Strength of Evidence Level: 3

PURPOSE:

To refresh the patient, relax muscles, stimulate circulation and prevent pressure areas.

CONSIDERATIONS:

1. Patients who spend a great deal of time in bed need special attention because of pressure caused by bedding and lack of movement.
2. DO NOT rub persistent reddened areas, broken skin or wounds.
3. May be performed as part of bathing.

EQUIPMENT:

Towels

Lotion of patient's choice

Basin of warm water

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Provide for privacy if appropriate.
4. Raise the bed to waist height or comfortable working position and lock the wheels (if applicable). Position the patient on side or abdomen so that you can easily reach his/her back. For warmth and privacy, cover the patient with a blanket.
5. For safety, keep the side rail up on the far side of the bed. Lower the side rail closest to you. If there are no side rails on the bed, assure the patient is safe from falling or harm.
6. Place the lotion bottle in a basin of warm water.
7. Expose the patient's back. DO NOT overexpose the patient. Prevent chilling from drafts or exposure by using bath towels or bath blanket.
8. Pour a small amount of lotion into the palm of your hand; rub hands together, using friction to warm the lotion.
9. Apply lotion to the entire back with the palms of your hands. Use firm long strokes from the buttocks to the shoulders, then around the shoulder area, and back to the lower back.
10. Use proper body mechanics. Keep your knees slightly bent and your back straight.
11. Exert firm but gentle pressure as you stroke upward from the lower back towards the shoulders. Use gentle pressure as you move down the back. DO NOT lift your hands as you massage.
12. Use a circular motion on each bony area. This rhythmic rubbing motion should be continued for 1 to 3 minutes.
13. Dry the patient's back by patting it with a towel.
14. Assist the patient in putting on appropriate attire.
15. Straighten bed linen.
16. Return the patient to a position of comfort.
17. Return side rails to upright position and lower bed to a safe height.
18. Tidy area and put supplies away.
19. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Skin condition.
   b. Patient's response to procedure.
2. Report any changes in patient's condition to supervisor.

REFERENCES:

Leahy, W., Fuzy, J., & Graf, J.,(1999). *Providing home care: A textbook for home care aides. (3rd ed.)*. Albuquerque, NM: Hartman Publishing, Inc

Strength of Evidence Level: 3

PURPOSE:

To remove waste products from the skin, stimulate the skin and improve circulation. Provide socialization and promote sense of well-being.

CONSIDERATIONS:

1. The nurse will give special instructions.
2. Have all the equipment assembled at the bedside before you begin.
3. Assure room temperature is comfortable for the patient and free of drafts.
4. Offer client bedpan or urinal.
5. Involve the patient in self-care to the limit of his/her abilities.
6. Adjust the bed to waist height or comfortable position. Secure wheels. Ensure patient safety.
7. Protect patient from exposure and chilling.
8. Use good body mechanics. Keep your feet separated, stand firmly, bend your knees and keep your back straight.
9. When using soap, keep it in the soap dish, not the basin of water.
10. Change the water when the water becomes cool, soapy or dirty.
11. Assess the condition of the patient's skin. If the patient has open wounds or broken skin, use Standard Precautions including gloves during the bathing process. During the bathing process, note changes in the skin, such as reddened or discolored areas or breaks in the skin.
12. Check the bed linen for personal items before putting in laundry and DO NOT place soiled linens on the floor.
13. Ask and assist the patient to participate in the bathing process.

EQUIPMENT:

Soap in soap dish

Washcloth

Several bath towels

Washbasin

Powder or deodorant (of patient's choosing)

Clean clothing as appropriate

Bath blanket or large towel

Lotion, if patient desires

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Provide privacy for the patient. Raise the bed to waist height or comfortable working position.
4. Take the bedspread and regular blanket off the bed. Fold them loosely over the back of the chair, leaving the patient covered with the top sheet.
5. Place the bath blanket over the top sheet. Ask the patient to hold the blanket in place, if appropriate.
6. Remove the top sheet from underneath without uncovering (exposing) the patient. Fold the sheet loosely over the back of the chair, if it is to be used again. If not, place in the laundry bag.
7. Using good body mechanics assist the patient to move if needed to allow for good body mechanics during the bath. The patient should be in a flat position, as flat as is comfortable for him/her and as is permitted.
8. Remove the patient's clothing and jewelry. Keep the patient covered with the bath blanket.
9. Place any jewelry in a safe place. Place the gown in a receptacle for dirty laundry.
10. Ask the patient how he/she prefers water temperature - hot, warm and/or cool. Fill the washbasin with warm water. Test water temperature with a bath thermometer or against the inside of your wrist. Water temperature should be between 105 to 100 degrees Fahrenheit on a thermometer. Request that the patient check the water temperature and adjust, if necessary.
11. Place a towel across the patient's chest and make a mitten with the washcloth. Without the use of soap on the washcloth, wash the patient's eyes from the nose to the outside of the face. Ask the patient if he/she wants soap used on his/her face. Wash the face. Be careful not to get soap in the eyes. Rinse the face with clean water twice and dry by patting gently with a bath towel.
12. Place a towel lengthwise under the patient's arm farthest from you. This will keep the bed from getting wet. Support the arm with the palm of your hand under his/her elbow. Then wash his/her shoulder, armpit (axilla) and arm. Use long firm strokes. Rinse and dry the area well. Repeat this step for the side of the body closest to you.
13. Apply lotion as ordered or directed by the patient to both arms and deodorant to both axilla.
14. Place a towel across the patient's chest. Fold the bath blanket down the patient's abdomen. Lift the towel only enough to wash the chest, rinse it and pat dry. Wash the patient's ear, neck, and chest. Take note of the condition of the skin under the female breasts. Dry the area thoroughly. Apply lotion as ordered or directed by the patient.
15. Cover the patient's entire chest with the towel. Fold the bath blanket down to the pubic area. Wash the patient's abdomen. Be sure to wash the umbilicus (navel) and in any creases of the skin. Dry the patient's abdomen. Then pull the bath blanket up over the abdomen and chest and remove the towels. Apply lotion as ordered or directed by the patient.
16. Empty the dirty water. Rinse the basin and refill the basin with warm water 105-110 degrees Fahrenheit on a thermometer.

17. Fold the bath blanket back from the patient's leg farthest from you.
18. Expose one leg at a time and place a towel lengthwise under that leg and foot.
19. Begin with the thigh and use long downward strokes towards the knee. Rinse and pat dry. Bend the knee by supporting the leg and foot. Take hold of the heel for more support when flexing the knee. Wash from the knee to the ankle, rinse, and dry the leg and foot.
20. Observe the toenails and the skin between the toes for general appearance and condition. Look especially for redness and cracking of the skin. Take the basin away. Dry the patient's leg and foot and between the toes. Cover the leg and foot with the bath blanket and remove the towel.
21. Repeat the entire procedure for the other leg and foot closest to you. Apply lotion as ordered or directed by the patient. Empty the basin, rinse and refill it with clean water.
22. Assist the patient to move towards the center of the bed and ask the patient to turn on his/her side with his/her back toward you.
23. Put the towel lengthwise on the bottom sheet near the patient's back. With long downward strokes wash the neck and back moving towards the bottom. Rinse and dry the back of the neck, behind the ears, neck and back.
24. Wash the buttocks and anus area moving from the front to the back. Rinse and pat dry.
25. Perform hand hygiene and adhere to Standard Precautions if there are wounds or broken skin. Provide skin care or lotion to the patient’s neck and back. Give the patient a back rub with warm lotion (lotion may be warmed by placing lotion bottle in wash basin of warm water). Give special attention to bony areas, e.g., shoulder blades, hips and elbows. Look for red areas. Dry the patient's back; remove the towel and reposition to him/her back.
26. Assist the patient to turn onto his/her back. Ask the patient if they are able to wash their own perineal area. Empty water and obtain clean, warm water. If the patient can provide the care independently, provide a clean washcloth and towel. Also, provide privacy for the patient.
27. If the patient is unable to provide the perineal care, perform hand hygiene; apply gloves to adhere to Standard Precautions.
28. **Male patient:** Uncircumcised males require the foreskin to be retracted. Next, hold the penis by the shaft and wash in a circular motion from the tip down toward the base.
    [**Note**: Use a clean area of the washcloth or clean washcloth for each stroke. Rinse in the same manner and dry thoroughly. Uncircumcised male patients will require foreskin to be un-retracted and over the tip of the penis.]
29. **Female patient**: Wash the perineum with soap and water from front to back. Place hand and hold labia majora open to expose urinary meatus and vaginal opening. Using single strokes, begin with the center of the perinmeum and then moving to each side. Use a new side of the washcloth with each stroke. DO NOT wipe from back to front as this can cause infection. Rinse the perineal area in the same manner from front to back, single strokes and using new side of the washcloth with each stroke. Pat dry.
30. As needed, assist the patient with applying clothing.
    [**Note:** Usually the patient's hair is combed and the bed is changed, however, this depends on the needs of your patient.]
31. Change bed linen if the linen is wet or soiled. Discard soiled towels, blankets and washcloths in laundry hamper or laundry basket.
32. Position the patient and lower the bed to the lowest position for patient safety.
33. Perform hand hygiene, clean equipment and place used equipment in the proper place as directed by the patient or caregiver.

AFTER CARE:

1. Document in patient's record:
    a. Skin condition.
    b. Patient's response to procedure.
    c. Any changes to the patient’s abilities since the last bath or shower.
2. Report any changes in patient's condition to supervisor.

REFERENCE:

Zucker, E. (2000). *Being a homemaker, home health aide.* (5th ed.) Upper Saddle River, NJ: 07458: Prentice Hall Health.

Strength of Evidence Level: 3

PURPOSE:

To remove waste products from the skin, stimulate and improve circulation, and to promote good health and well being.

CONSIDERATIONS:

1. Special instructions will be assigned by the nurse.
2. As able, encourage patients to participate in their personal care.
3. The bath may be given in the bathroom, kitchen, at the bedside or in the bed.
4. A complete bath may be given every other day. The face, hands, axilla and perineum should be washed every day.
5. As patients age, skin produces less perspiration and oil causing dry and become fragile skin.
6. Be gentle with skin when bathing older patients as older skin may be dry and fragile.
7. Have the patient void prior to bath. Provide privacy. Assemble equipment.
8. Precautions should be taken to prevent the patient from becoming chilled or exposed.
9. Use good body mechanics.
10. Observe skin condition during the bathing process for redness, breaks in the skin or sores.
11. Adhere to agency Standard Precautions while assisting patients with bathing.

EQUIPMENT:

Wash basin

Washcloths

Towels and bath blanket

Soap

Lotion

Powder, cornstarch, deodorant and lotion (optional)

Clean clothes

Gloves

Bath thermometer, if available

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Allow for privacy.
4. Place towel on surface patient is to sit on.
5. Assist patient to chosen site.
6. Make sure equipment is assembled and is within patient’s reach or hand equipment to patient, as needed.
7. Assist patient to undress. Cover patient with bath blanket and/or towels.
8. Fill basin or sink with warm water. Water temperature should be between 105-110 degrees Fahrenheit.
9. Check the water temperature and have the patient test to comfort level.
10. Place a towel or bath blanket around back and towel over genital area.
11. If needed, assist the patient to wash face beginning with the eyes. If the patient needs assistance, wash the patient's eyes from the nose to the outside of the face. Ask the patient if he/she wants soap used on his/her face. Be careful not to get soap in the eyes. Rinse the face with clean water twice and dry by patting gently with a bath towel.
12. If the patient cannot reach the sink in a safe position, have patient submerge hands in basin and thoroughly wash and dry hands. Assist the patient as needed to wash, rinse and dry his/her shoulder, armpit (axilla) and arm, starting with the side furthest away and then repeating the step for the side of the body closest to you. Apply lotion as ordered or directed by the patient to both arms and deodorant to both axillae.
13. As needed, assist the patient to wash his/her chest and abdomen. Lift the towel only enough to wash the chest, rinse it and pat dry. Wash the patient's ear, neck and chest. Take note of the condition of the skin under the female breasts. Dry the area thoroughly. Apply lotion as ordered or directed by the patient.
14. Assist the patient to wash and rinse his/her back. Dry the area thoroughly. Apply lotion as ordered or directed by the patient.
15. As needed, assist the patient with washing his/her legs and feet. Begin with the thigh and use long downward strokes toward the feet. Rinse and pat dry. DO NOT place the feet directly in the basin if the patient has diabetes or circulatory problems of the lower extremities. Observe the toenails and the skin between the toes for general appearance and condition. Look especially for redness and cracking of the skin. Apply lotion as ordered or directed by the patient.
16. Empty the dirty water. Rinse the basin and refill the basin with warm water 105-110 degrees Fahrenheit on a thermometer.
17. Assist patient to standing position. Make sure patient is steady and in safe position or has something to support him/herself, e.g., sideboard, or sink. DO NOT use a piece of furniture that could tip.
18. If the patient is unable to provide the perineal care, perform hand hygiene, apply gloves to adhere to Standard Precautions.
19. **Male patient:** Uncircumcised males require the foreskin to be retracted. Next, hold the penis by the shaft and wash in a circular motion from the tip down toward the base.
    [**Note**: Use a clean area of the washcloth or clean washcloth for each stroke. Rinse in the same manner and dry thoroughly. Uncircumcised male patients will require foreskin to be un-retracted and over the tip of the penis.]
20. **Female patient**: Wash the perineum with soap and water from front to back, Place hand and hold labia

Strength of Evidence Level: 3

majora open to expose urinary meatus and vaginal opening. Using single strokes, begin with the center of the perineum and then moving to each side. Use a new side of the washcloth with each stroke. DO NOT wipe from back to front as this can cause infection. Rinse the perineal area in the same manner from front to back, single strokes and using new side of the washcloth with each stroke. Pat dry.

