
b. Ensure scale is balanced or reading is at zero		
c. Place paper towel or other barrier on platform if resident is barefoot or wearing stockings		
d. Assist resident on to scale		
e. Steady resident (Resident must not be leaning or holding supports during measurements)		
f. Read scale and note weight		
g. Record weight on paper		
7. Height a. Raise measurement bar, rest gently on top of resident's head		
b. Locate correct area to read height		
c. Measure height		
d. Record height on paper		
8. Assist resident off scale		
9. Ensure resident's comfort and safety, leave call light within reach		

Competencies:	**Date**	**Instructors Initials**
10. Wash hands		
11. Report abnormal reading to nurse		
12. Return scale to storage area (if applicable)		
13. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the weight and height of a resident is obtained according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 13-1: Providing hydration and nutrition for resident in bed and record intake

STANDARD:
Resident must be fed prescribed diet and food intake must be recorded. Resident's face, hands, clothes and bed linen must be clean before and after procedure. Intake must be recorded and nurse must be notified if inadequate intake is recorded.

TOOLS AND EQUIPMENT:
Pencil/pen Paper to record results Clothing protector
Food tray with beverage, knife, fork, spoon and napkin, cereal and milk or jell-o or pudding

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assist resident to wash hands and face		
5. Check resident identification with labeled food tray and verify the diet type		
6. Provide towel or clothing protector		
7. Adjust bed (elevate head of bed to safe and comfortable eating position)		
8. Adjust overbed table		
9. Place food tray on overbed table		
10. Ask resident preference for condiments, etc.		
11. Cut the food as needed and prepare beverages		
12. Sit to maintain eye contact with resident while feeding		
13. Offer fluid to drink to moisten mouth before offering food		
14. Allow resident time to eat, observe for swallowing difficulty or choking.		
15. Feed resident as needed using small bites and adequate time to chew and swallow		

Competencies:	**Date**	**Instructors Initials**
16. Check to see if resident has swallowed before offering next bite		
17. Offer fluids to drink throughout feeding (after every 3-4 bites of food)		
18. Offer encouragement to resident towards maximizing food and fluid intake		
19. Converse with resident during meal		
20. Remove towel or clothing protector and food tray		
21. Observe the amount of food eaten		
22. Assist resident to clean hands and face and tidy the area		
23. Record amount eaten on flow chart if ordered		
24. Ensure resident's comfort and safety, leave call light within reach		
25. Wash hands		
26. Report abnormal findings and irregularities to nurse		
27. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident has been fed and intake recorded according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 13-2: Measure/Record Intake and Output

STANDARD:
Fluid intake and output must be measured and recorded accurately. The nurse must be notified if inadequate intake or output is recorded.

TOOLS AND EQUIPMENT:
Bedpan, urinal, measuring hat
Graduated measuring container
Small calculator
Intake and Output form
Paper to record results
Gloves
Pencil/pen

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment, including Intake and Output form		
5. Make sure resident name is on the Intake and Output form		
6. Place graduated container, measuring hat or commode in resident's bathroom and instruct resident to save all urine voided		
7. Record all fluids taken by mouth on the Intake portion of the form		
8. Review fluid amounts for commonly used containers		
9. Apply gloves		
10. Measure and record out put - Place barrier on flat surface		
- Set container on flat surface to read		
- Position self to read amount at eye level		
- Remove gloves		
- Wash hands		
- Record results on Intake and Output form		
11. Ensure resident's comfort and safety, leave call light within reach		
12. Total all intake and output at the end of the shift, use calculator if needed		

Competencies:	**Date**	**Instructors Initials**
13. Record total of all intake by mouth		
14. Record total of output (urine, emesis)		
15. Report abnormal findings and irregularities to nurse		
16. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the intake and output of a resident is obtained according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 14-1: Assist with bedpan and urinal

STANDARD:
Nursing assistants must respond promptly to a resident's call for assistance in using the bedpan or urinal. Resident's perineal area and hands must be cleaned after each use. Contents of bedpan or urinal must be recorded.

