

14

Core Healthcare Skills



1. Explain the importance of monitoring vital signs

Define the following terms:

vital signs

measurements—measurements—temperature, pulse, respirations, blood pressure—that monitor the functioning of the vital organs of the body.

circadian rhythm

the 24-hour day-night cycle.

Key Material 14-1: Normal Ranges for Adult Vital Signs

Temperature Site	Fahrenheit	Celsius
Mouth (oral)	97.6° - 99.6°	36.5° - 37.5°
Rectum (rectal)	98.6° - 100.6°	37.0° - 38.1°
Armpit (axillary)	96.6° - 98.6°	35.9° - 37.0°
Ear (tympanic)	96.6° - 99.7°	35.9° - 37.6°
Temporal Artery (forehead)	97.2° - 100.1°	36.2° - 37.8°

Normal Pulse Rate: 60-100 beats per minute

Normal Respiratory Rate: 12-20 respirations per minute

Blood Pressure

Normal Systolic – 90-119 mm Hg *and*
Diastolic – 60-79 mm Hg

Low
(hypotensive) Systolic- Below 90 mm Hg *or*
Diastolic- Below 60 mm Hg



Key Material 14-1: Normal Ranges for Adult Vital Signs (cont'd)

Blood Pressure (cont'd)

Elevated	Systolic – 120-129 mm Hg <i>and</i> Diastolic – Less than 80 mm Hg
Stage 1 hypertension	Systolic- 130-139 mm Hg <i>or</i> Diastolic- 80-89 mm Hg
Stage 2 hypertension	Systolic-At or over 140 mm Hg <i>or</i> Diastolic- At over 90 mm Hg
Hypertensive crisis	Systolic- Over 180 mm HG <i>and/or</i> Diastolic- Over 120 mm Hg

1. Explain the importance of monitoring vital signs

Temperature

- Normal ranges and variations are listed on page 237 in textbook
- There are five sites
- Mercury-free thermometers are color-coded: green or blue for oral; red for rectal
- Digital thermometers are commonly used for oral, rectal, and axillary temps in the home client and are quick, accurate, and easy to read (no need to shake down)
- Electronic thermometer is used for measuring oral, rectal, or axillary temperatures. The temperature registers quickly and the thermometer is battery operated

1. Explain the importance of monitoring vital signs

Temperature (cont'd)

- Tympanic thermometers are fast and accurate
- Temporal artery thermometers measure heat over temporal artery with a gentle stroke or scan across the forehead
- Mercury-free thermometer is safer than mercury thermometers. See environmentally friendly care box on page 239 in the textbook
- Mercury-free thermometer is color-coded: green or blue for oral; red for rectal
- Rectal temperatures are the most accurate, but taking rectal temperatures can be dangerous for some clients
- Axillary temperatures are considered least accurate
- All thermometers must be cleaned after use, or protective covers must be used

1. Explain the importance of monitoring vital signs

Define the following terms:

radial pulse

the pulse located on the inside of the wrist, where the radial artery runs just beneath the skin.

brachial pulse

the pulse located inside the elbow, about one to one-and-a-half inches above the elbow.

apical pulse

the pulse located on the left side of the chest, just below the nipple.

stethoscope

an instrument designed to listen to sounds within the body, such as the heart beating or air moving through the lungs.

1. Explain the importance of monitoring vital signs

Pulse

- Pulse is the number of heartbeats per minute
- Radial pulse is inside of the wrist and is most common site for measuring pulse
- Brachial pulse is inside the elbow, about 1 to 1.5 inches above the elbow
- Apical pulse is on the left side of the chest, just below the nipple

1. Explain the importance of monitoring vital signs

Pulse (cont'd)

- Normal rate is 60 to 100 beats per minute for adults
- Slow/weak pulse may indicate dehydration, infection, or shock
- A stethoscope is an instrument to listen to sounds within the body
- Common pulse sites are listed on page 237 in the textbook

1. Explain the importance of monitoring vital signs

Define the following terms:

respiration

the process of inhaling air into the lungs (inspiration) and exhaling air out of the lungs (expiration).

inspiration

the process of inhaling air into the lungs.

expiration

the process of exhaling air out of the lungs.

apnea

the absence of breathing.

dyspnea

difficulty breathing.

1. Explain the importance of monitoring vital signs

Define the following terms:

eupnea

normal respirations.

orthopnea

shortness of breath when lying down that is relieved by sitting up.

tachypnea

rapid respirations.

bradypnea

slow respirations

Cheyne-Stokes

alternating periods of slow, irregular respirations and rapid, shallow respirations, along with periods of apnea.

1. Explain the importance of monitoring vital signs

Respirations

- Respiration consists of an inspiration and an expiration
- Normal rate is 12 to 20 breaths per minute
- Do the counting while you are counting the pulse
- Do not let the client know you are counting breaths
- Report any unusual sounds or difficulties the client has in breathing

1. Explain the importance of monitoring vital signs

Define the following terms:

systolic

first measurement of blood pressure; phase when the heart is at work, contracting and pushing the blood out of the left ventricle.

diastolic

second measurement of blood pressure; phase when the heart relaxes or rests.

hypertension (HTN)

high blood pressure, regularly measuring 130/80 mm Hg or higher.