21. Wash the buttocks and anus area moving from the front to the back. Rinse and pat dry. Assist patient to return to sitting position.
22. As needed, assist the patient with applying clothing. [**Note:** Usually the patient's hair is combed and the bed is changed, however, this depends on the needs of your patient.]
23. Perform hand hygiene, clean equipment and place used equipment in the proper place as directed by the patient or caregiver.

AFTER CARE:

1. Document in patient's record:
    a. Skin condition.
    b. Patient's response to procedure.
    c. Any changes to the patient's abilities since the last bath or shower.
2. Report any changes in patient's condition to supervisor.

REFERENCES:

Zucker, E. (2000) *Being a homemaker and home health aide.* (5th ed.) Upper Saddle River, NJ: Prentice Hall Health.

Strength of Evidence Level: 3

PURPOSE:

To remove waste products from the skin, stimulate the skin and improve circulation. To promote health and well-being.

CONSIDERATIONS:

1. Special instructions will be assigned by the nurse regarding safety in the shower.
2. Provide privacy. Have patient void prior to procedure.
3. Protect patient from exposure, chilling.
4. Use good body mechanics.
5. Observe skin condition for dry areas, redness or wounds.
6. Assemble equipment.

EQUIPMENT:

Soap

Shower cap (optional)

Washcloth

Non-skid bath mat

Clean clothes

Equipment to clean shower (optional)

Gloves

Towel(s)

Powder, lotion, deodorant (optional)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Assess bathroom for cleanliness and safety.
4. If applicable, set up tub or shower chair and place rubber mat on shower floor. A non-slip bath rug may be placed next to the tub or shower.
5. Place the patient's clean clothing in bathroom. Assist the patient to the bathroom and provide privacy.
   [**Note:** Assure no electrical appliances are near the shower or may be accidentally exposed to water. Make sure electrical devices are not plugged into electricity during the showering process.] Turn on the shower and adjust the water temperature. Water temperature should be 105-110 degrees Fahrenheit. Test the water temperature on the inside of the wrist to determine temperature. Ask the patient his/her preferred water temperature. Have the patient test the water and adjust the water temperature.
6. Assist the patient to undress and assist the patient into the shower.
7. Allow the patient as much privacy as possible. DO NOT leave the patient unattended during the shower.
8. As needed, assist patient to complete the shower process.
   [**Note**: Wash the body from clean to dirty areas and rinse the body well to prevent irritated skin.]
9. As needed, assist with shampooing and rinsing hair.
10. When the patient is finished washing, turn off the water and assist the patient out of the shower. Wrap body in a towel to provide warmth and privacy. Assist the patient to sit on the toilet seat or chair. Offer assistance to dry difficult-to-reach body area(s).
11. Dry hair with a towel and as needed, assist with hair care.
12. As indicated, assist in applying lotion, powder and/or deodorant.
13. As needed, assist the patient to dress.
14. Assist the patient out of the bathroom to bed or a chair. Return to the bathroom to clean the shower and bathroom area as directed. Remove all used linen and put it in the proper place. Discard soiled supplies in appropriate containers and perform hand hygiene.

AFTER CARE:

1. Document in patient's record:
   a. Patient's response to procedure.
   b. Skin condition.
   c. Assistance required.
2. Report any changes in patient's condition to supervising nurse.

REFERENCES:

Zucker, E. (2000) *Being a homemaker and home health aide.* (5th ed.) Upper Saddle River, NJ: Prentice Hall Health.

Strength of Evidence Level: 3

PURPOSE:

To cleanse, relax and increase circulation to the area; to assist in healing; and to provide relief from discomfort.

CONSIDERATIONS:

1. Often, sitz baths are prescribed for hemorrhoids or postoperative bladder, genital or rectal surgery.
2. The bath lasts 15 to 30 minutes.
3. Water temperature is usually 105-110 degrees Fahrenheit for pain and stimulating circulation and 100-104 degrees Fahrenheit for cleaning perineal area.
4. The nurse will assign special instructions.
5. Have patient void prior to procedure.
6. Precautions should be taken to prevent the patient from becoming chilled.
7. Strict cleanliness must be maintained to prevent infection.
8. Observe skin condition.

EQUIPMENT:

Portable sitz bath

Bath thermometer

Non-skid mat (optional)

Towels

Gloves

Cleaning supplies, if required

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Allow for privacy.
4. Review and follow nurse's instructions.
5. Clean portable sitz bath. Follow the manufacturer's instructions for operating and cleaning the equipment.
6. Fill the portable sitz bath with warm water to approximately 2/3 (two-thirds) full of warm water. Water temperature should be approximately 100-104 degrees Fahrenheit for cleansing the perineal area. Water temperature should be approximately 105-110 degrees Fahrenheit for pain and circulation stimulation. Check the water temperature and have the patient test to comfort level.
7. Remove any dressings patient may have in place, unless otherwise indicated.
8. Assist patient onto the portable sitz bath and unclamp the valve.
9. Remain with the patient during the procedure if they are weak or unsteady. Check with patient every 5 minutes for feelings of dizziness or weakness. The sitz bath should take approximately 20 minutes.
10. A valve on the tubing connected to the bag will allow more hot water to be placed in the bag.
11. Dry the patient.
12. Reapply any dressings as ordered by the nurse.
13. Assist the patient to dress and return to a position of comfort.
14. Clean tub or portable sitz bath according to the manufacture's directions and straighten bathroom.
15. Discard soiled supplies in appropriate containers.
16. Perform hand hygiene.

AFTER CARE:

1. Document in patient's record:
   a. Procedure, time, duration and water temperature.
   b. Skin condition.
   c. Assistance required.
   d. Patient's response to procedure.
2. Report any changes in patient's condition to supervisor.

REFERENCES:

Zucker, E. (2000) *Being a homemaker and home health aide.* (5th ed.) Upper Saddle River, NJ: Prentice Hall Health.

Leahy, W., Fuzy, J., & Graf, J.(1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To relieve itching associated with certain skin conditions such as urticaria or eczema. To promote comfort, relief of skin irritation, and to create an antibacterial and drying effect.

CONSIDERATIONS:

1. Need physician orders to perform an Alkaline bath.
2. Special instructions will be given by the nurse.
3. Precautions should be taken to prevent the patient from becoming chilled.
4. Strict cleanliness must be maintained to prevent infection.
5. Have patient void prior to procedure.
6. Use precaution and safety to prevent slipping when using any bath additive.
7. It is easier for the patient to get out of an empty tub.
8. Observe skin condition.

EQUIPMENT:

Sodium bicarbonate or carbonate of soda

Non-skid mat

Unbreakable cup

Towel

Bath thermometer (if available)

Gloves

Cleaning supplies as required

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Review and follow nurse's instruction.
4. Clean tub. Make sure that the tub is well rinsed after cleaning.
5. Place non-skid mat in tub.
6. Fill the tub halfway (approximately 30 gallons) with warm water. Check the water temperature. Water temperature should be 105-110 degrees Fahrenheit.
7. Place the ordered amount of powder in tub, making sure it is well dissolved.
8. Assist patient to the bathroom and have the patient test the water to their comfort level.
9. Transfer patient into the tub using proper body mechanics.
10. With unbreakable cup, pour water from the tub over all affected skin areas. Make sure all areas are moistened thoroughly with the solution.
11. Allow for privacy and safety.
12. Allow the patient to soak 10 to 20 minutes so that the skin is coated, but chilling is prevented. Check on the patient every 5 minutes.
13. Empty the tub. Place towel across shoulders to prevent chilling while tub is emptying.
14. Place towel on seat surface.
15. Transfer from tub to chair or toilet seat.
16. Pat the skin dry with a soft towel; DO NOT rub.
17. Assist patient to dress and make comfortable. Assist patient out of the bathroom.
18. Clean tub and straighten bathroom.
19. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Type of bath and amount of powder used.
   b. Duration.
   c. Condition of skin prior to bath.
   d. Condition of skin upon completion of bath.
   e. Patient's response to procedure.
2. Report any changes in patient's condition to supervisor.

REFERENCES:

Zucker, E. (2000). *Being a homemaker, home health aide.* (5th ed.) Upper Saddle River, NJ: 07458: Prentice Hall Health.

Strength of Evidence Level: 3

PURPOSE:

To relieve itching associated with certain skin conditions such as urticaria or eczema. To promote comfort of skin irritation and to create an antibacterial and drying effect. To soften and lubricate skin.

CONSIDERATIONS:

1. Need physician orders to perform an oatmeal or bran therapeutic bath.
2. Special instructions will be given by the nurse.
3. Precautions should be taken to prevent the patient from becoming chilled.
4. Strict cleanliness must be maintained to prevent infection.
5. Have patient void prior to procedure.
6. Use precaution and safety to prevent slipping when using any bath additive.
7. It is easier for the patient to get out of an empty tub.
8. Observe skin condition.

EQUIPMENT:

Porous oatmeal bag or bran bag (issued by pharmacy)

Non-skid mat

Towel

Gloves

Cleaning materials, as needed

Bath thermometer, if available

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Review and follow nurse's instruction.
4. Clean tub. Make sure that the tub is well rinsed after cleaning.
5. Place non-skid mat in tub.
6. Fill the tub halfway (approximately 30 gallons) with warm water check the water temperature. Water temperature should be 105-110 degrees Fahrenheit.
7. Place the ordered amount of powder in tub, making sure it is well dissolved.
8. Assist patient to the bathroom and have the patient test the water to their comfort level.
9. Transfer patient into the tub, using proper body mechanics.
10. With unbreakable cup, pour water from the tub over all affected skin areas. Make sure all areas are moistened thoroughly with the solution.
11. Allow for privacy and safety.
12. Allow the patient to soak 10 to 20 minutes so that the skin is coated, but chilling is prevented. Check on the patient every 5 minutes.
13. Empty the tub. Place towel across shoulders to prevent chilling while tub is emptying.
14. Place towel on seat surface.
15. Transfer from tub to chair or toilet seat.
16. Pat the skin dry with a soft towel, DO NOT rub.
17. Assist patient to dress and make comfortable.
18. Assist patient out of the bathroom.
19. Clean tub and straighten bathroom.
20. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Type of bath.
   b. Duration.
   c. Condition of skin prior to bath.
   d. Condition of skin upon completion of bath.
   e. Patient's response to procedure.
2. Report any changes in patient's condition to supervisor.

REFERENCES:

Zucker, E. (2000). *Being a homemaker, home health aide.* (5th ed.) Upper Saddle River, NJ: 07458: Prentice Hall Health.

Strength of Evidence Level: 3

PURPOSE:

To remove waste products from the skin, stimulate the skin and improve circulation. To promote good health and well-being.

CONSIDERATIONS:

1. Special instructions will be given by the nurse or therapist regarding safety in the tub.
2. Tub baths should only be done if patient is able to assist himself/herself into and out of the tub or with a patient who has a mechanical lift or bath bench.
3. Use good body mechanics.
4. Have patient void prior to procedure.
5. Precautions should be taken to prevent the patient from becoming chilled.
6. Assess the condition of the patient's skin while bathing, especially noting changes in the skin, such as reddened or discolored areas or breaks in the skin.
7. It is easier for the patient to get out of an empty tub and use precautions to prevent slipping.
8. Observe skin condition for wounds, rashes or reddened areas.

EQUIPMENT:

Bath towels

Non-skid bath mat on bathroom floor

Washcloths

Soap

Non-skid bath mat to be used in the tub

Chair for patient to sit on or use commode

Bath bench, if appropriate

Cleaning supplies, as required

Clean clothing

Gloves

Bath thermometer (if available)

Lotion, powder, deodorant (optional)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Check the tub and clean if necessary.
4. Place non-skid mat in bottom of tub. Assess bathroom for cleanliness, safety and adequate ventilation. Check for bathing assistive devices, e.g., grab bars, shower chair.
5. Place patients clean clothing in bathroom.
6. Provide for privacy.
7. Fill the bathtub half full with warm water. Check the water temperature (105-110 degrees Fahrenheit) and have the patient test for comfort level.
8. Assist the patient as needed in undressing and transferring into the bathtub.
9. Let the patient stay in the bathtub no longer than 20 minutes. Check on patient every 5 minutes.
10. As needed, assist patient to wash. Always wash from clean to dirty areas of the body. Rinse soap thoroughly from the body to prevent irritation or dryness.
11. Empty the tub. Place towel across patient's shoulder to prevent chilling while tub is emptying. Dry patient's upper body first and then assist out of tub.
12. Put one towel across the chair, or commode. Assist the patient to transfer out of the tub and to sit on a chair, commode or toilet.
13. Allow the patient to dry as much of his/her body as he/she can. Assist patient to dry hard-to-reach areas.
14. Assist patient in applying lotion, powder and/or deodorant as indicated. Assist patient to dress.
15. Assist the patient out of the bathroom to bed or chair. Make comfortable.
16. Return to the bathroom. Clean and straighten area.
17. Remove all used linen and put it in the proper place.
18. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Patient's response to procedure.
   b. Skin condition.
   c. Assistance required.
2. Report any changes in patient's condition to supervisor.