TOOLS AND EQUIPMENT:

Bedpan	Urinal	Gloves	Soap and water
Towel and washcloth	Air freshener	Toilet tissue	
Pencil/pen	Paper to record results		

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Provide for privacy		
6. Apply gloves		
7. Adjust bed clothes (fold linen to one side)		
8. Place an underpad to protect bedding		
9. Placing a bedpan (bed position should be flat, if possible) - Position resident with knees flexed and ask to raise hips		
- Slide the bedpan under resident (check proper placement of pan)		
- Note: If resident cannot raise hips: - Turn resident onto side - Place bedpan close to buttocks - Roll resident back onto pan		
- Replace linen over resident		
- Raise head of bed as condition permits		
- Place call light and toilet tissue within resident reach		
- Instruct resident to call when ready and step behind privacy curtain		
- Check on resident to see when completed		
- Lower head of bed before removing bedpan (see steps 6 & 7)		
- Remove bedpan without spillage and observe contents, use air freshener if needed		

Competencies:	Date	Instructors Initials
10. Placing a urinal - Instruct resident to position urinal so that urine flows into urinal (position urinal if resident is unable)		
- Place call light and toilet tissue with in resident reach		
- Instruct resident to call when ready and step behind privacy curtain		
- Check on resident to see when completed		
- Remove urinal without spillage and observe contents, use air freshener if needed		
11. Provide for perineal cleaning		
12. Measure contents if indicated		
13. If abnormal findings and irregularities, summon nurse prior to emptying bedpan or urinal and rinse		
14. Return bedpan or urinal to storage		
15. Remove gloves		
16. Wash hands		
17. Assist resident to wash hands		
18. Tidy work area		
19. Ensure resident's comfort and safety, leave call light within reach		
20. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the bedpan and urinal for a resident is placed and removed according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 14-2: Assist with bedside commode

STANDARD:
Nursing assistants must respond promptly to a resident's call for assistance in using the commode or toilet. Resident's perineal area and hands must be cleaned after each use. Contents of the commode must be recorded.

TOOLS AND EQUIPMENT:
Bedside commode Non-skid footwear Gloves Soap and water
Towel and washcloth Air freshener Toilet tissue
Pencil/pen Paper to record results

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Provide for privacy		
6. Fold bed linens to the foot of bed		
7. Assist resident to sit at edge of bed, apply non-skid footwear and gait belt		
8. Assist resident to stand, turn and sit on commode using appropriate transfer technique		
9. Place call light and toilet tissue within resident reach		
10. Instruct resident to call when ready and step behind privacy curtain		
11. Check on resident to see when completed		
12. Provide for perineal cleaning		
13. Use air freshener if needed		
14. Remove gloves		

Competencies:	Date	Instructors Initials
15. Wash hands		
16. Assist resident to wash hands		
17. Assist resident to return to bed		
18. Reapply gloves		
19. Observe contents of commode and measure contents if indicated		
20. Report abnormal findings and irregularities to nurse, such as unusual color, texture or odor of urine or feces prior to emptying commode and rinse		
21. Remove gloves		
22. Wash hands		
23. Tidy work area		
24. Ensure resident's comfort and safety, leave call light within reach		
25. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when a resident is place on and removed from the commode according to the procedure of the training program and the achievement indicators listed.

Student Name: ___________________________

TASK 14-3: Catheter care

STANDARD:
The nurse aide will provide catheter care to promote personal hygiene and comfort to decrease the risk of infection and inflammation in the resident who has an indwelling catheter

TOOLS AND EQUIPMENT:

Catheter inserted into the manikin
Underpad
Gloves
Soap and water
Towel and washcloth
Basin
Bath blanket

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Provide for privacy		
6. Adjust bed clothes (fold linen to foot of bed) and cover resident with bath blanket		
7. Place an under pad on bed to protect bedding		
8. Position resident on back with legs separated and knees flexed		
11. Fill basin with warm water		
12. Apply gloves		
13. For the male resident – gently draw foreskin back.		
i. Cleanse around the catheter insertion site and the glans from the meatus toward the shaft for approximately 4 inches.		
ii. Change spot on washcloth for each washing stroke.		
14. For the female resident – separate the labia		
i. Cleanse around the catheter insertion site wiping from front to back		
ii. Change spot on washcloth for each washing stroke.		