1. Explain the importance of monitoring vital signs

Define the following terms:

hypotension

low blood pressure, measuring 90/60 mm Hg or lower.

sphygmomanometer

a device that measures blood pressure.

1. Explain the importance of monitoring vital signs

Blood Pressure

- The two parts of the BP are systolic (top number) and diastolic (bottom number)
- Normal BP range for systolic is below 120 mm Hg and for diastolic is below 80 mm Hg
- When blood pressure is consistently high, it may be categorized as elevated, stage 1 hypertensive, stage 2 hypertensive, or hypertensive crisis
- Brachial artery at the elbow is used.
- Equipment used is a sphygmomanometer

1. Explain the importance of monitoring vital signs

Blood Pressure (cont'd)

- One online resource to use to help students measure blood pressure (Korotkoff sounds) may be found here, although there are several examples online:
<https://www.youtube.com/watch?v=VJrLHePNDQ4>

1. Explain the importance of monitoring vital signs

Pain

- Although it is not a vital sign, it is very important to monitor and manage
- Pain is an uncomfortable, subjective, and personal experience
- Ask questions to get accurate information and immediately report the answers to a supervisor
- Take complaints of pain seriously
- Pain is not a normal part of aging
- Use methods listed on page 251 in textbook to reduce pain

1. Explain the importance of monitoring vital signs

Measures to reduce pain:

- Report complaints of pain or unrelieved pain promptly to your supervisor
- Gently position the body in good alignment. Use pillows for support. Assist in frequent changes of position if the client desires it.
- Give back rubs
- Ask if the client would like to take a warm bath or shower

1. Explain the importance of monitoring vital signs

Measures to reduce pain (cont'd):

- Assist the client to the bathroom or commode or offer the bedpan or urinal
- Encourage slow, deep breathing
- Provide a calm and quiet environment. Use soft music to distract the client
- If a client is taking pain medication, remind him when it is time to take it
- Be patient, caring, gentle, empathetic, and responsive to clients who are in pain

1. Explain the importance of monitoring vital signs

Weight and Height

- HHAs should report any weight loss no matter how small
- It is important to provide for privacy when measuring height and weight
- Weight should be measured at the same time of the day
- A pound is a unit of weight equal to 16 ounces. A kilogram is a unit of mass equal to 1000 grams; one kilogram equals 2.2 pounds
- There are 12 inches in a foot

1. Explain the importance of monitoring vital signs

When measuring and recording an oral temperature, HHAs should keep these points in mind:

- A digital, electronic, or mercury-free thermometer can be used for this procedure
- Cover thermometer with a new disposable plastic cover each time it is used
- If using a mercury-free thermometer, you may need to practice shaking it down and reading it
- Remember to wash your hands

Measuring and recording an oral temperature

Do not take an oral temperature if the client has smoked, eaten or drunk fluids, chewed gum, or exercised in the last 10-20 minutes.

Equipment: clean digital, electronic, or mercury-free thermometer, gloves, disposable sheath/cover for thermometer, tissues, pen and paper

1. Identify yourself by name. Identify the client by name.
2. Wash your hands.
3. Explain procedure to the client. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for client's privacy with curtain, screen, or door.
5. Put on gloves.

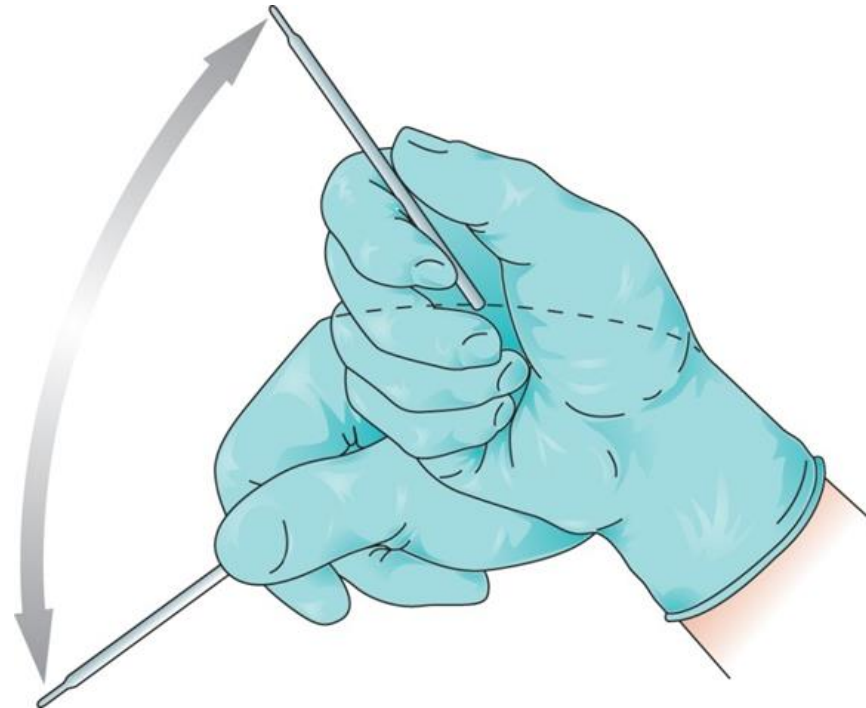
Measuring and recording an oral temperature

6. **Digital thermometer:** Put on the disposable sheath. Turn on thermometer and wait until ready sign appears.