REFERENCES:

Zucker, E. (2000). *Being a homemaker, home health aide.* (5th ed.) Upper Saddle River, NJ: 07458: Prentice Hall Health.

Strength of Evidence Level: 3

PURPOSE:

To provide for elimination of bodily waste in a way that respects patient's privacy.

CONSIDERATIONS:

1. Special instructions will be provided by nurse.
2. The patient in bed may be concerned about how he/she can eliminate through his/her bladder and bowels while in bed. This is particularly true of the elderly. Be aware of patient concerns and respond quickly to patient needs.
3. In giving the bedpan or urinal to a patient, consider his/her privacy and the importance of making him/her feel comfortable.
4. May use powder on the bedpan to prevent the bedpan from sticking to the patient's skin. DO NOT use powder if the patient has open sores or stool/ urine sample is needed.
5. Use good body mechanics.
6. Observe skin condition.

EQUIPMENT:

Bedpan or urinal

Paper or washable cover

Toilet tissue

Towel

Plastic or rubber bed protector

Gloves

PROCEDURE:

Procedure for Use of Bedpan:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Warm the bedpan with warm tap water and dry it.
4. Cover the bedpan with a paper or washable cloth when carrying it to the person.
5. Provide privacy by closing curtains, shades or doors.
6. Put bed waist high or at comfortable working height. Be sure bed wheels are locked. Add extra protection to the bed even if a plastic or rubber sheet is used on the mattress; an extra cloth may be placed under the patient's hips.
7. Sprinkle powder or cornstarch on the bedpan seat. DO NOT use powder if there are open sores, dressings or obtaining specimens.
8. With the open end of the bedpan facing towards the foot of the bed, place the bedpan near the patient. The wider end of the bedpan should be positioned towards the patient's buttocks.
9. Fold the top covers to one side to avoid soiling and partially drape the sheet or blanket to prevent chilling and provide privacy. Assist patient in removing undergarments.
10. If able, have the patient raise his/her hips and slide the bedpan under his/her hips. Have the patient raise his/her hips, have patient flex knees, place one hand under the small of the back, and on signal, push hips up as patient pushes down with hands and heels. With the other hand place the bedpan under patient's hips and adjust the pan for comfort. If patient is unable to provide assistance, roll the patient on his/her side; place the bedpan under their hips, and roll the patient back onto the bedpan.
11. Assist the patient to a sitting position if possible and provide toilet paper and a call signal. Provide for privacy and safety.
12. Remind the female to wipe from front to back to avoid bringing germs to vaginal and urethral areas. Assist patient if necessary with cleansing area.
13. Have the patient flex knees and push down with heels and hands as the bedpan is removed. Hold the bedpan firmly to prevent it from overturning. If patient is unable to provide assistance, roll to the patient on his/her side and remove the bedpan.
14. As needed, assist the patient to perform perineal care. Female patients wipe from front to back with washcloth or disposable washcloths. Pat the perineal area dry. The soiled tissues and disposable washcloths are placed in a disposable bag. Place towel in the hamper. Remove gloves, perform hand hygiene and apply clean gloves.
15. Remove the bed protector, cover the pan and take it to the bathroom.
16. Assist the patient to wash hands.
17. Position patient comfortably.
18. Inspect the contents of the bedpan. Check for blood, clots, etc., in contents, and for condition of stool, i.e., watery, hard. Discard contents in toilet.
19. Rinse the bedpan with cold water.
20. Clean the bedpan, cover and store.

Procedure for Use of Urinal:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Use protector under the patient's hips.
4. Give the patient the urinal. If the patient needs assistance, place it between his legs in a position to collect the urine.
5. Provide for privacy by replacing covers and leave the room, if safety permits.
6. Remove the urinal; assist the patient with hand washing and undergarments.
7. Measure urine, if ordered. Discard urine in toilet.
8. Rinse the urinal with cold water.
9. Clean urinal, cover, and store.

AFTER CARE:

1. Document in patient's record:
   a. Time and results of elimination.
   b. Assistance required.
   c. Report any changes in the patient's condition to supervisor.

Strength of Evidence Level: 3

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J.(1999). *Providing home care: A textbook for home care aides. (3rd ed.).* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 1

PURPOSE:

To measure the force of the blood pushing against the walls of the blood vessels.

CONSIDERATIONS:

1. It is essential that the blood pressure cuff used be the right size.
2. Normal blood pressure in adults is considered when the systolic pressure is 100-119 mm Hg and the diastolic pressure is approximately 60-79 mm Hg.
   a. Prehypertension in adults is considered when the systolic pressure is 120-139 mm Hg and the diastolic pressure is approximately 80-89 mm Hg.
   b. High Blood Pressure in adults is considered when the systolic pressure is 140mm Hg and above and the diastolic pressure is approximately 90 mm Hg and above.
   c. Hypotension is when blood pressure is below the normal range.
3. The patient should be lying down or sitting in a chair with the arm extended and supported at the level of the heart.
4. The stethoscope should be cleaned per agency process.
5. Note specific infection control procedures as they relate to use of blood pressure cuff with other patients.
6. Consider the use of a disposable blood pressure cuff for patients with contact precautions.

EQUIPMENT:

Sphygmomanometer (blood pressure cuff)

Stethoscope

[**Note:** Some stethoscopes are built in the sphygmomanometers.]

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Have the patient resting quietly, either lying down or sitting in a chair.
4. Determine which extremity to obtain blood pressure from. DO NOT take blood pressure on an injured extremity, post-operative mastectomy extremity or one in which an intravenous device or shunt is located.
5. Roll patient's sleeve well above the elbow to properly position blood pressure cuff. If the rolled up sleeve is tight, then have the patient remove his/her arm from the sleeve and take the blood pressure on the bare arm. A tightened rolled up sleeve may act as a tourniquet and falsely elevate the blood pressure.
6. Rest patient's fully extended arm on bed or arm of chair with palm upward.
7. Clean earpieces and bell of stethoscope with alcohol wipes. Unroll the cuff and loosen the valve on the bulb. Squeeze the compression bag to deflate it completely.
8. Wrap the cuff around the patient's arm above the elbow snugly and smoothly. Place the center of the cuff over the brachial artery (1 to 1/2 inches above the elbow). DO NOT wrap it so tightly that the patient is uncomfortable from the pressure.
9. Leave the area clear where the bell or diaphragm of the stethoscope will be placed. Position the manometer dial so that the numbers are visible.
10. With your fingertips, find the patient's radial pulse. Close the valve (turn it clockwise) and inflate the cuff until unable to feel the radial pulse. Note the reading, this is an estimate of the systolic blood pressure and will allow adding 30 mm Hg to this number later in the procedure. Open the valve (turn it counter clockwise) and deflate the cuff.
11. With your fingertips, locate the brachial pulse. Put the earpieces of the stethoscope into your ears and place the bell or diaphragm of the stethoscope on the brachial pulse. Hold it snugly but not too tightly. Do not let the stethoscope touch the blood pressure cuff. Advise the patient to relax and refrain from talking and moving.
12. Tighten the thumbscrew of the valve to close it (turn it clockwise).
13. Hold the stethoscope in place. Inflate the cuff until the dial points to 30 mm Hg above the estimated systolic pressure.
14. Open the valve counter-clockwise to allow air to escape slowly until the sound of the pulse is heard. If pulse sounds are heard immediately stop the procedure and deflate the cuff. After a few seconds, inflate the cuff 30 mm Hg higher than the estimated systolic blood pressure. Again, loosen the thumbscrew to let the air escape and listen for a repeated pulse sound while watching the manometer dial.
15. Note the number that the pointer passes as the first sound is heard. This point indicates the systolic pressure (the top number).
16. Continue releasing the air from the cuff until the sounds change to a softer thud or completely disappear. Note the number. This is the diastolic pressure (bottom number).
17. Deflate the cuff completely. Remove it from the patient's arm.
18. Make the patient comfortable.
19. Clean the equipment with a sanitary antibacterial wipe or alcohol wipe.

AFTER CARE:

1. Document in patient's record:
   a. Blood pressure reading.
   b. Position.
   c. Site used.

Strength of Evidence Level: 1

2. Report unusual (high or low) readings and symptoms to nurse.

REFERENCES:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

U.S. Department of Health and Human Services (2004). Seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure (NIH Publication No. 04-5230). Bethesda, MD: Author.

Strength of Evidence Level: 3

PURPOSE:

To prevent bad breath, gum irritation and pyorrhea, etc.

CONSIDERATIONS:

1. Dentures, like natural teeth, should be cleansed at least once a day.
2. Soaking of dentures does not take the place of brushing.

EQUIPMENT:

Denture brush

Water or commercial mouthwash

Toothpaste (optional)

Denture cleaner (optional)

Denture paste (optional)

Bowl

Cup

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain the procedure to the patient. Allow patient to remove dentures if able and place them in a denture cup. If not, gently remove dentures and place them in a cup.
3. Line sink with a paper towel or wash cloth. Fill the sink 1/2 full of water so that if dentures slip out of your hand, they will be cushioned if they fall.
4. Apply toothpaste or cleanser to the denture brush. Brush all surfaces inside and out with denture brush and toothpaste or denture cleaner.
5. After brushing, rinse dentures thoroughly under cool water. Dentures may be soaked in water or a commercial denture cleaner if desired. Read the directions on the bottle and prepare the solution according to manufacturers directions.
6. Have patient rinse his/her mouth with water and/or mouthwash.
7. Inspect mouth for irritation or sores.
8. If patient desires, apply a thin layer of denture paste (optional). Have the patient replace the dentures in their mouth. Be certain the dentures are moist before replacing them.

AFTER CARE:

1. Document in patient's record:
   a. Procedure, date and time.
   b. Condition of mouth.
2. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J.(1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To maintain physiologic integrity of the wound by keeping the wound bed moist and normothermic and the surrounding skin dry.

CONSIDERATIONS:

1. Use a dressing that will keep the wound surface continuously moist. (Wet-to-dry dressings should be used only for debridement unless cost is a factor.)
2. The following criteria should be considered when selecting a dressing:
   a. Wound-related factors, such as etiology, severity, environment and depth, anatomic location, volume of exudate and the risk or presence of infection.
   b. Patient-related factors, such as vascular, nutritional, and medical status; odor-control requirements; comfort and preferences; and cost-versus-benefit ratio.
   c. Dressing-related factors, such as availability, durability, adaptability and uses.
3. Dressing changes may be painful. Pain medication may be necessary 30 minutes before each dressing change.
4. A dressing is not indicated when skin integrity is compromised by caustic or excessive drainage. Pouching may be indicated to protect the skin when the draining is copious or excoriating.
5. Follow manufacturer's guidelines regarding length of time dressing may be left on wound. Always reapply if leaking exudate or loosening of dressing occurs.
6. Certain wounds may require sterile technique. Use appropriate sterile supplies.

EQUIPMENT:

Sterilized instrument pack (optional)

Dressings (as needed)

Hypoallergenic tape

Gloves

Skin protectant

Basin (optional)

Cleansing solution, normal saline or other

Protective bed pad

Scissors

Optional protective equipment: apron/gown, eyewear

Impervious trash bag

Montgomery straps (optional)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Review physician's orders.
3. Explain procedure to patient/caregiver.
4. Establish a clean field (sterile, if necessary) with all the supplies and equipment that will be necessary.
5. Remove tape by pushing skin from tape. Remove soiled dressing. Discard dressing and gloves in appropriate containers. Decontaminate hands and don clean gloves.
6. Observe for:
   a. Wound size including length, width and depth. Document weekly and when needed.
   b. Wound bed tissue type/color including necrotic, slough, eschar, granulating, clean, non-granulating, epithelial.
   c. Evidence of wound healing or deterioration.
   d. Drainage characteristics including type, amount, color and odor.
   e. Symptoms of infection including redness, swelling, pain, discharge or increased temperature.
   f. Development of undermining or sinus tract that may require packing.
7. Cleanse wound with normal saline or wound cleanser per wound care orders. *(See Integumentary - Wound Cleansing.)*
8. Dress wound with appropriate dressings following manufacturer's guidelines and physician orders.
9. If the dressing's edges need to be secured with tape, apply a skin sealant to the intact skin around the wound. After area dries, secure the dressing to the skin with hypoallergenic tape.
10. For frequent dressing changes Montgomery straps or a hydrocolloid dressing may be used to prevent trauma to the periwound skin.
11. Write date of application and initials of applier directly on the dressing (optional).
12. To apply a wet-to-dry dressing follow these steps:
    a. Moisten the gauze with solution, such as normal saline, and wring it out until it is slightly moist.
    b. Fluff the gauze completely and place it over the wound bed.
    c. Cover the wound with dry gauze allowing enough layers to absorb drainage until the next dressing change. Secure dressing with tape.
    d. Remove the dressing when it is almost dry.
13. Discard soiled supplies in appropriate containers.
14. Clean reusable supplies before leaving the home, according to agency policy.