Competencies:	**Date**	**Instructors Initials**
15. Cleanse the catheter washing away from the body and down the catheter about 3-4 inches.		
16. Use a clean wet washcloth for rinsing, changing the spot on the washcloth with each rinsing stroke		
17. Observe the insertion site for abnormal discharge/signs or symptoms of skin irritation. Dry the entire perineal area		
18. Inspect the catheter and tubing for secretions. Remove secretions using a clean washcloth or alcohol wipes if available. (Note do not use alcohol wipes on the perineal area.)		
19. Leave tubing coiled on bed without kinks, obstructions or loops hanging over the side of the bed		
20. Remove bath blanket, underpad and replace with a new underpad and bed linens if necessary		
21. Remove gloves		
22. Wash hands		
23. Tidy work area		
24. Ensure resident's comfort and safety, leave call light within reach		
25. Report abnormal findings and irregularities to nurse		
26. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the catheter care for a resident is completed according to the procedure of the training program and the achievement indicators listed.

Student Name: ________________________

TASK 14-4: Urine/Stool Specimen Collection

STANDARD:
The nurse aide will collect routine urine and stool specimens utilizing standard precautions.

TOOLS AND EQUIPMENT:
Gloves Tongue blades Toilet tissue Soap Washcloth
Bedpan with cover or urinal Graduate pitcher specimen containers with lids
Small plastic bag

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Provide for privacy and apply gloves		
6. Routine Urine Specimen a) Have resident urinate into the clean bedpan or urinal		
b) Instruct the resident to <u>not</u> discard toilet tissue in the pan with the urine, and place in plastic bag.		
c) After the resident has voided, offer a wet washcloth to cleanse hands		
d) Take the pan to the bathroom or utility room, measure if necessary, pour Approximately 120 cc (4oz.) into the specimen container.		
e) Cover container tightly		
7. Clean – Catch Urine Specimen Wash the resident's genital area properly or instruct the resident to do so.		
8. **For female residents:** a) Using the soap and warm water on washcloth, cleanse the outer folds of the vulva (folds are also called labia lips) wiping from front to back.		
b) Re-fold washcloth and use clean side, cleansing the inner folds of the vulva wiping from front to back.		
c) Re-fold washcloth and finally, cleanse middle, innermost area (meatus or urinary opening) in the same manner. Put cloth in small plastic bag.		
d) Keep the labia separated so that the folds do not fall back and cover the meatus.		
e) Instruct resident to void, allowing first part to escape		

Competencies:	Date	Instructors Initials
9. **For male residents:** a) Using the washcloth, warm water and soap solution, cleanse the tip of the penis from the urinary meatus down, using a circular motion. Put cloth in small plastic bag.		
b) Instruct the resident to void, allowing the first part of the urine to escape		
10. Catch the urine stream that follows in the sterile specimen container.		
11. Allow the last portion of the urine stream to escape. Note: If the resident's I & O is being monitored, or if the amount of urine passed must be measured, catch the first and last part of the urine in a bedpan or urinal.		
12. Place the sterile cap on the urine container immediately to prevent contamination of the urine specimen		
13. Offer the resident the opportunity to wash hands		
14. With the cap securely tightened, wash the outside of the specimen container		
15. **Stool Specimen** a) Collect stool from daily bowel movement. Offer wash water to resident		
b) Use tongue blade to remove specimen, place in specimen container		
c) Cover container. Make sure cover is on tightly		
16. Remove disposable gloves		
17. Wash your hands		
18. Write resident's name on label for each specimen container		
19. Take specimen to charge nurse or designated area		
20. Report that you have obtained the specimen and any observations you have made. Record the specimen on appropriate forms		
21. Straighten up work area		
22. Ensure resident's comfort and safety, leave call light within reach		
23. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident urine/stool specimens are collected according to the procedure of the training program and the achievement indicators listed.

Student Name____________________________

TASK 15-1: Proper Body Mechanics

STANDARD:
The nurse aide will use the appropriate muscles to perform the task in order to conserve energy and reduce injuries.