Electronic thermometer: Remove the probe from base unit. Put on probe cover.

Measuring and recording an oral temperature

Mercury-free thermometer: Hold the thermometer by the stem. Before inserting it in the client's mouth, shake thermometer down to below the lowest number (at least below 96°F or 35°C). To shake the thermometer down, hold it at the end opposite the bulb with the thumb and two fingers. With a snapping motion of the wrist, shake the thermometer. Stand away from furniture and walls while doing so.



Measuring and recording an oral temperature

6. **Digital thermometer:** Insert the end of digital thermometer into the client's mouth, under the tongue and to one side.
- Electronic thermometer:** Insert the end of electronic thermometer into client's mouth, under tongue and to one side.
- Mercury-free thermometer:** Put on disposable sheath if available. Insert bulb end of the thermometer into client's mouth, under tongue and to one side.

Measuring and recording an oral temperature

7. **For all thermometers:** Tell the client to hold the thermometer in her mouth with her lips closed. Assist as necessary. The client should breathe through her nose. Ask the client not to bite down or talk.

Digital thermometer: Hold in place until thermometer blinks or beeps.

Electronic thermometer: Hold in place until you hear a tone or see a flashing or steady light.

Mercury-free thermometer: Hold in place for at least three minutes.



Measuring and recording an oral temperature

8. **Digital thermometer:** Remove the thermometer. Read temperature on display screen. Remember the temperature reading.

Electronic thermometer: Read the temperature on the display screen. Remember the temperature reading. Remove the probe.

Mercury-free thermometer: Remove the thermometer. Wipe with a tissue from the stem to bulb or remove sheath. Discard the tissue or sheath. Hold the thermometer at eye level. Hold the thermometer at eye level. Rotate until the line appears, rolling the thermometer between your thumb and forefinger. Read the temperature. Remember the temperature reading.

Measuring and recording an oral temperature

9. **Digital thermometer:** Using a tissue, remove and discard the sheath. Replace the thermometer in case.
Electronic thermometer: Press the eject button to discard the cover. Return the probe to the holder.
Mercury-free thermometer: Clean thermometer according to facility guidelines. Rinse with clean water and dry. Return it to case.
10. Remove and discard gloves.
11. Wash your hands.
12. Immediately record the temperature, date, time, and method used (oral).

1. Explain the importance of monitoring vital signs

When measuring and recording a rectal temperature, HHAs should keep these points in mind:

- Gloves must be worn
- Thermometer must be lubricated for this procedure
- The privacy of the client is important
- HHA must hold on to thermometer at all times
- Remember to wash hands

Measuring and recording a rectal temperature

Equipment: clean rectal mercury-free, digital, or electronic thermometer, lubricant, gloves, tissues, disposable sheath/cover, pen and paper

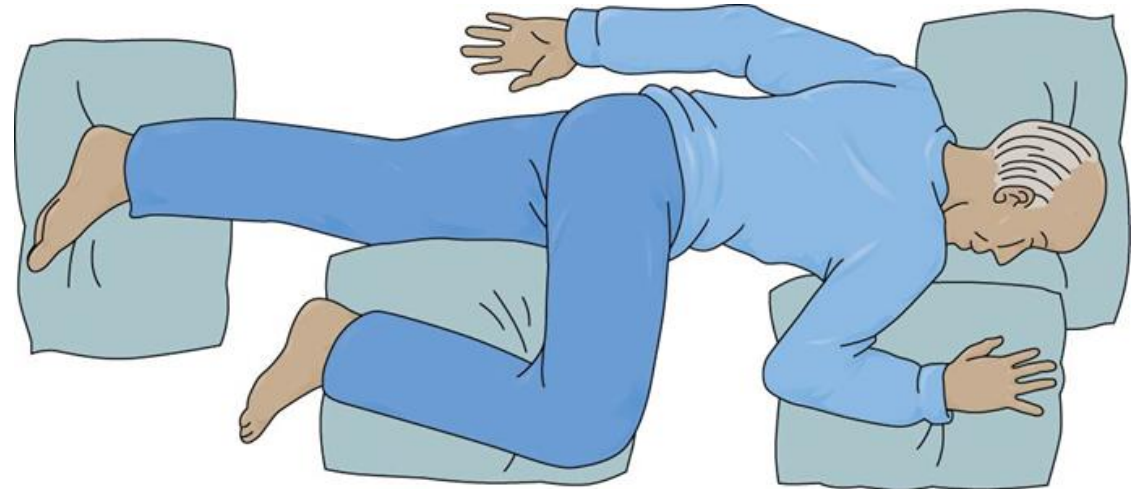
1. Wash your hands.
2. Explain procedure to the client. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible. Remind the client that the procedure will only take a few minutes.
3. Provide privacy for the client
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If the bed is movable, lock the bed wheels.

Measuring and recording a rectal temperature

5. Assist the client to the left side-lying (Sims') position.
6. Fold back the linens to expose only the rectal area.
7. Put on gloves.
8. **Digital thermometer:** Put on the disposable sheath. Turn on thermometer and wait until ready sign appears.