Strength of Evidence Level: 3

AFTER CARE:

1. Document in patient's record:
    a. Procedure and type of dressing used.
    b. Patient's response to procedure.
    c. Temperature and vital signs.
    d. Wound observations.
    e. Response of the wound to the prescribed treatment.
    f. Weekly wound measurements.
2. Instruct patient/caregiver in care of the wound including:
    a. Reporting any changes in pain, drainage, temperature, or other signs and symptoms of infection.
    b. Techniques to change or reinforce dressings. It is not routine to teach lay people to pack wounds.
    c. Diet to promote healing.
    d. Medications/disease processes that may be impeding healing.
    e. Activities permitted.

Strength of Evidence Level: 3

PURPOSE:

To maintain self-esteem, comfort and protection while dressing the patient.

CONSIDERATIONS:

1. If patient has weakness or paralysis on one side:
   a. When dressing, put garment on affected extremity first.
   b. When undressing, remove from non-affected extremity last.
   c. Support affected extremity and DO NOT pull on it.
2. The patient should be allowed to choose clothing and dress self as much as possible.
3. Lay out the pieces of clothing where the patient can reach, in the order the patient will put them on.
4. If patient cannot stand, pants should be put on while patient is lying flat in bed.
5. If patient is bedbound, it is easier to put on pullover and upper garments with the head of the bed elevated, otherwise roll patient from side to side, dressing one side at a time.
6. The above principles apply whether patient is in bed or sitting up in the chair.

EQUIPMENT:

Clean clothes

Laundry bag or container

Adaptive dressing devices (optional)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Allow the patient to select clothing for the day or retrieve appropriate clothing for the patient.
4. Provide for privacy. If the patient just had a bath, cover with a towel or bath blanket, as needed.
5. Place patient in position that makes arms and legs easily accessible and is safe for patient.
6. Assist in removing soiled clothes using considerations noted and avoiding undue exposure.
7. Assist patient to dress with clean clothes beginning with upper garments and ending with pants.
8. Female patients: ensure bra cups fit over the breasts. For bras that fasten in the back; Place around the waist, fasten, rotate, push up into place and then place arms through straps.
9. Socks and stockings should be rolled or folded down and slipped over toes and feet. Make certain toes, heels and seams of socks are in the right place as they are unrolled into place.
10. Put soiled clothes in designated container.
11. Return patient to position of comfort.

AFTER CARE:

1. Document in patient’s record:
   a. Patient’s response to procedure.
   b. Assistance required.
2. Report any changes in patient's condition to nurse.

REFERENCES:

Zucker, E. (2000). *Being a homemaker, home health aide.* (5th ed.) Upper Saddle River, NJ: 07458: Prentice Hall Health.

Strength of Evidence Level: 3

PURPOSE:

To provide adequate nutrition to the patient.

CONSIDERATIONS

1. Position patient in bed in High-Fowlers Position.
1. Cue blind patient to open mouth by verbal command or touching lip with eating utensil, glass or cup.
2. Be sure patient is able to chew and swallow food. Allow adequate time between spoonfuls of food.
3. DO NOT tilt head back when feeding. Should be at eye level with client when feeding.
4. Be aware of special diet and/or food restrictions.
5. If patient gags turn head to side and make sure airway is clear.

EQUIPMENT:

Food

Dishes

Utensils

Napkin or towel

Washcloth

Soap

PROCEDURE:

1. Adhere to Standard Precautions.
2. Wash patient's hands.
3. Explain procedure to patient. Tell patient what food has been prepared.
4. Place patient in upright position unless contraindicated.
5. Place napkin or towel on front of patient. Place the food in the patient's field of vision. May need to use modified utensils to promote self-feeding. Aide should be at eye level with client when feeding.
6. Adhere to food items on the diet and texture to promote safe swallowing and reducing risk of choking.
7. Offer small portions of food (approximately a teaspoon full). Feed the foods separately rather than mixed. Make sure the food is swallowed before offering more bites.
8. Offer fluid frequently.
9. DO NOT rush patient.
10. After patient has finished eating, wash patient's hands and face.
11. Return patient to position of comfort.
12. Remove tray from room and dispose of uneaten food.
13. Straighten work area, wash and put away cooking and eating utensils.

AFTER CARE:

1. Document in patient's record:
    a. Patient's response to procedure.
    b. Patient's intake.
2. Report any change in condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J.(1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To prevent deformities of the feet, prevent infection, maintain comfort and cleanliness, maintain optimal peripheral circulation and to soften skin and nails.

CONSIDERATIONS:

1. Possible injuries to the feet may result from:
    a. Repeated trauma (bumping, being stepped on, having objects dropped on them).
    b. Ill-fitting shoes and stockings.
    c. Poor circulation.
    d. Use of tight garter or improperly applied anti-embolytic stockings.
2. Patients with diabetes require special foot care. Instructions must be obtained from the nurse. DO NOT soak patient's feet if the patient has a diagnosis of diabetes or circulatory issues.

EQUIPMENT:

Towel

Basin or tub with warm water

Mild soap

Lotion or powder (optional)

Protective cover, i.e., plastic sheet or newspaper

Gloves

Emery board/nail file

Orangewood stick

PROCEDURE:

1. Adhere to Standard Precautions.
2. Review and follow nurse's instructions.
3. Assemble equipment and explain procedure to patient.
4. Position patient comfortably in chair or bed.
5. Cover floor or bed linens with protective covering. Inspect the feet for any changes and report. Patients may not be able to notice changes in their feet.
6. Fill basin or tub with sufficient warm water to cover feet. Check the water temperature and have the patient test to comfort level. Place feet in basin or tub.
7. Wash feet gently with soap.
8. Soak feet 5 to 10 minutes changing water or adding warm water as necessary to maintain a comfortable temperature.
9. Remove basin leaving protective covering in place. Dry feet thoroughly with towel giving special attention to areas between toes. Pat feet with towel rather than rubbing to avoid breaking skin.
10. Clean under nails using orangewood. File with emery board or nail file straight across no shorter than tips of toes, using care. DO NOT clip or cut nails.
11. Apply lotion and/or dust lightly with powder, if patient requests. DO NOT put lotion between toes.
12. Clean and put away equipment.
13. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
    a. Patient's response to procedure.
    b. Foot care provided.
    c. Condition of skin and nails.
    d. Report any changes in patient's condition to supervisor.

REFERENCE:

leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.).* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To assure patient and caregiver safety during transfers and ambulation.

CONSIDERATIONS:

1. **[Note:** It is recommended that a gait belt be worn by the patient when staff and caregivers are transferring or ambulating the patient. The gait belt provides a firm grasping surface for the staff person and protects the patient from accidental trauma to the skin. The gait belt gives the patient a sense of security as it is tightened. The belt also allows the staff person to gradually lower a patient to the floor, if necessary, without injuring self or patient.]
2. Provides firm, safe contact with the patient without causing harm.
3. If a gait belt is not used, there is a tendency to pull the patient up by their arms which can easily cause a back injury to the caregiver and a shoulder injury to the patient.
4. Contraindications for gait belt use:
    a. Recent colostomy/ileostomy surgery.
    b. Severe cardiac condition.
    c. Severe respiratory problems.
    d. Recent abdominal, chest or back surgery.
    e. Abdominal aneurysm.
    f. Phobia regarding belts.
    g. Fragile skin.

EQUIPMENT:

Gait belt

PROCEDURE:

1. Gait belt is applied snugly to the patient's waist.
2. To bring patient to standing position, keep your back relatively straight, bend knees, lift client by grasping gait belt firmly and straightening knees and pull on the gait belt. (Lift with legs)
3. After the patient is standing, use gait belt to assist in stabilizing and turning patient.
4. If patient begins to fall, draw patient close to your body using gait belt and slowly lower patient to the floor.

AFTER CARE:

1. If the gait belt becomes soiled after use, follow appropriate infection control procedures for cleaning the belt.
2. Document in patient's record:
    a. Use of gait belt.
    b. Compliance with use of gait belt.
3. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J.(1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To maintain a clean and safe environment and prevent spread of infection and to clean clothes and linens.

CONSIDERATIONS:

1. Laundering should not be done in kitchen sink because of possible contamination of sink.
2. Not all fabrics are washable; ensure that the items can be washed.
3. Delicate items may need to be washed by hand.
4. When possible, the labels should be read to determine care of each item. If uncertain, ask the patient. The wrong temperature or cleaning agent will damage some clothing.
5. Not all clothes should be dried in the dryer. Hang clothes to air dry that are delicate or prone to shrinkage.
6. Some clothes or linens, if heavily soiled, may require soaking before being washed.
7. If article is damaged, point this out to patient prior to beginning procedure.

EQUIPMENT:

Laundry bag or pillow case

Washing machine

Stain remover (optional)

Bleach (optional)

Fabric softener (optional)

Detergent

Laundry basket

Laundry sink or basin for hand laundry (optional)

Hangers/drying rack (optional)

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Place soiled clothes in laundry bag or pillow case, and take to washing machine area.
3. Prepare washable clothes and linens for laundry by:
   a. Sorting according to color or soil.
   b. Emptying pocket. If possible, empty pockets in front of the patient or patient's caregiver.
   c. Use stain remover on heavily stained areas. (optional.)
   d. Turn down cuffs on pants.
   e. Close zippers.
4. Place clothes in washing machine and set for appropriate cycle.
5. Select correct detergent or bleach, if appropriate, and add to machine.
6. When cycle completed, put clothes in dryer or hang to air dry.
7. When dried, fold or hang.
8. Return to usual place of storage, i.e., drawer, closet, etc.

Washing by Hand

1. If no machine is available or garments are too delicate, i.e., nylon hose:
   a. Adhere to Standard Precautions.
   b. Wear gloves.
   c. Select appropriate soap and water temperature for garments.
   d. Wash clothes in bathroom sink or large basin.
   e. Rinse well and hang to dry in bathtub, shower or outside line.
   f. Be sure someone is available to remove dry clothes and put away if the patient is unable to do so.

AFTER CARE:

1. Document procedure in patient's record.
2. Report any problems, such as damaged blouse, etc., to your supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To provide safety, comfort, warmth, freedom of movement and to prevent skin breakdown and infection.

CONSIDERATIONS:

1. Egg crate or air mattress:
   a. Cover loosely with a single sheet only.
   b. May use incontinent pad.
2. Use a single layer of incontinent pads.
3. Use good body mechanics to avoid back strain.
4. If side rail present, raise on patient's side.

EQUIPMENT:

Bath blanket or large towel

Sheets

Incontinent pad on sheet (optional)

Sheepskin (optional)

Blanket

Bedspread

Gloves

Apron/gown (optional)

PROCEDURE:

1. Adhere to Standard Precautions. Be aware of potentially loose needles (sharps).
2. Obtain needed linen.
3. Explain procedure to patient.
4. If hospital bed, raise level of bed waist height and place patient in flat position, if possible.
5. Take the bedspread and regular blanket off the bed. Fold them loosely over the back of the chair, and leave the patient covered with the top sheet.
6. Place the bath blanket over the top sheet. Ask the patient to hold the blanket in place.
7. Remove the top sheet from underneath without uncovering (exposing) the patient. Fold the sheet loosely over the back of the chair, if it is to be used again; if not, put it in the laundry bag.
8. Move mattress to top of bed:
   a. Stand to side of bed facing the head. Grasp mattress at about the center and bottom edge, and move it toward head of bed. Use proper body mechanics.
   b. Have patient assist, if able, by grasping head of bed with his hands and pull when you are ready.
   c. Have family member assist, if necessary.
9. Have patient move, or turn patient toward far side of bed (be sure side rail is up on patient's side). Maintain patient's proper body alignment.
10. To make the foundation of the bed on one side:
    a. Loosen draw sheet (if present) and fold or roll toward the patient.
    b. Loosen plastic protective sheet (if present) and fold or roll toward the patient.
    c. Loosen bottom sheet and fold or roll toward the patient.
    d. Straighten mattress pad (if present).
    e. Place clean bottom sheet right side up on bed lengthwise, with hem of sheet even with the foot of the mattress.
    f. Unfold toward center of bed.
    g. Tuck under at head of mattress, miter corner.
    h. Tuck sheet under mattress along side of bed.
    i. Unfold or unroll plastic draw sheet, and place it over bottom sheet and tuck under mattress.
    j. Place cotton draw sheet over plastic, unfold toward center of bed, and tuck under mattress.
    k. Assist patient to turn back toward you over all the sheets.
    l. Raise side rail (if present) and proceed to opposite side of bed.
    m. Roll and remove soiled draw sheet, lift plastic protective sheet, remove bottom sheet and place with soiled linen.
    n. Adjust bottom sheet, tuck under at head of mattress, miter corner and tuck in tautly along side of mattress.
    o. Smooth and tuck in plastic sheet.
    p. Tuck in draw sheet.
    q. Have patient turn onto back.
    r. Change covers on pillows and place under head.
11. Place top sheet over bath blanket on bed lengthwise, placing hem of sheet even with top edge of mattress with wrong side up.
12. Remove bath blanket.
13. Straighten and center top sheet - allow sufficient room to make a 6-8 inch cuff over edge of blanket.
14. Place blanket and/or spread over sheet lengthwise. With fold in center, right side up, unfold from top to bottom.
15. Tuck top sheet, blanket and/or spread under mattress at foot of bed. Allow enough room to avoid pressure on feet. Consider using small pillow between patient's feet and the foot of the bed to decrease pressure and prevent patient from sliding down.
16. Miter corners.
17. Fold top sheet over spread at top of bed to form a cuff.
18. Position patient for comfort and safety.
19. If leaving the patient alone in the room place the bell or telephone within patient's reach in case the patient needs to call for help.
20. Remove soiled linen from room.