TOOLS AND EQUIPMENT:
None

Competencies:	**Date**	**Instructors Initials**
1. Assess the need for assistance prior to beginning task. Has good standing posture: a. Feet flat on floor, shoulder width apart b. Arms at side c. Back straight d. Abdominal muscles tightened		
2. Bend from the hips and knees, work close to the object		
3. Use body weight to help push or pull the object rather than lift		
4. Use the strongest muscles to do the job		
5. Avoid twisting your body -PIVOT		
6. Hold heavy objects close to the body		
7. Get assistance if you feel the resident or object is too heavy		
8. Use mechanical devices when necessary to move patients		
9. Tidy work area		
10. Ensure resident's comfort and safety, leave call light within reach		
11. Report abnormal findings and irregularities to nurse		
12. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the student body mechanics are maintained according to the procedure of the training program and the achievement indicators listed.

Student Name__________________________

TASK 15-2: Ambulate Resident

STANDARD:
Resident's pulse, respiration and blood pressure should be taken before walking exercise begins. The nurse aide must steady the resident while the resident walks: a gait belt must be used. Tolerance of exercise and distance ambulated must be recorded/reported.

TOOLS AND EQUIPMENT:
Non-skid footwear Dressed for the day or a Robe Gait Belt

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment		
5. Provide for privacy		
6. Take resident's pulse, respiration and blood pressure if facility policy		
7. Follow the procedure for assisting a resident to transfer		
8. Lock wheels of bed in place		
9. Elevate head of bed		
10. Assist resident to sit and dangle at bedside, if vital signs not taken, check pulse		
11. Put non-skid footwear on resident		
12. Put on gait belt		
13. Assist resident to stand		
14. Steady resident		

Competencies:	**Date**	**Instructors Initials**
15. Walk with resident keeping pace slow and walking close to wall		
16. Walk close behind the resident and slightly to the side of resident holding gait belt		
17. Return resident to bedside		
18. Assist resident to return to bed or chair and remove gait belt		
19. Ensure resident's comfort and safety, leave call light within reach		
20. Wash hands		
21 Report/record tolerance of exercise		
22. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident has been ambulated with assistance according to the procedure of the training program and the achievement indicators listed.

Student Name____________________

TASK 15-3: Transfer Resident from Bed to Wheelchair

STANDARD:
Resident will be transferred in a safe and comfortable manner with use of good body mechanics.

TOOLS AND EQUIPMENT:
Wheelchair Bath blanket Gait belt Cushions Support devices
Non-skid footwear

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Provide for privacy		
5. Decide which side of the bed will be used. Move furniture to provide space		
6. Assess need for assistance. Place the chair or wheelchair at the side of the bed		
7. Place any padding or cushions on the seat of the wheelchair. Lock both wheels of the wheelchair and raise the footrests, or swing the leg rests out of the way		
8. Make sure the bed is in the lowest position to allow for safe transfer and make sure that the wheels of the bed are locked		
9. Fanfold top linens to the foot of the bed		
10. Put the non-skid footwear on the resident		
11. Help the resident to sit on the side of the bed. Make sure the resident's feet touch the floor		
12. Help the resident put on clothing or a robe		
13. Apply gait belt, securely around resident's waist making sure it is not too tight or too loose, if conditions warrants or facility policy permits		
14. Assist the resident to a standing position. Use the following method with a gait belt: a. Stand in front of the resident		
b. Ask the resident to place his or her hands on your shoulders		

Competencies:	Date	Instructors Initials
c. Grasp the gait belt at each side with your hands		
d. Brace your knees against the resident's knees and block his or her feet with your feet		
e. Ask the resident to stand on the count of "3". At "3" assist the resident up into a standing position as you straighten your knees		
f. Maintain your body mechanics in assisting resident to stand		
15. Assist the resident to a standing position. If a gait belt is not needed, use the following method: a. Stand in front of the resident		
b. Place your hands under the resident's arms. Your hands should be around the resident's shoulder blades		
c. Ask the resident to push his/her fists into the mattress and lean forward on the count of "3"		
d. Brace your knees against the resident's knees and block his or her feet with your feet		
e. Assist the resident up into a standing position on the count of "3", straighten your knees as the resident rises		
f. Maintain your body mechanics in assisting resident to stand		
16. Support the resident in the standing position by holding the gait belt or with your hands around the resident's shoulder blades. Continue to block the resident's feet and knees with your feet and knees. This helps prevent him or her from falling		
17. Turn the resident so the resident can grasp the far arm of the chair. The legs will touch the edge of the chair. Continue to turn the resident until the other armrest is grasped		
18. Lower the resident into the chair as you bend your hips and knees. The resident assists by leaning forward and bending the elbows and knees		
19. Maintain your body mechanics in assisting resident to sit		
20. Make sure the buttocks are to the back of the seat. Position the resident in good alignment		
21. Position the feet on the footrests		
22. Cover the resident's lap and legs with a lap robe or bath blanket. Make sure the blanket is off the floor and wheels		
23. Remove gait belt if used		
24. Position the chair as the resident prefers		
25. Ensure resident's comfort and safety, leave call light within reach		