Electronic thermometer: Remove the probe from the base unit. Put on the probe cover.

Mercury-free thermometer: Hold the thermometer by stem. Shake the thermometer down to below the lowest number. Put on the disposable sheath.



Measuring and recording a rectal temperature

9. Apply a small amount of lubricant to the tip of the bulb or probe cover.
10. Separate the buttocks. Gently insert thermometer into rectum 1/2 to 1 inch. Stop if you meet resistance. Do not force the thermometer into the rectum.
11. Replace the sheet over buttocks while holding on to the thermometer at all times.



Measuring and recording a rectal temperature

12. **Digital thermometer:** Hold in place until the thermometer blinks or beeps.
Electronic thermometer: Hold in place until you hear a tone or see a flashing or steady light.
Mercury-free thermometer: Hold thermometer in place for at least three minutes.
13. Gently remove the thermometer. Wipe with tissue from stem to bulb or remove sheath. Discard the tissue or sheath.
14. Read the thermometer at eye level as you would for an oral temperature. Remember the temperature reading.

Measuring and recording a rectal temperature

15. **Digital thermometer:** Clean the thermometer according to policy and replace it in the case.
Electronic thermometer: Press the eject button to discard the cover. Return the probe to the holder.
Mercury-free thermometer: Clean thermometer according to policy. Rinse with clean water and dry. Return it to case.
16. Remove and discard your gloves. Wash your hands.
17. Assist the client to a safe and comfortable position. If you raised an adjustable bed, return it to its lowest position.
18. Wash your hands.
19. Immediately record the temperature, date, time, and method used (rectal).

1. Explain the importance of monitoring vital signs

When measuring and recording a tympanic temperature, HHAs should keep these points in mind:

- New disposable sheath is required for each client
- Ear opening must be sealed to obtain an accurate reading
- When measuring the temperature the HHA must pull up and back on the pinna of the ear
- Remember to wash hands

Measuring and recording a tympanic temperature

Equipment: tympanic thermometer, gloves, disposable probe sheath/cover, pen and paper

1. Wash your hands.
2. Explain procedure to the client. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Put a disposable sheath over the earpiece of the thermometer.

Measuring and recording a tympanic temperature

6. Position the client's head so that the ear is in front of you. Straighten the ear canal by gently pulling up and back on the outside edge of the ear for an adult. Pull straight back for infants and children. Insert the covered probe into the ear canal and press the button.
7. Hold thermometer in place until the thermometer blinks or beeps.



Measuring and recording a tympanic temperature

8. Read the temperature. Remember the temperature reading.
9. Dispose of sheath. Return the thermometer to storage or to the battery charger if thermometer is rechargeable.
10. Remove and discard gloves.
11. Wash your hands.
12. Immediately record the temperature, date, time, and method used (tympanic).

1. Explain the importance of monitoring vital signs

When measuring and recording an axillary temperature, HHAs should keep these points in mind:

- Axillary temperatures are less reliable
- The axillary site should be wiped with tissues before placing thermometer
- Remember to wash your hands

Measuring and recording an axillary temperature

Equipment: clean digital, electronic or mercury-free thermometer, gloves, tissues, disposable sheath/cover, pen and paper

1. Wash your hands.
2. Explain procedure to the client. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe working level, usually waist high. If the bed is movable, lock the bed wheels.
5. Put on gloves.
6. Remove the client's arm from the sleeve of gown or top to allow skin contact with the end of the thermometer. Wipe the axillary area with tissues before placing the thermometer.

Measuring and recording an axillary temperature

7. **Digital thermometer:** Put on the disposable sheath. Turn on the thermometer and wait until ready sign appears.

Electronic thermometer: Remove the probe from the base unit. Put on the probe cover.

Mercury-free thermometer: Hold the thermometer by the stem. Shake the thermometer down to below the lowest number. Put on the disposable sheath.

Measuring and recording an axillary temperature

8. Position the thermometer (bulb end for mercury-free) in center of the armpit. Fold the client's arm over his chest.
9. **Digital thermometer:** Hold in place until thermometer blinks or beeps.
Electronic thermometer: Hold in place until you hear a tone or see a flashing or steady light.
Mercury-free thermometer: Hold in place, with the arm close against the side, for eight to 10 minutes.

Measuring and recording an axillary temperature

10. Digital thermometer: Remove the thermometer. Read temperature on display screen. Remember the temperature reading.

Electronic thermometer: Read the temperature on the display screen. Remember the temperature reading. Remove the probe.

Mercury-free thermometer: Remove the thermometer. Wipe with a tissue from stem to bulb or remove sheath. Dispose of the tissue or sheath. Read the thermometer at eye level as you would for an oral temperature. Remember the temperature reading.

11. Digital thermometer: Using a tissue, remove and dispose of sheath. Replace the thermometer in case.

Electronic thermometer: Press the eject button to discard the cover. Return the probe to the holder.

Mercury-free thermometer: Clean thermometer with soap and water. Rinse with clean water and dry. Return it to case.