AFTER CARE:

1. Document procedure in the patient's record.
2. Report any changes in patient's condition to supervisor.

Strength of Evidence Level: 3

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To provide healthy and therapeutic nourishment to patients unable to prepare own meals.

CONSIDERATIONS:

1. Consider patient's food allergies.
2. If patient is on a special diet, prepare foods only as directed by nurse or dietician. If uncertain, ask the patient/caregiver or nurse.
3. Consider patient's likes and dislikes when possible.
4. Food should appear attractive to stimulate patient's appetite. Environment should be clean and pleasant.
5. Cook meat and fish thoroughly. Rationale: A patients with impaired immune system is prone to infections and it is imperative to limit patient's exposure to food-borne pathogens.
6. Wash all fresh vegetables and fruit before use.
7. Wash tops of cans before opening.
8. Check foods for spoilage and do not serve those foods to patient.

EQUIPMENT:

Pots, pans, dictated menu

Dishes and eating utensils

Food to be prepared

Spices (optional)

Stove

PROCEDURE:

1. Adhere to Standard Precautions.
2. Assemble all needed food and equipment.
3. Assist patient to wash hands.
4. Prepare food and serve to patient.
5. Assist patient with eating, if indicated.
6. Assist patient to wash face and hands after eating.
7. Remove empty plates and utensils from patient.
8. Straighten work area, wash and put away cooking and eating utensils.

AFTER CARE:

1. Document in patient's record:
   a. Food prepared.
   b. Amount eaten by patient.
2. Report any change in patient's condition or appetite to supervisor.

REFERENCES.

National Library of Medicine. *Foodborne illness.* (n.d). Retrieved March 1, 2010, from http://digestive.niddk.nih.gov/ddiseases/pubs/bacteria/

Strength of Evidence Level: 3

PURPOSE:

To transfer or lift patients and reduce weight lifted by caregiver to eliminate back injuries.

CONSIDERATIONS:

1. There are different types of lifts, but the principles of operation are the same.
2. Manufacturer's brochure should be reviewed before using lift.
3. Homecare and hospice aides are permitted to use the mechanical lift only after demonstration of use and deemed competent by a registered nurse.
4. Keep the chair or wheelchair close to the bed as the patient is moved a short distance.
5. Check the sling, valves and equipment on the lift prior to the use of the equipment.
6. Pump the lift only to the point where the patient clears the surface level and to move to the other level.

EQUIPMENT:

Lift

Sling

Blanket or sheet

Wheelchair or chair

Lifting partner (if available)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to the patient. Assistance of second person may be needed.
3. Position chair next to bed with back of chair in line with headboard of bed. Lock the wheels of the bed and the mechanical lift.
4. Cover the chair with a blanket or sheet, if indicated.
5. Place the sling under the patient by turning the patient from side to side on the bed.
6. Roll the mechanical lift to the edge of the bed and open the base to the widest possible point.
7. If the mechanical lift has chains, create a long side and short side of the chain by counting 7 or 9 links and place the link on the hook of the mechanical lift.
8. Lower the hydraulic lift by loosening valve counter-clockwise to lower bracket. When the main bracket is at an appropriate position, close the hydraulic valve (turn valve clockwise).
9. Attach the sling to the mechanical lift with the hooks in place through the metal frame facing out.
10. Have the patient fold both arms across chest.
11. Using the crank, gently lift the patient from the bed. [**Note**: Avoid hitting legs or feet on the parts of the mechanical lift by guiding the patient’s legs.]
12. Lower the patient onto the chair by gently releasing the mechanical valve (counter-clockwise) slowly.
13. Remove the hooks from the frame.
14. Position the patient for comfort and safety in the chair for specified amount of time and leave the sling in place.
15. To return patient to bed, put the hooks facing out through the metal frame of the sling, which is still under the patient.
16. Using the crank, lift the patient from the chair to the bed while guiding the patient's leg. (Partner may assist by guiding the patient's legs.)
17. Lower the patient onto the center of the bed; remove the hooks from the frame.
18. Remove the sling from under the patient by turning from side to side.
19. Position the patient for comfort and safety, and straighten the bed.
20. Perform sling hygiene and return lift to storage area.

AFTER CARE:

1. Document in patient's record:
   a. Length of time in chair.
   b. Patient's response to procedure.
2. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To promote cleanliness, prevent infection and enhance sense of well being.

CONSIDERATIONS:

1. Nail clipping or cutting requires an order from the nurse. DO NOT cut or clip nails if skin around them is reddened, swollen or showing other signs of infection. DO NOT clip toenails.
2. DO NOT cut corns, calluses, bunions or ingrown toenails.
3. Patients with diabetes require special nail care. Home Health and Hospice Aides SHOULD NOT cut the nails of diabetic patients or patients with peripheral vascular disease (P.V.D.).

EQUIPMENT:

Towels

Basin or tub with warm water

Nail file or orangewood stick

Protective cover, i.e., plastic sheet or newspaper

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Review and follow nurse's instructions.
4. Assemble equipment.
5. Fill basin or tub with warm water. Check the water temperature and have the patient test for comfort level. Soak hands and/or feet for 5 to 10 minutes to soften and cleanse nails.
6. Gently clean under nails with orangewood stick. Work gently so as not to injure skin under the nails.
7. File toenails straight across.
8. Use nail file to shape and smooth rough edges. Apply lotion after drying the hands and feet. Note for any redness or problems.
9. Clean and put away equipment.
10. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Nail care provided.
   b. Patient's response to procedure.
2. Report to supervisor any reddened, swollen or other signs of infection around nail.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To promote healing, provide relief from pain/inflammation and to prevent infection from irritation of the oral mucosa.

CONSIDERATIONS:

1. Irritation of the oral mucosa can occur from chemotherapeutic or anticholinergic drugs, Candida, decaying teeth, ill-fitting dentures, vitamin deficiencies, dehydration, ulcerations and infectious diseases, i.e., herpes.
2. Preventive measures should be instituted on high-risk patients before irritation occurs.
3. Obtain physician order for oral rinse agent. The patient may have other medications, such as antifungal rinses or lozenges, which must be administered as prescribed. Freezing nystatin may make it more tolerable for patient. Offer ice chips for numbing effect.
4. Adequate nutrition and hydration will promote healing.
   a. Encourage fluids (8-10 glasses/day) in frequent small amounts. Use of a straw may make swallowing easier, unless contraindicated.
   b. Use of Viscous Xylocaine (requires physician's prescription) or a tablespoon of honey before meals may make eating easier.
5. To minimize further mucosal trauma, encourage the patient to change food textures and other items that may cause mechanical abrasions, burning, changes in the pH of the mouth, dryness and decreased saliva formation:
   a. Foods that are harsh or abrasive.
   b. Food/fluids that are acidic.
   c. Food/fluids with extreme temperatures (hot or cold).
   d. Highly seasoned or salty foods.
   e. Ill-fitting dentures.
   f. Smoking.
   g. Alcoholic beverages.
   h. Lemon and glycerine swabs.
   i. Use of abrasive instruments for cleansing, i.e., toothbrushes.
   j. Commercial mouthwash.
   k. Encourage patient to suck hard, sour candies to stimulate salivary flow.
   l. Ensure adequate hydration.
6. Rinses that <u>can be used</u> to relieve discomfort:
   a. Hydrogen peroxide and water mixed one to one.
   b. Hydrogen peroxide and normal saline mixed one to one.
   c. One cup of warm water mixed with one teaspoon of baking soda.
   d. One cup warm water with one teaspoon salt.
   e. Viscous Xylocaine (requires physician's prescription).
   f. Kaopectate/Benadryl/Viscous Xylocaine (requires physician's prescription).
7. Keep lips lubricated to prevent drying and further irritation.
8. Use at least 2 patient identifiers prior to administering medications.

EQUIPMENT:

Flashlight

Soft-bristle toothbrush

Toothettes ®

Normal saline

Hydrogen peroxide

Baking soda

Viscous Xylocaine

Prescribed medication(s)

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. With flashlight, inspect the oral mucosa to identify the irritation. Determine the most appropriate treatment.
4. Provide oral care to promote hygiene and to prevent the mouth from becoming a breeding place for bacteria.
   a. Cleanse with soft-bristle toothbrush or Toothettes ®.
   b. Instruct patient to gargle and rinse mouth with rinse of choice. Instruct patient to hold rinse in mouth for 1 minute.
5. Rinse mouth with Viscous Xylocaine to relieve discomfort (if ordered).
6. Discard soiled supplies in appropriate container.

AFTER CARE

1. Instruct the patient/caregiver in mouth care and the importance of repeating it several times daily.
2. Document in patient's record:
   a. Status of oral mucosa.
   b. Treatment provided.
   c. Instructions given regarding mouth care, prescribed medications including application and importance of plaque care/removal.

Strength of Evidence Level: 3

PURPOSE:

Keep the teeth, gums and mouth in good condition; freshen the mouth and relieve it of offensive odors; prevent sores and infection; and provide a sense of well -being and comfort.

CONSIDERATIONS:

1. Oral hygiene should be completed daily or as necessary to maintain a healthy and fresh mouth.

EQUIPMENT:

Toothbrush and/or swabs and toothpaste (medicated/optional)

Curved basin, sink or small basin

Towel

Cool water and cup

Straw (optional)

Mouthwash (optional)

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain the procedure to patient.
3. Have the patient sit up or assist patient to the sink.
4. Spread towel across patient's chest.
5. Inspect mouth and gums for redness or skin breakdown. Offer the patient some water to rinse mouth.
6. Hold curved basin under the patient's chin, so patient can spit out the water.
7. Offer toothbrush to patient, if able to brush own teeth. Put toothpaste on wet toothbrush. If patient is unable to brush own teeth, use a gentle motion, starting above the gum line and going down the teeth. Repeat this until you have brushed all the teeth. If the patient CANNOT swallow or is at risk for aspiration, may need to cleanse mouth with swabs.
8. If no teeth, cleanse mouth with swabs and brush tongue gently, if needed.
9. If there are oral sores present, consult care plan or nurse for direction in providing oral care.
10. Give patient water to rinse mouth.
11. Offer mouthwash (optional).
12. Clean and put equipment away.
13. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Patient's response to procedure.
   b. Oral care provided.
   c. Condition of mucosal membranes
   d. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J.(1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To cleanse the perineal area, minimize irritation and infection and promote comfort.

CONSIDERATIONS:

1. To prevent contamination, wipe toward the anus.
2. Avoid using a scrubbing motion to prevent infection and/or irritation.

EQUIPMENT:

Small container with warm water

Clean wash cloth(s)

Towel

Bedpan

Pad to protect bed (may be thick towel on a piece of plastic)

Gloves

Apron or gown (optional)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Place protective pad under the patient's buttocks.
4. Place patient on bedpan with legs bent and separated, feet flat on bed. Drape sheet over patient for privacy and warmth.
5. Fill small container with warm water. Check the water temperature and have the patient test to comfort level. Pour warm solution slowly over the perineal area.
6. Wash perineum with soap and water, wiping front to back. Use a clean area of the washcloth for each stroke. Starting on side closest to you, cleanse area using a downward stroke for right side, for center and for left side.
7. Rinse by pouring warm water slowly over the perineal area.
8. Remove patient from bedpan.
9. Pat area dry with towel, being sure to turn patient on side. Dry back area.
10. Position patient for comfort and safety.
11. Empty and clean bedpan.
12. Return equipment to designated area.
13. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
    a. Patient's response to procedure.
    b. Drainage, if present.
    c. Appearance of skin.
    d. Odor.
    e. Complaints of tenderness or pain.
2. Report any change in condition to supervisor.

REFERENCES:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM : Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To cleanse the perineal area, minimize irritation and infection, and promote comfort.

CONSIDERATIONS:

1. To prevent contamination, wipe toward the anus.
2. Scrubbing motion should be avoided to prevent infection and/or irritation.