Competencies:	**Date**	**Instructors Initials**
26. Wash hands		
27. Report abnormal findings and irregularities to nurse		
28. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident has been transferred according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 15-4: Position Resident on Side in Bed

STANDARD:
Resident must be positioned in good body alignment in bed

TOOLS AND EQUIPMENT:
Pillows or Positioning Devices Hand rolls

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Provide privacy		
5. Lock wheels and then fan fold bedding to the end of the bed		
6. Adjust bed to resident's comfort level, then assist resident to move close to the edge of the bed. Position resident according to turn schedule		
7. Assist resident to roll toward the center of the bed		
8. Place a pillow or the loose end of rolled up bath blanket (trochanter roll) under resident and from shoulder to hip		
9. Tuck the roll along the side of the body to maintain side-lying position		
10. Place pillow between resident's knees and ankles to avoid contact of skin surfaces		
11. Adjust pillow under resident head and shoulder to provide for comfort		
12. Position resident's upper arm for comfort and alignment		
13. Place hand roll in resident's hand with thumb straightened out to prevent thumb contracture		
14. Place top bedding over resident		
15. Ensure resident's comfort and safety, leave call light within reach		
16. Wash hands		
17. Report abnormal findings and irregularities to nurse		

Competencies:	**Date**	**Instructors Initials**
18. Use appropriate physical and verbal contact		
19. Ensure resident's comfort and safety, leave call light within reach		

CRITERIA: Competency in the task will be recognized when the resident has been positioned in a side lying position in bed recorded according to the procedure of the training program and the achievement indicators listed.

Student Name___________________

TASK 15-5: Turn Resident in Bed

STANDARD:
One additional staff member must help in turning the bedridden resident. Positioning rails must be raised and pillows placed behind back and between knees. Skin condition must be examined and any reddened areas/pressure sores must be recorded and reported to nurse.

TOOLS AND EQUIPMENT:
Lift Pad Pillows Positioning rails One additional staff member

Competencies:	**Date**	**Instructors Initials**
1. Check order/nursing care plan		
2. Introduce self		
3. Verify resident's identity and explain procedure		
4. Wash hands		
5. Assemble equipment		
6. Lock bed wheels		
7. Provide privacy		
8. Place the lift pad under resident by gently turning resident with help of a staff member		
9. Pull resident close to edge of bed		
10. Turn resident, with help, to opposite side holding resident so the skin condition may be examined		
11. Examine skin condition		
12. Position pillows behind resident's back and between knees, avoid contact between bony prominences of knees and ankles		
13. Adjust arm, shoulder and head to avoid pressure and provide support		
14. Straighten work area		
15. Ensure resident's comfort and safety, leave call light within reach		
16. Wash hands		

Competencies:	**Date**	**Instructors Initials**
17. Record procedure noting resident's skin condition on resident chart		
18. Report any abnormalities to the nurse		
19. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident has been positioned on the side according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 15-6: Mechanical Lift

STANDARD:
The nursing assistant will safely move a resident using a mechanical lift.