Measuring and recording an axillary temperature

12. If you raised an adjustable bed, return it to its lowest position.
13. Remove and discard your gloves.
14. Wash your hands.
15. Immediately record the temperature, date, time, and method used (axillary).

1. Explain the importance of monitoring vital signs

When counting and recording apical pulse, HHAs should keep these points in mind:

- You may wish to purchase your own stethoscope so it is available in the client's home at all times
- Clean the diaphragm and earpieces before use
- Report any irregularities or unusual beats to the supervisor
- Remember to wash your hands

Measuring and recording apical pulse

Equipment: stethoscope, watch with second hand, alcohol wipes, pen and paper

1. Wash your hands.
2. Explain procedure to the client. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide for client's privacy with curtain, screen, or door.
4. Before using the stethoscope, wipe the diaphragm and earpieces with alcohol wipes.
5. Fit the earpieces of the stethoscope snugly into your ears. Place the flat metal diaphragm on the left side of the chest, just below the nipple. Listen for the heartbeat.

Measuring and recording apical pulse

6. Use the second hand of your watch. Count the heartbeats for one minute. Each lub-dub that you hear is counted as one beat. A normal heartbeat is rhythmical. Leave the stethoscope in place to count respirations (see procedure later in chapter).
7. Wash your hands.



Measuring and recording apical pulse

8. Immediately record the pulse rate, date, time, and method used (apical). Note any irregularities in the rhythm.
9. Clean earpieces and diaphragm of stethoscope with alcohol wipes. Store stethoscope.
10. Wash your hands.

1. Explain the importance of monitoring vital signs

When counting and recording radial pulse and counting and recording respirations, HHAs should keep these points in mind:

- A watch with a second hand is mandatory
- The ability to feel the pulse comes with practice
- A pulse less than 60 or more than 100 must be reported to the supervisor
- It is important to observe and document pattern and character of breath
- Remember to wash hands

Counting and recording radial pulse and counting and recording respirations

Equipment: watch with a second hand, pen and paper

1. Wash your hands.
2. Explain procedure to the client. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.

Counting and recording radial pulse and counting and recording respirations

4. Place the fingertips of your index finger and middle finger on the thumb side of the client's wrist to locate the radial pulse.
5. Count the beats for one full minute.
6. Keeping your fingertips on the client's wrist, count respirations for one full minute. Observe for the pattern and character of the client's breathing. Normal breathing is smooth and quiet. If you see signs of difficult breathing, shallow breathing, or noisy breathing, such as wheezing, report it to your supervisor.



Counting and recording radial pulse and counting and recording respirations

7. Wash your hands.
8. Immediately record the pulse rate, date, time, and method used (radial). Notify your supervisor if the pulse is less than 60 beats per minute, over 100 beats per minute, or if the rhythm is irregular. Record the respiratory rate and the pattern or character of breathing.



1. Explain the importance of monitoring vital signs

When measuring and recording blood pressure manually, Keep these points in mind:

- The cuff must first be completely deflated
- Ask the client to remain still and quiet during the measurement
- It is not always easy to perfect the skill of hearing the first and last sounds of the BP. HHAs may have to do the procedure over and over again and check for correct results
- Remember to wash hands

Measuring and recording blood pressure manually

Equipment: sphygmomanometer, stethoscope, alcohol wipes, pen and paper

Do not check blood pressure if the client has smoked, eaten food, drunk alcohol or fluids containing caffeine, or exercised in the last 30 minutes.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Before using the stethoscope, wipe diaphragm and earpieces with alcohol wipes.
5. Ask the client to roll up his sleeve so that his upper arm is exposed. Do not measure blood pressure over clothing.

Measuring and recording blood pressure manually

6. Position the client's arm with the palm up. The arm should be level with the heart.
7. With the valve open, squeeze the cuff to make sure it is completely deflated.
8. Place the blood pressure cuff snugly on client's upper arm. The center of the cuff with sensor/arrow is placed over the brachial artery (1 to 1½ inches above the elbow toward inside of elbow).



Measuring and recording blood pressure manually

9. Ask the client to remain still and quiet during the measurement.
10. Locate the brachial pulse with fingertips.
11. Place the earpieces of the stethoscope in your ears.
12. Place the diaphragm of the stethoscope over the brachial artery.
13. Close the valve (clockwise) until it stops. Do not over-tighten it.
14. Inflate the cuff to between 160 mm Hg to 180 mm Hg. If a beat is heard immediately upon cuff deflation, completely deflate cuff. Reinflate cuff to no more than 200 mm Hg.



Measuring and recording blood pressure manually

15. Open the valve slightly with thumb and index finger. Deflate the cuff slowly.
16. Watch the gauge and listen for sound of pulse.
17. Remember the reading at which the first clear pulse sound is heard. This is the systolic pressure.
18. Continue listening for a change or muffling of pulse sound. The point of a change or the point at which the sound disappears is the diastolic pressure. Remember this reading.
19. Open the valve to deflate cuff completely. Remove cuff.
20. Wash your hands.

Measuring and recording blood pressure manually

21. Immediately record both the systolic and diastolic pressures. Record the numbers like a fraction, with the systolic reading on top and the diastolic reading on the bottom (for example: 110/70). Note which arm was used. Use RA for right arm and LA for left arm. (You may need to note the client's position when blood pressure is measured, i.e. lying down, sitting, or standing.)
22. Wipe diaphragm and earpieces of the stethoscope with alcohol wipes. Store equipment.
23. Wash your hands.