EQUIPMENT:

Small container with warm water

Clean wash cloth(s)

Towel

Bedpan

Pad to protect bed (may be thick towel on a piece of plastic)

Gloves

Apron or gown (optional)

Incontinence supplies (optional)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Place protective pad under the patient's buttocks.
4. Place patient on bedpan with legs bent and separated, feet flat on bed. Drape sheet over patient for privacy and warmth.
5. Fill small container with warm water. Check the water temperature and have the patient test to comfort level. Pour warm solution slowly over the perineal area.
6. Wash perineum with soap and water. Use a clean area of the washcloth for each stroke.
   a. Circumcised male: start on side closest to you, cleanse area using a downward stroke beginning at the tip and moving toward the anus.
   b. Uncircumcised male: retract foreskin gently to expose tip of penis, cleanse tip of penis, and then cleanse rest of penis in a downward motion.
7. Rinse by pouring warm water slowly over the perineal area.
   a. Circumcised male: start on side closest to you, rinse area using a downward stroke beginning at the tip and moving toward the anus.
   b. Uncircumcised male: foreskin retracted and tip of penis exposed, rinse tip of penis, and rinse rest of penis in a downward motion.
8. Remove patient from bedpan.
9. Pat area dry with towel. If patient is not circumcised, dry tip of penis well and then replace foreskin over the tip of the penis. Turn patient on their side and dry back area.
10. Position patient for comfort and safety.
11. Empty and clean bedpan.
12. Return equipment to designated area.
13. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Patient's response to procedure.
   b. Drainage, if present.
   c. Appearance of skin.
   d. Odor.
   e. Complaints of tenderness or pain.
2. Report any change in condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To prevent contractures, deformities and pressure ulcers.

CONSIDERATIONS:

1. Patient and caregiver should be instructed in proper positioning and support for all parts of the body.
2. Turn patient frequently (a minimum of every 1 to 2 hours) and instruct caregiver in proper techniques and support. Patient should lie on alternating sides and on stomach at various intervals during the day. Always consider postural alignment, distribution of weight, stability, comfort and pressure relief when positioning a patient.
3. Encourage frequent skin inspection and proper care for prevention of decubiti.
4. Support weak extremities with pillows after turning or transferring patient.

EQUIPMENT:

Firm bed or firm chair with high back and arm rests

Several firm pillows (both large and small)

Bath towel or small sheet blanket for towel roll

Wash cloth and rubber band or tape for hand roll

Foot board (cardboard box or pillows may be substituted)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. To position patient on back:
   a. Place flat pillow under head.
   b. Place towel roll along thigh, from above the hip to below the knee, to correct external rotation of the hip.
   c. Support feet in dorsiflexion position to prevent foot drop. Loosen top sheet so pressure is removed from the toes. Be sure heels are off the mattress with either heel protectors or a flat pillow placed under both calves.
   d. Place upper extremity on moderate size pillow at side, and position fingers around hand roll to raise wrist slightly.
   e. A small pillow may be placed under knees to prevent back strain, unless contraindicated.
4. To position patient on stomach:
   a. Place flat pillow under abdomen to flatten back. The exact positioning may be adjusted for patient's comfort, i.e., under lower rib cage for large breasted females.
   b. Place pillow or towel under ankles to relieve tension behind the knees and to prevent pressure on the toes, or patient may slide down to allow toes to fit over edge of mattress.
   c. Place one arm down by side, other bent by head. Position of arms may be varied, depending on patient's shoulder range of motion and patient comfort.
5. To position patient on side:
   a. Place a small pillow under the head. Keep the head in alignment with the spine.
   b. Turn patient on side, placing pillow between legs. Top leg should be flexed at the knee and well supported on the pillow.
   c. Rest top arm on a pillow, the same height as the shoulder joint, with elbow slightly bent.
   d. Place rolled pillows at back and/or chest for support.
6. To position patient sitting in chair, try to maintain the 90/90/90 position:
   a. Place arm rests or pillow supports under arms if needed. This is especially important for a weak upper extremity.
   b. Place feet flat on floor or on foot rests of wheelchair.
   c. Place a small pillow at back for comfort.

AFTER CARE:

1. Document in patient's record:
   a. Positioning done, i.e., patient positioned on right side.
   b. Observations of patient.
2. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To apply an artificial replacement for a missing portion of the body.

CONSIDERATIONS:

1. Each prosthesis is individually designed for the patient.
2. A new prosthesis may be uncomfortable. Report any discomfort to supervisor.
3. DO NOT apply prosthesis without specific instruction and demonstration by the nurse or therapist.
4. Careful skin hygiene is essential to prevent skin irritation, infection and breakdown. Any untoward effects should be reported immediately.
5. Check the prosthesis and socks to assure that they are clean and dry before donning. A new fresh sock should be used every day.
6. The prosthesis should be maintained and cleaned according to manufacturer's directions.

EQUIPMENT:

Prosthesis

Sock/stump cover

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Review and follow nurse or therapist's instructions.
4. Check skin of stump for evidence of pressure areas. Place a sock over the residual limb before donning the prosthesis. This protects the skin from injury and sores. Be sure seams are facing outward and away from bony prominences. DO NOT place self-adhesive bandages or tape on the leg before wearing the prosthesis.
5. Apply as instructed.

AFTER CARE:

1. Document in patient's record:
   a. Procedure.
   b. Patient's response to procedure.
2. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To prevent infection and encrustation (formation of dried mucus material) in eye socket and around artificial eye.

CONSIDERATIONS:

1. Never use alcohol, ether or acetone on the prosthetic eye because they dissolve plastic and dull the luster.
2. Only home health and hospice aides who have been instructed, supervised and have demonstrated competence by the registered nurse may perform procedure.
3. Observe the condition of the socket and report any signs of trauma and infection.
4. Observe the condition of the prosthesis, and report any nicks, cracks or chips.

EQUIPMENT:

Eyecup or small container

Gauze or clean cloth (2)

Small basin

Cotton balls

Washcloth

Cleaning solution (optional)

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Place gauze or clean cloth in bottom of eyecup or container. Fill halfway with warm water.
3. Fill basin with warm water.
4. Explain procedure to patient.
5. Have patient lie down on the bed to prevent accidental dropping of the artificial eye.
6. Have the patient close eyes. Clean any drainage from the upper eyelid using cotton balls and warm water. Clean from the inner part of the eye (from the nose) to the outside of the eye area.
7. Remove the artificial eye by carefully depressing the lower eyelid down over the cheekbone with your thumb. Exert slight pressure on the lower portion of the eyelid to release the suction. Lift the upper lid gently with your forefinger. The eye should slide out. (Have the patient do this, if able.)
8. Place the eye in the cup on gauze or clean cloth. Let it soak in the water while performing rest of procedure.
9. Clean the eye socket by spreading the lids apart and washing off external matter and encrustations with cotton balls and warm water. Using gentle strokes, clean from the inner part of the eye (from the nose) to the outside of the eye. Be certain to clean inside folds. Dry the socket. Use a clean and fresh cotton ball for each stroke.
10. Take the eyecup to the patient's bathroom. Close the drain in the sink. Fill the sink half full with water and put washcloth in the bottom of the sink to prevent breakage if the eye is dropped.
11. Hold the artificial eye with gauze or soft cloth, and wash with lukewarm running water by gently rubbing between thumb and forefinger. (Use plain water unless the doctor ordered a special solution.)
12. Rinse the eye under running lukewarm water. Discard the water from the eyecup. Place the slightly moistened eye on dry gauze in the eyecup (a slightly moistened eye is easier to insert).
13. Before inserting the artificial eye, have patient wash hands, if inserting eye.
14. Insert the eye in the patient's eye socket with the notched edge toward the nose. Raise the upper lid with forefinger. With other hand, insert the eye by placing the eye under the upper lid. Depress the lower lid with thumb. The eye will settle into place.
15. Position patient for comfort and safety.
16. If the patient cannot wear the eye, store it in the eyecup with water and place in bedside table drawer.
17. Clean and store equipment.
18. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Procedure.
   b. Condition of eye socket.
   c. Drainage.
   d. Patient's response to procedure.
2. Report any changes in patient's condition to supervisor.

Strength of Evidence Level: 1

PURPOSE:

To count how fast the heart is beating.

CONSIDERATIONS:

1. Characteristics of a pulse are:
   a. Rate: Number of beats per minute.
   b. Rhythm: Regularity of the pulse beats.
   c. Force: Weak, pounding.
2. Normal pulse ranges are as follows:
   a. 1 year old, 115 to 130 beats per minute.
   b. Childhood years, 80 to 115 beats per minute.
   c. Adult years, 64 to 80 beats per minute.
   d. Senior years, 60 to 70 beats per minute.

EQUIPMENT:

Watch or clock with a second hand

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Have patient sit or lie in a comfortable position. Wait 5 minutes before counting the pulse.
4. The patient's hand and arm should be well supported and resting comfortably.
5. Feel the pulse by placing the pads of your middle three fingers on the palm side of the patient's wrist in a line with patient's thumb. Press lightly until the pulse is felt. The thumb is never used because it has its own pulse. If you press too hard, you may stop the flow of blood and then you will not be able to feel a pulse.
6. When the pulse is felt, note the rhythm, whether it is steady or irregular; note the force of the beat, whether it is strong, weak or pounding.
7. Look at the position of the second hand on the watch or clock. Start counting the pulse beats (what is felt) until the second hand returns to the same number on the watch or clock.
   a Method A: Count the pulse beats for one full minute and report the full minute count. This is always done if the patient has an irregular beat.
   b Method B: Count for 30 seconds (until the second hand is opposite its position when you started). Multiply the number of beats by 2; record this number.
      (1). EXAMPLE: If the count for 30 seconds is 35, the count for 60 seconds is 35 x 2 or 70 beats for 60 seconds.

AFTER CARE:

1. Document in patient's record:
   a. Rate.
   b. Rhythm.
   c. Force of pulse.
2. Report any deviation from normal pulse to supervisor.

REFERENCES:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

U.S. Department of Health and Human Services. (2004). *Seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure.* (NIH Publication No. 04-5230). Bethesda, MD.

Strength of Evidence Level: 1

PURPOSE:

To provide an accurate count of the number of times a patient breathes in 1 minute and to determine type of breathing.

CONSIDERATIONS:

1. The patient should not know that respirations are being counted, since this is one function that can be controlled.
2. Adults normally breathe at a rate of 12 to 20 breaths per minute. Children typically breathe at a rate of 16 to 20 breaths per minute.
3. These are several types of respirations:
   a. Normal respirations: Chest expands when the patient breathes in and contracts when breathing out.
   b. Stetorous respirations: The patient makes abnormal noises like snoring sounds when breathing.
   c. Abdominal respirations: Breathing in which the patient mainly uses abdominal muscles. [**Note**: Abdominal breathing in infants and toddlers is normal.]
   d. Shallow respirations: Breathing with only the upper part of the lungs, chest barely rising.
   e. Irregular respirations: The depth and rate of breathing is not steady.
   f. Cheyne-Stokes respirations: At first the breathing is slow and shallow, and then the respiration becomes faster and deeper until it reaches a peak. The respiration then slows down and becomes shallow again. The breathing may then stop completely for 10 seconds, and begin the pattern again. This type of respiration may be caused by certain cerebral (brain), cardiac (heart) or pulmonary (chest) diseases or conditions. It frequently occurs before death.

EQUIPMENT:

Watch with second hand

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
   [**Note:** DO NOT inform the patient of exact time when you assess their respirations.] You may count respiratory rate while checking patient’s pulse. Allow the patient to rest for about 5 minutes before assessing their respirations. Ask the patient to relax and refrain from talking and moving.
3. Hold patient's wrist as if you are taking his/her pulse. You may lay the arm over the chest so that you can feel the rise and fall of the chest.
4. If the patient is a child who has been crying or is restless, wait until he/she is quiet before counting respirations. If a child is asleep, count his/her respirations before he/she wakes up. Always count a child's pulse and respirations before you measure the temperature. (Most children get upset when you measure their temperature.)
5. One rise and fall of the patient's chest counts as one respiration.
6. Check the position of the second hand on the watch. Count "one" when you see or feel the patient's chest rise. The next time the chest raises count "two." Do this for 1 minute.
   [Note: Respirations may be counted for 30 seconds and multiplied by 2, if permitted by your agency. If a patient's respirations are irregular, you must always count 1 full minute.]
7. Observe the depth and type of breathing while you are counting. Note whether the respirations were noisy or labored.
8. Return patient to position of comfort.

AFTER CARE:

1. Document in patient's record:
   a. Number of respirations per minute.
   b. Type of respirations.
2. Report abnormal respirations to your supervisor.

REFERENCE:

U.S. Department of Health and Human Services. (2004). *Seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure*. (NIH Publication No. 04-5230). Bethesda, MD.

Strength of Evidence Level: 3

PURPOSE:

To prevent complications related to swallowing disorders such as aspiration, choking, pocketing, dehydration and malnutrition. To promote safe feeding measures in patients with swallowing disorders. To promote optimum nourishment.