TOOLS AND EQUIPMENT:
Mechanical Lift Additional staff Slings appropriate for the lift

Competencies:	**Date**	**Instructors Initials**
1. Wash hands		
2. Identify the resident and introduce self		
3. Provide for privacy		
4. Check equipment to be sure it is in good working order		
5. Obtain assistance – a safe transfer requires a minimum of 2 people		
6. Discuss the transfer with the resident. Realize that this is a frightening procedure for a dependent person		
7. Select correct sling for the lift and resident		
8. Place the sling under the resident according to manufacturer's instructions. Be sure sling is straight and smooth under the resident		
9. Bring lift to the bed		
10. Open the base of the lift for a broad base of support.		
11. Secure the brakes on the lift		
12. Lower the arm of the lift until you are able to attach the sling to the arm a). Keep the sling untangled and balanced		
13 Raise the sling just high enough to clear the bed. Have the second assistant help support the resident's neck/head		
14. Move the lift slowly until the resident is positioned over the chair, stretcher or bed. a) Steady the sling with your hand b) Reassure the resident of his/her safety		
15. Slowly and steadily lower the lift until resident is positioned in chair		
16. Disconnect or remove sling and return lift to storage area		

Competencies:	**Date**	**Instructors Initials**
17. Reverse the steps to return the resident to bed		
18. Wash hands		
19. Straighten work area		
20. Ensure resident's comfort and safety, leave call light within reach		
21. Report findings and irregularities to nurse		
22. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident has been transferred using a mechanical lift according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 15-7: Range of motion upper and lower extremity

STANDARD:
Exercises must be repeated times three. Joints must be moved smoothly and slowly and all notable changes must be recorded and reported to the nurse.

TOOLS AND EQUIPMENT:
Bath blanket

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Elevate bed to comfortable working height for you		
5. Provide privacy		
6. Position resident in supine position		
7. Range of motion Upper Extremity a) Abduct, adduct, flex, extend and rotate the shoulder		
b) Flex and extend the elbow		
c) Flex, extend and rotate the wrist		
d) Abduct, adduct, flex, extend and rotate each finger and the thumb		
8. Range of motion Lower Extremity a) Abduct, adduct, flex, and extend the hip		
b) Flex and extend the knee		
c) Flex, extend and rotate the ankle		
d) Abduct, adduct, flex, extend and rotate each toe		
9. Hold each extremity to be exercised above and below the joint		
10. Flex and rotate smoothly and slowly through its ranges		
11. Repeat range of motion times three for each joint		
12. CAUTION: Do not use force and stop if resident experiences pain		

Competencies:	**Date**	**Instructors Initials**
13. Straighten up work area		
14. Lower bed to the lowest position		
15. Ensure resident's comfort and safety, leave call light within reach		
16. Wash hands		
17. Report abnormal findings and irregularities to nurse		
18. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when range of motion exercises have been performed on the upper and lower extremities according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 15-8: Walker Assistance

STANDARD:
Resident must be instructed on how to use walker; resident must be steadied during walking exercise. Tolerance of use of walker and distance walked must be recorded on resident's chart.

TOOLS AND EQUIPMENT:
Walker Non-skid footwear Resident is dressed in appropriate clothing
Gait belt

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Assemble equipment and check for rubber tips on legs and hand grips Replace walker if necessary		
5. Provide privacy		
6. Assist resident to sit and dangle		
7. Assist resident in putting on non-skid footwear		
8. Put gait belt on resident		
9. Lock wheels of bed		
10. Assist resident to stand (use proper technique and body mechanics)		
11. Position walker in front of resident		
12. Instruct resident to grasp hand grips keeping elbows flexed		
13. Adjust height of walker so that hand grips are just below resident's waist		
14. **Instruct resident on how to use walker, per PT instructions** For resident with both legs weak: a) move walker ahead 6 inches		
b) move right foot up to walker		
c) move left foot up to right foot		

Competencies:	**Date**	**Instructors Initials**
For resident with one weak leg: a) move walker and weak leg ahead 6 inches at same time		
b) move stronger leg ahead		
15. Steady resident as resident proceeds to walk		
16. Walk close behind and slightly to side of resident, holding gait belt		
17. Assist resident back to bed		
18. Remove gait belt from resident		
19. Assist resident with non-skid footwear (if appropriate) and return to bed or chair		
20. Straighten work area		
21. Ensure resident comfort and safety – call light within reach		
22. Position walker within resident's reach as condition dictates		
23. Wash hands		
24. Report/record resident tolerance of use of walker		
25. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident is ambulated with the walker with assistance according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 15-9: Cane Assistance

STANDARD:
The nurse aide will provide necessary assistance for use of a cane by the resident who needs support and balance