1. Explain the importance of monitoring vital signs

When measuring and recording blood pressure electronically, Keep these points in mind:

- The cuff must first be completely deflated
- This measurement does not require the use of a stethoscope
- Results are delayed digitally
- Remember to wash hands

Measuring and recording blood pressure electronically

Equipment: electronic blood pressure machine, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Ask the client to roll up his sleeve so that his upper arm is exposed. Do not measure blood pressure over clothing.
5. Position the client's arm with his palm up. The arm should be level with the heart.
6. Make sure the cuff is completely deflated. Place the blood pressure cuff snugly on the client's upper arm. The center of the cuff with sensor/arrow is placed over the brachial artery (1–1½ inches above the elbow, toward the inside of the elbow).

Measuring and recording blood pressure electronically

7. Ask the client to remain still and quiet during the measurement.
8. Turn on the blood pressure machine and press the start button.
9. When the measurement is complete, the reading will be displayed on the screen and the machine may beep. The cuff should deflate.
10. Remove the cuff.
11. Wash your hands.
12. Immediately record both the systolic and diastolic pressures that are displayed on the screen. Note which arm was used.
13. Store equipment.
14. Wash your hands.

1. Explain the importance of monitoring vital signs

Pain is not a vital sign, but it is important to monitor and manage. HHAs should keep these points in mind:

- Pain is an uncomfortable, subjective, and personal experience
- Ask questions to get accurate information and immediately report the answers to a supervisor
- Take complaints of pain seriously
- Pain is not a normal part of aging
- Use methods listed on page 251 in textbook to reduce pain

1. Explain the importance of monitoring vital signs

When measuring and recording weight of an ambulatory client, HHAs should keep these points in mind:

- Weight changes may indicate problems
- Weighing must be done at the same time of day each time.
- Provide for privacy
- Clothing should not be different and the bladder should be empty for an accurate weight
- The client should not lean on or touch the scales, as that may interfere with the reading
- Immediately record the weight in pounds or kilograms, depending on agency policy
- Remember to wash hands

Measuring and recording weight of an ambulatory client

Equipment: bathroom scale or standing scale, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If using a bathroom scale, set the scale on a hard surface (not on carpet) in a place the client can get to easily.

Measuring and recording weight of an ambulatory client

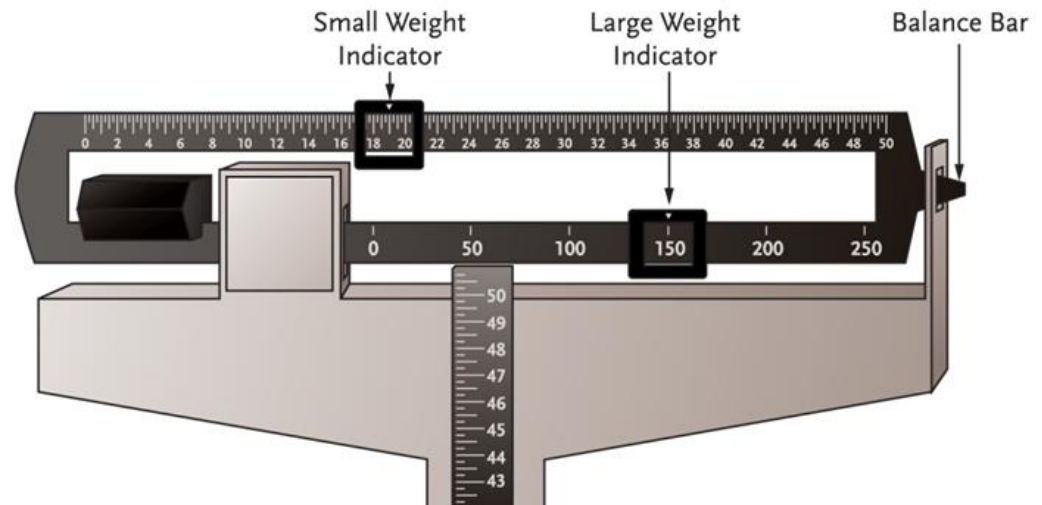
5. Make sure the client is wearing non-skid shoes before walking to scale.
6. Start with the scale balanced at zero before weighing the client.
7. Help client step onto the center of the scale as needed. Be sure she is not holding, touching, or leaning against anything. This interferes with weight measurement. However, do not force someone to let go if she is holding on to something. If you are unable to obtain a weight, notify your supervisor.

Measuring and recording weight of an ambulatory client

8. Determine the client's weight.

Using a bathroom scale: Read the weight on the display screen or when the dial has stopped moving.

Using a standing scale: Balance the scale by making the balance bar level. Move the small and large weight indicators until the bar balances. Read the two numbers shown (on the small and large weight indicators) when the bar is balanced. Add these two numbers together. This is the client's weight.



Measuring and recording weight of an ambulatory client

9. Help the client to safely step off scale before recording weight. Help her back into a comfortable position.
10. Wash your hands.
11. Immediately record the weight. Report any changes in client's weight to your supervisor.
12. Store the scale if it was moved.
13. Wash your hands.