CONSIDERATIONS:

1. The major complication of swallowing disorders is aspiration.
2. Specific precautions/directions for feeding a patient with a swallowing disorder should be provided by a registered nurse or speech-language pathologist.
3. Criteria for food selection to facilitate chewing and swallowing:
    a. Semi-solid foods, i.e., purees or foods with some shape, are easiest to swallow. Form provides stimulation to initiate the swallow. Foods should be moist enough to prevent crumbling but dry enough to hold a bolus shape, e.g., casseroles, custards, scrambled eggs, applesauce. Generally, thin liquids, i.e., water, are excluded from diet.
    b. Chewing assists in stimulation of swallowing reflex. Foods with texture stimulate chewing.
    c. Sweet, sour and salty foods stimulate chewing, which helps swallowing.
    d. Avoid tepid or room temperature foods - they are not stimulating enough.
    e. Avoid sticky foods, e.g., peanut butter, chocolate milk, ice cream, rice.
    f. Milk, ice cream and milkshakes form excessive mucus in the mouth and are difficult to swallow due to thin consistency and lack of texture. Ice cream, ice chips, and gelatin usually melt to a thin liquid that can be difficult to swallow due to the thin consistency.
    g. Dry foods can be moistened with margarine, gravy or broths.
    h. If liquids are a problem, juices can be thickened with sherbets, cornstarch or commercial food thickener, as ordered.
    i. Meats are difficult to manage, as they require a lot of chewing. Ground meats may crumble and be aspirated. Chicken may be easiest to chew and holds its form as a bolus.
4. The patient should be well rested prior to the meal. The environment should be pleasant, peaceful and free from distractions.
5. The patient should be alert and aware of the meal.
6. The patient should have control of mouth movements.
7. The patient should have the ability to protect the airway.
8. The patient must be able to hold and swallow saliva.
9. Staff and family members who feed the patient should know the Heimlich maneuver.
10. Make sure you are in the patient's visual field.
11. DO NOT hurry the patient.
12. DO NOT encourage conversation during mealtime.

EQUIPMENT:

Feeding utensils, including any special adaptive equipment prescribed

Napkin or towel

Food and liquids

PROCEDURE:

1. Adhere to Standard Precautions.
2. Wash patient's hands or assist him/her to do so.
3. Explain procedure to patient.
4. Place patient in an upright position in a chair or in bed in high-Fowler's position, supported with pillows if necessary, with head slightly flexed for approximately 15 to 20 minutes before and after meal.
5. Provide mouth care before meals. If the patient's mouth is dry, provide a lemon wedge or a pickle to promote salivation.
6. Give 1/2 (one-half) to 1/3 (one-third) teaspoon at a time.
7. Place the food on the strong side, or side without sensory or motor loss.
8. Put the spoon down between portions.
9. Check for emptying of the mouth before proceeding.
10. Instruct patient to repeat a dry swallow.
11. Instruct the patient to form bolus by moving tongue around inside the mouth.
12. If the patient cannot voluntarily chew, manipulate jaw in an upward and downward motion, which will stimulate the chewing response.
13. Have the patient chew and swallow slowly concentrating only on the feeding process. Instruct in the voluntary swallow:
    a. Hold the food in your mouth.
    b. Hold your breath.
    c. Think about swallowing.
    d. Swallow.

    [**Note**: If the patient does not swallow, press his/her chin downward toward the sternum. This elevates larynx and causes a swallow reflex.
14. Encourage the patient to close his/her lips once the food is in his/her mouth.]
15. If the patient has an increase in saliva during the meal, instruct him/her to collect the saliva with the tongue and consciously swallow it between bites of meal.
16. If he/she complains of a dry mouth, instruct him/her to move the tongue in a circular fashion against the insides of the cheeks.
17. A straw for sipping liquids may be used only after evaluation and instruction by a speech-language pathologist.
18. Stop feeding if:
    a. Patient states he/she is having difficulty.
    b. Patient is coughing or choking.

Strength of Evidence Level: 3

   c. Change in voice, i.e., gurgly, wet quality.
   d. Change in mental status.
19. Instruct patient to voluntarily clear throat.
20. Provide mouth care after meals.

AFTER CARE:

1. Document in patient's record:
   a. Patient's response to procedure.
   b. Effectiveness of procedure.
   c. Instructions given to patient/caregiver.
   d. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To promote cleanliness, prevent scalp and hair breakdown, stimulate circulation, distribute natural oils, and to improve appearance and well-being of patient.

CONSIDERATIONS:

1. Keep the patient free of drafts.
2. Never use a hot comb, curling iron or heated rollers on a patient's hair.
3. Never use chemicals, such as hair dyes or permanents on a patient's hair.
4. Maintain the patient's comfort throughout the shampoo.

EQUIPMENT:

Comb or brush

Shampoo

Conditioner or rinse (optional)

Towels and small washcloth

Plastic sheet or other protective cover

Newspaper or paper bags

Container with warm water

Basin or other receptacle

Pitcher or pan

Chair or small table

Cotton balls (optional)

Electric blow dryer (optional)

Shampoo tray (optional)

Apron and gloves (necessary for Standard Precautions)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Assemble equipment.
4. Make sure there is no draft on patient.
5. Protect floor with newspaper or paper bags.
6. Raise the bed to the highest horizontal position. Lower the headrest and the side rails on the side you are working.
7. Place the chair or small table at the side of the bed near the patient's head. Protect with paper. The chair/table should be lower than the mattress. The back of the chair should be touching the mattress.
8. Inspect the patient's hair for knots and lice. If the patient has knots, carefully comb them out. If the client has lice, stop the procedure and report this to your supervisor. Lice are tiny wingless insects that live on hair and scalp.
9. Place the large basin or pail on the chair/table. Place container with warm water on table within easy reach.
10. Remove the pillow from under the patient's head.
11. Use shampoo tray or ring, if available; if not, roll sides of plastic sheet to form a trough. This makes a channel for the water to run into the pail. Three sides must be rolled to make a channel. The top edge should be rolled around a rolled bath towel. Place the edge with the rolled bath towel under the patient's neck and head. Have the open edge hanging into the pail or basin.
12. Position patient so that head is at edge of bed, and roll pillow under neck for support.
13. Fasten towel around patient's neck. Cover pillow and bed with plastic.
14. Put small amounts of cotton in the patient's ears for protection.
15. Loosen clothing, so the patient is comfortable and no clothing is in the trough.
16. Ask patient to hold washcloth over his/her eyes.
17. Fill container with warm water. Check the water temperature and have the patient test to comfort level. Using a pitcher or cup, pour some water over the patient's hair. Repeat until the hair is completely wet.
18. Apply shampoo. Using both hands, wash the hair and massage the scalp with your fingertips. Avoid using your fingernails, as they could scratch the patient's scalp.
    [**Note**: You may want to use gloves if you see lesions, sores or lice in the patient's scalp].
19. Rinse hair thoroughly to remove all soap. Repeat lather and rinse thoroughly again.
20. Apply conditioner or rinse if patient requests.
21. Dry the patient's forehead and ears.
22. Remove the cotton from the patient's ears.
23. Raise the patient's head and wrap it in a bath towel.
24. Remove plastic sheet from pillow and bed. Dry hair by rubbing with towels. If an electric blow dryer is available, use it on low setting. Keep patient well covered to prevent chilling.
25. Comb or brush, and style hair.
26. Lower the bed to its lowest horizontal position and raise the side rails.
27. Make the patient comfortable.
28. Clean equipment and put it in its proper place.
29. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document procedure in patient's record and patient tolerance.
2. Document Standard Precautions used.
3. Report any changes in condition of scalp to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To promote cleanliness, prevent scalp and hair breakdown, stimulate circulation, distribute natural oils, improve patient appearance and self-esteem.

CONSIDERATIONS:

1. Keep patient free from drafts.
2. Never use a hot comb, curling iron or heated rollers on a patient's hair.
3. Never use chemicals, such as hair dyes or permanents on a patient's hair.
4. Maintain the patient's comfort throughout the shampoo.

EQUIPMENT:

Comb or brush

Shampoo

Conditioner or rinse, as desired by patient

Towels

Pitcher for water (optional)

Chair that allows patient to sit comfortably facing the sink

Cotton balls (optional)

Washcloth

Electric blow dryer (optional)

Apron and gloves (necessary for standard precautions)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Assemble equipment.
4. Make sure there is no draft on patient.
5. Assist the patient to the sink. Be sure a chair is available for patient to sit on, if patient gets tired.
6. Place a towel around the patient's shoulders.
7. Inspect the patient's hair for knots and lice. If the patient has knots, carefully comb them out. If the patient has lice, stop the procedure and report this to your supervisor. Lice are tiny wingless insects that live on hair and scalp.
8. Put small amount of cotton in the patient's ears for protection.
9. Give the patient a washcloth to cover his/her eyes.
10. Adjust temperature of water to patient's comfort.
11. Ask the patient to lean forward so that his/her head is over the sink.
12. Wet patient's head thoroughly.
13. Apply shampoo. Using both hands, wash the hair and massage the scalp with your fingertips. Avoid using your fingernails as they may scratch the patient's scalp.
    [**Note**: You may want to use gloves to wash the patient's hair if you suspect or see lesions, open areas or lice on the patient's scalp].
14. Rinse the shampoo off by pouring water over the hair. Repeat lather, rinse thoroughly again. Apply conditioner or rinse, if patient requests.
15. Dry the patient's forehead and ears. Have patient assume a comfortable position. Raise the patient's head and wrap it in a towel.
16. Remove the cotton from the patient's ears.
17. Rub the patient's hair with a towel to dry it as much as possible.
18. Comb the patient's hair, as patient is accustomed to having it done. You may leave a towel around the patient's shoulders while it is drying. Leave a towel under the patient's head if he/she prefers to lie down as his/her hair dries. You may also set the hair and use the electric blow dryer on low setting.
19. Make sure the patient is comfortable and safe following this procedure.
20. Clean equipment and put it in its proper place.
21. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document procedure and patient tolerance in patient's record.
2. Document Standard Precautions used.
3. Report any changes in condition of scalp to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To shave a patient in a safe and efficient manner.

CONSIDERATIONS:

1. Only shave patient when the procedure is included in the personal care assignment by the supervising nurse.
2. Preferably, shave patients with electric razors.
3. Only use patient's own electric shaver or safety razor.
4. DO NOT use safety razor with a patient who is prone to bleed, takes blood-thinning medication, fragile skin or has poor circulation.
5. When a patient has no personal equipment, use only one-time disposable safety razors and dispose of properly.
6. Observe condition of safety razors for rust, nicks, cracks or chips.
7. Avoid potential electrical sparks around oxygen (shave with safety razor instead of electric razor).
8. Patients on anti-coagulant therapy should use an electric razor. The nurse/therapist should indicate if the patient is on bleeding precautions.

EQUIPMENT:

Basin of water - very warm

Shaving cream (optional)

Safety razor or electric shaver

Face towel

Tissues

Mirror, if available for patient to use

After-shave lotion (optional)

Face powder (optional)

Washcloth

Gloves and apron (for Standard Precautions)

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Position the patient for comfort in a sitting or semi-sitting position.
4. Adjust a light so that it shines on the patient's face, but not in his eyes.
5. Shaving with a safety razor:
   a. Spread the face towel under the patient's chin. If the patient has dentures, be sure they are in his mouth.
   b. Soften beard with warm water, or use a damp, warm washcloth on the patient's face.
   c. Apply shaving cream generously to the face. If using soap, make a good, heavy lather.
   d. With the fingers of one hand, hold the skin taut as you shave in the direction that the hair grows. Start under the side burns, and work downward over the cheeks. Continue carefully over the skin. Work upward on the neck under the chin. Use short firm strokes.
   e. Rinse the razor often in the basin of water.
   f. Areas under the nose and around the lips are sensitive. Take special care in these areas.
   g. Wash off remaining shaving cream when finished.
   h. Apply after-shave lotion or powder, as the patient prefers.
6. Shaving with an electric razor:
   a. Adhere to Standard Precautions.
   b. Explain procedure to patient.
   c. Position the patient for comfort in a sitting or semi-sitting position.
   d. Adjust a light so that it shines on the patient's face, but not in his eyes.
   e. Make the patient comfortable.
   f. Turn on the electric razor. Shave with smooth movements in a back and forth motion. Shave in the direction of beard growth if the electric razor is a foil razor. Use a circular motion if the electric razor is a three-head razor.
   g. If applicable, moisten hands with aftershave lotion and pat the lotion on the patient’s face.
7. Clean equipment and put it in its proper place.
8. Place disposable razor in a hard plastic disposable container. Electric razor needs to be cleaned by removing the head of the razor, removing whiskers and recapping head of razor.
9. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document procedure and patient tolerance in patient's record.
2. Document Standard Precautions used.
3. Report any changes in patient's condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To facilitate adequate nutrition and patient self-care in the home.

CONSIDERATIONS:

1. Note patient's prescribed diet.
2. Shopping should be limited as much as possible to the nearest supermarket/grocery store.
3. Shopping should be limited as much as possible to food shopping. No other shopping is to be done by the home health aide without specific direction from the nurse or dietician.

EQUIPMENT:

Receipt form

PROCEDURE:

1. Review shopping list with patient.
2. Obtain money for purchase of items on list. DO NOT use patient’s ATM card or unsigned checks.
3. Purchase items on list from prearranged, convenient store. (If shopping requests seem inappropriate, report to nurse).
4. Return change with store receipt. Give receipt to patient. Have patient sign agency receipt form, if agency policy.
5. Put purchased items in proper place.

AFTER CARE:

1. Document procedure in patient's record.
2. Return agency receipt to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To maintain maximal skin health and prevent skin breakdown.