TOOLS AND EQUIPMENT:
Variety of canes

Competencies:	**Date**	**Instructors Initials**
1. Introduce self		
2. Verify resident's identity and explain procedure		
3. Wash hands		
4. Verify type of cane to use with charge nurse, rehab nurse and/or physical therapy person		
5. Check cane's condition		
6. Check pathways for items that could cause falls		
7. Check height of cane for correct fit		
8. Position cane on side of stronger leg		
9. Instruct resident in appropriate use of cane – check care plan a) Hold the cane on the stronger side		
b) Put the cane about 4 inches to the side of the stronger leg		
c) Instruct the resident to put the weight on the stronger side		
d) Move the cane about 4 inches ahead and bring the weaker leg up next to the stronger leg, using the cane to help support the weight		
10. Monitor resident for steadiness		
11. Ensure resident's comfort and safety, leave call light within reach		
12. Report/record observations		
13. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident is ambulated with a cane according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 15-10: Wheelchair assistance

STANDARD:
The nurse aide will provide safe wheelchair assistance.

TOOLS AND EQUIPMENT:
Variety of styles of wheelchairs   Support devices   Gait belt

Competencies:	**Date**	**Instructors Initials**
1. Identify the resident and introduce self		
2. Wash hands		
3. Provide for privacy		
4. Check wheelchair's condition, then position the wheelchair next to the bed		
5. Lock the brakes and raise the footrests, or swing leg rests out of the way		
6. Follow the procedure for assisting a resident to transfer		
7. Maintain proper body position for the resident by: a) Positioning hips well back in the chair		
b) Positioning feet on the footrests		
c) Making sure the trunk of the body is aligned left and right		
d) Use of support devices to prevent sliding		
e) Use of armrests or pillows for arm comfort		
8. Provide a covering for the resident's lap, if needed		
9. Unlock the wheels of the chair		
10. If assistance is needed to move the wheelchair, guide the chair from behind: a) Stay to the right in hallways, pushing resident forward, never backwards		
b) Be careful when approaching intersecting hallways		
c) Back down slanted ramps		
d) Back into and out of elevators and doors		
11. Avoid pulling or dislodging nasogastric tubes, catheters and tubing, dressings or braces		
12. Dependent residents should be repositioned every 1 to 2 hours while in the wheelchair and not be up longer than 3 hours without a rest period in bed		

Competencies:	**Date**	**Instructors Initials**
13. Ensure resident's comfort and safety, leave call light within reach		
14. Report/record observations		
15. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the resident has is seated in the wheelchair according to the procedure of the training program and the achievement indicators listed.

Student Name__________________

TASK 18-1: Postmortem care

STANDARD:
The nurse aide will provide care after death with respect and dignity for the body

TOOLS AND EQUIPMENT:

Shroud/clean sheet	Basin	Soap and water	Incontinent pads as needed
Washcloth and towel	Gloves	Cotton balls	Bandages

Competencies:	**Date**	**Instructors Initials**
1. Wash hands		
2. Provide privacy		
3. Identify the resident		
4. Put on gloves		
5. Have the nurse remove tubing and appliances		
6. Work quietly; maintain an attitude of respect. If it is necessary to speak, do so softly and in relation to the procedure		
7. Position the body on the back with head and shoulders elevated on a pillow		
8. Close the eyes. Place moistened cotton ball on each eye if the lids do not remain closed		
9. Ask the charge nurse if dentures should be placed in the resident's mouth or in a denture cup		
10. Bathe the body as necessary. Remove any soiled dressings and replace with clean ones.		
11. Groom hair and shave male resident, place glasses in a case on the bedside table.		
a. Place an incontinent pad underneath the buttocks, to catch secretions that may seep from the body		
b. Put a clean gown on the resident		
c. Cover the body to the shoulders with a sheet, do not cover the face		
d. Make sure the room is neat and tidy		
e. Adjust the lights to a subdued level		
f. Allow the family to visit in private		
12. Collect all resident belongings and make a list		
13. Remove gloves and dispose of properly		

14. Wash hands		
15. Report any irregularities to nurse		
16. Use appropriate physical and verbal contact		

CRITERIA: Competency in the task will be recognized when the postmortem chare has been completed according to the procedure of the training program and the achievement indicators listed.