1. Explain the importance of monitoring vital signs

When measuring and recording height of a client, HHAs should keep these points in mind:

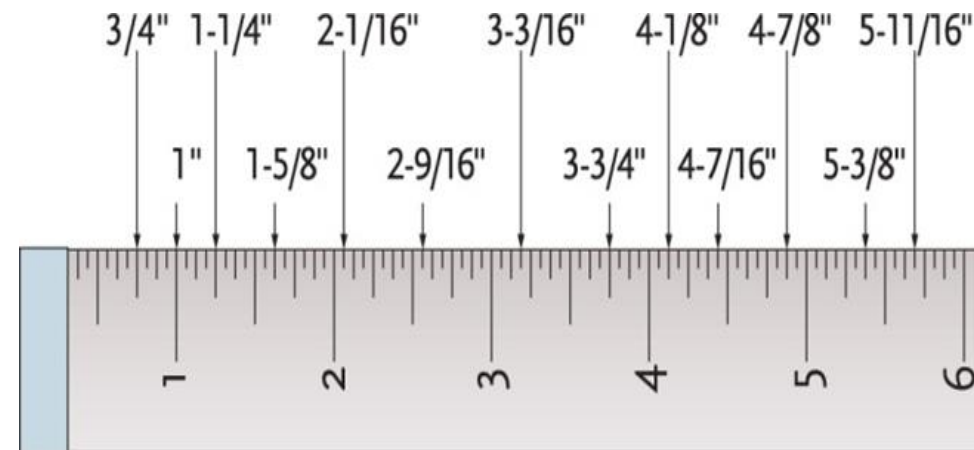
- Procedure will be different for bedbound and ambulatory clients
- Remember to wash hands

Measuring and recording height of a client

Some clients will be unable to get out of bed. If so, height can be measured using a tape measure.

Equipment: tape measure, pencil, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.



Measuring and recording height of a client

4. Position the client lying straight in bed, flat on his back with arms and legs at his sides. Be sure the bed sheet is smooth underneath the client.
5. Make a pencil mark on the sheet at the top of the head.
6. Make another mark at the client's heel.



Measuring and recording height of a client

7. With the tape measure, measure the distance between the marks.
8. Wash your hands.
9. Immediately record the height.
10. Store equipment.
11. Wash your hands.

For clients who can get out of bed, you will measure height while they stand against a wall.

Equipment: tape measure, pencil, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.

Measuring and recording height of a client

4. Have the client stand with his back to the wall, with his arms at his sides and without shoes. A hard floor is better than carpet.
5. Make a pencil mark on the wall at the top of the client's head.
6. To determine the client's height, ask the client to step away. Use the tape measure to measure the distance between the pencil mark and the floor.
7. Wash your hands.
8. Immediately record the height.
9. Store equipment.
10. Wash your hands.

Measuring and recording height of a client

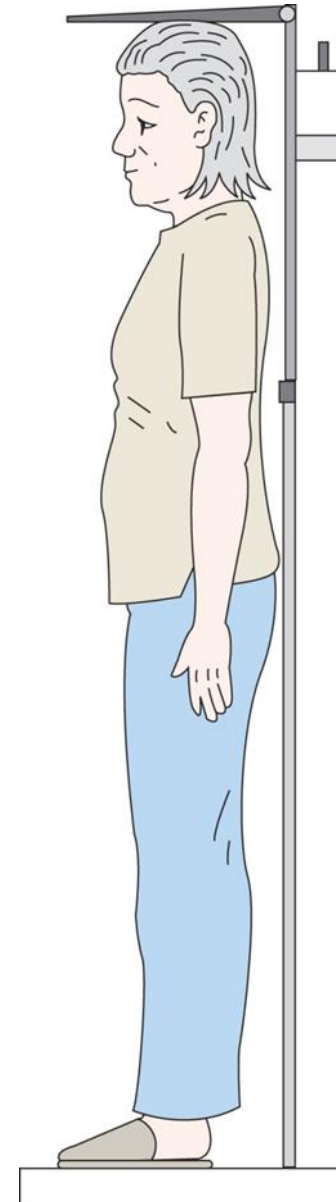
For clients who can get out of bed, you can also measure height using a standing scale.

Equipment: standing scale, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Make sure the client is wearing nonskid shoes before walking to scale.
5. Help client to step onto scale, facing away from the scale.

Measuring and recording height of a client

6. Ask client to stand straight if possible. Help as needed.
7. Pull up measuring rod from back of the scale and gently lower the rod until it rests flat on the client's head.
8. Determine the client's height.