CONSIDERATIONS:

1. Skin should be assessed daily by caregiver.
2. Be aware that pressure areas may develop, especially on bony prominences.
3. It is important to keep the patient clean and dry and positioned properly. Linen should be kept wrinkle free.
4. Pressure-reducing surfaces or pressure-relieving surfaces may be considered.
5. Frequent position changes (every 2 hours) are essential in maintaining good skin health.
6. Irritation may result if rubber, plastic or under pads are in contact with skin.
7. When massaging the skin, DO NOT rub very hard. Always rub the skin with lotion and in a circular motion. Rubbing stimulates the circulation of blood to the skin, but very hard rubbing can damage skin that is very fragile. DO NOT rub or massage skin that is persistently reddened, frail. Attempt instead to relieve the pressure in this area.
8. Be careful when using bedpans. Pressure from sitting on the rim, and friction when getting on and off the pan, can create or worsen bedsores. Never leave your patient on the bedpan longer than necessary. Use care when removing the bedpan to avoid spilling urine on the skin, as urine could irritate and cause further damage to the reddened or tender area. Padding the bedpan with pads can reduce some pressure. Powdering the rim will minimize friction.
9. Obese clients tend to develop decubiti where body parts rub together, causing friction, such as under the breasts, between the folds of the buttocks and between the thighs.

EQUIPMENT:

Powder (optional)

Cornstarch (optional)

Skin lotion (optional)

Gloves

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Check the entire skin area, especially the bony prominences.
4. Observe for discoloration, rashes, breaks in the skin, scrapes, increased paleness or redness of skin.
5. Clean skin area at time of soiling; avoid hot water and irritating agents.
6. Use moisturizer on dry skin.
7. Carefully check any area where 2 skin surfaces rub together. Use powder or cornstarch sparingly where skin surfaces come together and form creases. Examples are under the breasts of women patients, between the buttocks and in folds of skin on the abdomen. DO NOT use cornstarch if a yeast infection is suspected.
8. Use lubricants, protective dressings and proper lift techniques to avoid skin injury from friction/shear during transferring and turning of patient.
9. Position patient:
   a. To position patient on side:
      (1). Turn patient on side, placing pillow between legs. Top leg should be flexed at the knee and well supported on the pillow.
      (2). Rest top arm on a pillow with elbow slightly bent.
      (3). Place rolled pillows at back and/or chest for support.
   b. To position patient sitting in chair:
      (1). Place arm rests or pillow supports under arms, if needed. This is especially important for a weak upper extremity.
      (2). Place feet flat on floor or on footrests of wheelchair.
      (3). Place a small pillow at back for comfort.
      (4). Instruct patient to shift his/her weight every 15 minutes, if able. Patients who are unable to reposition themselves should be repositioned at least every 1 to 2 hours.

AFTER CARE:

1. Document in patient's record:
   a. Positioning done, i.e., patient positioned on right side, and patient tolerance.
   b. Observations of patient.
2. Report any changes in patient's condition to supervisor.
3. Document Standard Precautions used.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

Provide care to altered skin where a rash is present from moisture.

CONSIDERATIONS:

1. Caregiver should assess skin daily.
2. Rashes may develop due to moisture, medication reactions or heat.
3. It is important to keep the patient clean and dry and positioned properly. Keep linen wrinkle free.
4. Irritation may result if rubber, plastic or under pads are in contact with skin.
5. Must demonstrate competence for registered nurse prior to performing procedure.

EQUIPMENT:

Basin

Washcloths

Warm water

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Check the entire skin area, especially the bony prominences.
4. Observe for discoloration, rashes, breaks in the skin, scrapes, increased paleness or redness of skin.
5. Clean skin area at time of soiling; avoid hot water and irritating agents.
6. Cleanse skin area with mild soap and water.
7. Pat skin area dry.
8. Reinforce to patient care of rash area needs to be completed as prescribed or directed by the nurse.

AFTER CARE:

1. Document in patient's record:
    a. Procedure performed and patient tolerance.
    b. Observations of patient.
2. Report any changes in patient's condition to supervisor.
3. Document Standard Precautions used.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To measure the body temperature when oral and rectal routes are not possible.

CONSIDERATIONS:

1. Normal axillary temperature is 97.6 -98.0 degrees Fahrenheit (36.6 degrees Centigrade).
2. To convert Celsius to Fahrenheit, multiply degrees Celsius by 9/5 and add 32. To convert Fahrenheit to Celsius, subtract 32 from degrees Fahrenheit and multiply by 5/9.
3. Axillary temperatures are to be done only when assigned by nurse.
4. DO NOT use a mercury thermometer. Encourage the patient/caregiver to obtain a digital or disposable thermometer.
5. If non-mercury-in-glass thermometer is used, follow manufacturer's guidelines for use.

EQUIPMENT:

Oral thermometer

Tissue

Disposable sheaths

Wrist watch

Non-sterile gloves

Alcohol or antiseptic wipes

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Clean thermometer by wiping with alcohol wipe.
4. When using alcohol thermometer, shake thermometer until the mercury is below 97 degrees Fahrenheit or 35 degrees Centigrade mark. Inspect thermometer for cracks or chips. DO NOT use if you see any. If using digital thermometer, turn the thermometer on.
5. Place disposable sheath on thermometer.
6. Remove the patient's arm from clothing. If the axillary region is moist with perspiration, pat dry with a towel.
7. Place the bulb of the oral thermometer in the center of the armpit in an upright position.
8. Place the patient's arm across the chest or abdomen to hold the thermometer in place. If the patient is unconscious or too weak to help, you may have to hold the arm in place.
9. Leave the thermometer in place 3 to 5 minutes. Read manufacturer's instructions, if available. If using a digital thermometer, leave it in place until it beeps. Remain with the patient as long as the thermometer is in place.
10. Remove the thermometer from under patient's arm. Remove disposable sheath and discard.
11. Read the thermometer.
12. Shake down the alcohol in the thermometer, or turn off digital thermometer.
13. Clean the thermometer, return to case.
14. Position patient for comfort and safety.
15. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Temperature.
   b. Observation of the patient.
   c. Method used.
   d. Patient tolerance.
2. Report any deviation from normal temperature to supervisor.
3. Document Standard Precautions used.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To measure body temperature.

CONSIDERATIONS:

1. Normal oral temperature is 97.6 -98.0 degrees Fahrenheit (36.6 degrees Celsius).
2. To convert Celsius to Fahrenheit, multiply degrees Celsius by 9/5 and add 32. To convert Fahrenheit to Celsius, subtract 32 from degrees Fahrenheit and multiply by 5/9.
3. DO NOT use a mercury thermometer. Encourage the patient/caregiver to obtain a digital or disposable thermometer.
4. DO NOT expect the patient to talk with the thermometer in their mouth.
5. Procedure should not be done within 10 minutes of the patient drinking hot or cold liquids or smoking a cigarette since you will get an inaccurate reading.

EQUIPMENT:

Oral thermometer

Tissues or cotton balls

Disposable thermometer sheaths (optional)

Gloves

Wrist watch

Alcohol or antiseptic wipes

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Take thermometer out of container and inspect it for cracks and chips. DO NOT use if you see any.
4. When using alcohol thermometer, shake thermometer until the mercury is below 97 degrees Fahrenheit or 35 degrees Celsius mark. If using digital thermometer – turn on.
5. If thermometer is not patient's own, place disposable sheath on the thermometer after wiping it with alcohol.
6. Ask the patient to lift up tongue. Insert the thermometer gently into the patient's mouth, positioning the bulb end of the thermometer under the tongue and to the side of the mouth.
7. Instruct the patient to hold or place his/her lips gently around the thermometer without biting it. If patient is unable to do this, another method should be used. *(See Personal Care and Support-Temperature: Axillary or Temperature: Rectal.)*
8. Leave the thermometer in place 3 to 5 minutes or until digital thermometer beeps. Stay with the patient if you feel that he/she cannot keep his/her mouth closed.
9. Remove the thermometer from the patient's mouth. Remove disposable sheath and discard.
10. Read the thermometer.
11. Shake down the mercury in thermometer.
12. Clean the thermometer, return to case.
13. Position patient for comfort and safety.
14. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
    a. Temperature.
    b. Observation of patient.
    c. Method used.
2. Report any deviation from normal temperature to supervisor.
3. Document Standard Precautions used.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To measure the body temperature when taking an oral temperature would be unsafe or inaccurate.

CONSIDERATIONS:

1. Rectal temperature should be taken:
   a. When the patient is having warm or cold applications on his/her face or neck.
   b. When the patient cannot keep his/her mouth closed around the thermometer, e.g., stroke or facial surgery.
   c. When the patient finds it hard to breathe through his/her nose.
   d. When the patient's mouth is dry or inflamed.
   e. When the patient is unconscious or confused.
   f. When the patient is getting oxygen by cannula, catheter or facemask.
2. Normal rectal temperature is 99.6 degrees Fahrenheit (37.5 degrees Celsius)
3. To convert Celsius to Fahrenheit, multiply degrees Celsius by 9/5 and add 32. To convert Fahrenheit to Celsius, subtract 32 from degrees Fahrenheit and multiply by 5/9.
4. DO NOT use a mercury thermometer. Encourage the patient/caregiver to obtain a digital or disposable thermometer.
5. If non-mercury-in-glass thermometer is used, follow manufacturer's guidelines for use.
6. Rectal temperatures are to be done only when assigned by the nurse.

EQUIPMENT:

Rectal thermometer

Disposable thermometer sheaths

Tissues

Lubricating jelly

Soap and water

Gloves

Alcohol or antiseptic wipes

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Shake thermometer until the alcohol is below 97 degrees Fahrenheit or 35 degrees Celsius mark. If using a digital thermometer, turn on the thermometer.
4. Inspect thermometer for cracks or chips. DO NOT use if you see any.
5. Clean thermometer with alcohol wipe, place disposable sheath on thermometer.
6. Place a small amount of lubricating jelly on a piece of tissue.
7. Lubricate the bulb end of the thermometer with lubricating jelly to make insertion easier and more comfortable for the patient.
8. Ask the patient to turn on his/her side. If unable to turn, position patient on side. Turn back the top covers just enough to expose the patient's buttocks. Avoid overexposing patient.
9. With one hand, raise the upper buttock to expose anus. With the other hand, gently insert the thermometer 1 inch into the rectum.
10. Hold the thermometer in place for 3 to 5 minutes or as instructed by the manufacturer, if user manual is available. When using digital thermometer hold in place until it beeps. Never leave a patient alone with a thermometer in the rectum, no matter what his/her condition.
11. Remove the thermometer from the patient's rectum. Hold the stem end of the thermometer; wipe it with tissue from stem to bulb to remove particles of feces and the disposable sheath.
12. Read the thermometer.
13. Shake down the mercury in thermometer.
14. Clean the thermometer with alcohol wipe; return to case.
15. Position the patient for comfort and safety.
16. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's record:
   a. Temperature.
   b. Method used.
   c. Observation of the patient.
2. Report any deviation from normal temperature to supervisor.
3. Document Standard Precautions used.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

To maintain a record of weight gain or loss.

CONSIDERATIONS:

1. Scale should be placed on a flat, hard surface for accuracy.
2. Patient should be dressed about the same way each time he/she is weighed, i.e., with slippers or without slippers.
3. Each weighing should be done at about the same time of day with the same scale.
4. Consider elimination pattern. If possible, check patient's weight after bowel movement and urination.

EQUIPMENT:

Scale

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Balance scale so that needle is on "0". If digital scale turn on and wait for digital display to show "0".
4. Assist patient to stand on scale.
5. Have patient stand still and note weight.
6. Assist patient off scale and to bed or chair.
7. Return scale to usual place.

AFTER CARE:

1. Document in patient's record:
    a. Weight.
    b. Clothing worn.
    c. Time weighed.
    d. Tolerance to procedure.
2. Report any change in condition to supervisor.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

Strength of Evidence Level: 3

PURPOSE:

Provide care to altered skin where a yeast rash is present.

CONSIDERATIONS:

1. Caregiver should assess skin daily.
2. Rashes may develop due to moisture, medication reactions or heat.
3. It is important to keep the patient as clean and dry as possible, positioned properly and linen wrinkle free.
4. Irritation may result if rubber, plastic or under pads are in contact with skin.
5. Must demonstrate competence for registered nurse prior to performing procedure.

EQUIPMENT:

Basin

Washcloths

Warm water

PROCEDURE:

1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Check the entire skin area, especially the bony prominences.
4. Observe for discoloration, rashes, breaks in the skin, scrapes, increased paleness or redness of skin.
5. Clean skin area at time of soiling; avoid hot water and irritating agents.
6. Cleanse skin area with mild soap and water.
7. Pat skin area dry.
8. Reinforce to patient care to yeast area needs to be completed as prescribed or directed by the nurse.

AFTER CARE:

1. Document in patient's record:
   a. Procedure performed and patient tolerance.
   b. Observations of patient.
2. Report any changes in patient's condition to supervisor.
3. Document use of Standard Precautions.

REFERENCE:

Leahy, W., Fuzy, J., & Graf, J. (1999). *Providing home care: A textbook for home care aides. (3rd ed.)* Albuquerque, NM: Hartman Publishing, Inc.

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