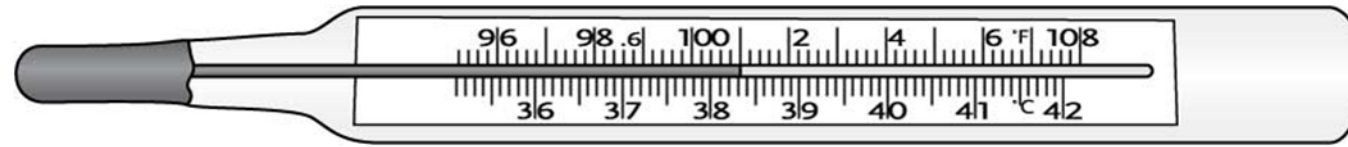


Measuring and recording height of a client

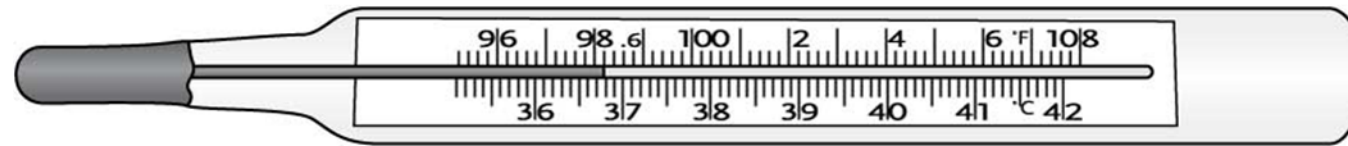
9. Assist the client in stepping off scale before recording height. Make sure that the measuring rod does not hit the client on the head while trying to help the client off of the scale.
10. Wash your hands.
11. Immediately record the height.

Handout 14-1: Thermometer Worksheet

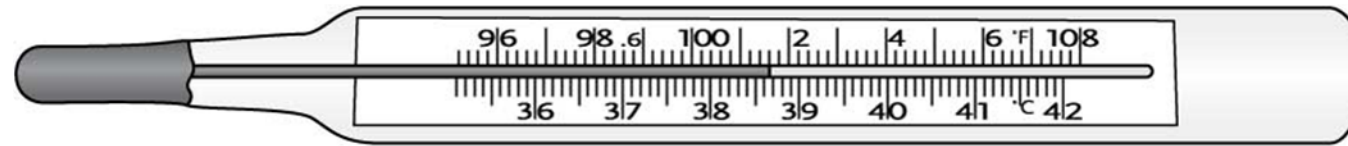
Write the temperature reading to the nearest tenth degree underneath each of the examples below



1. Reading: _____



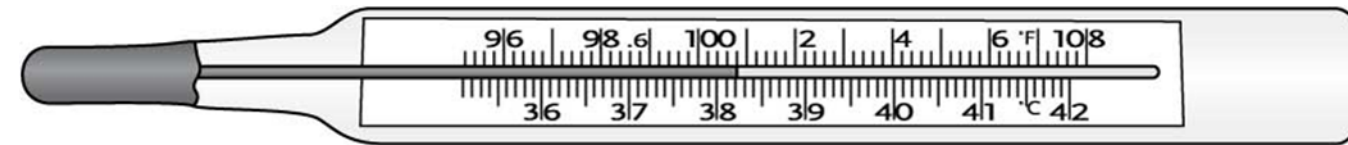
2. Reading: _____



3. Reading: _____



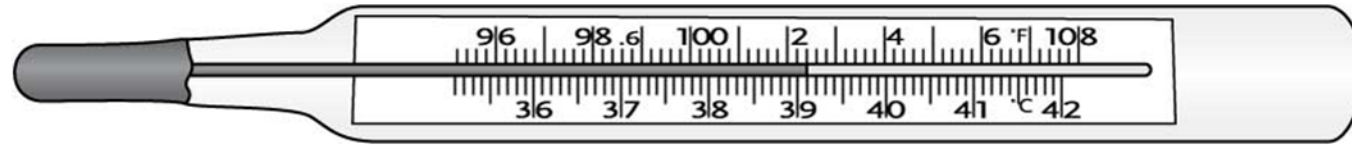
4. Reading: _____



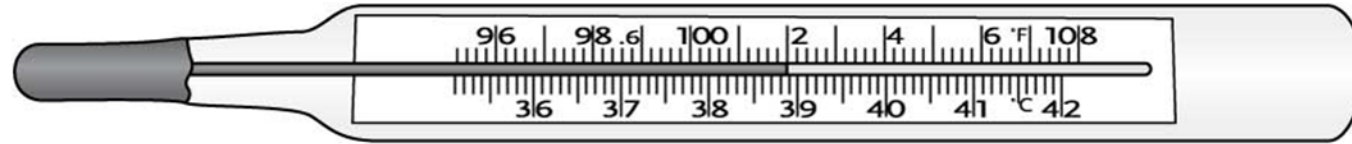
5. Reading: _____

Handout 14-1: Thermometer Worksheet (cont'd)

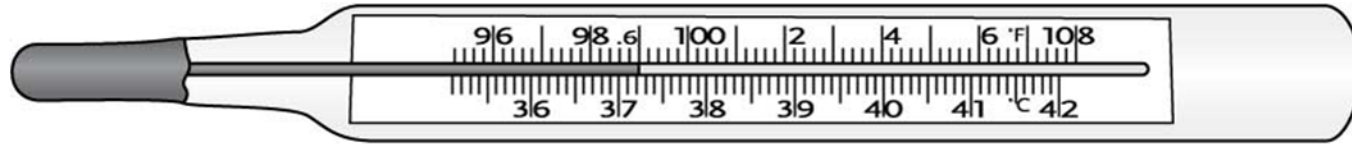
14



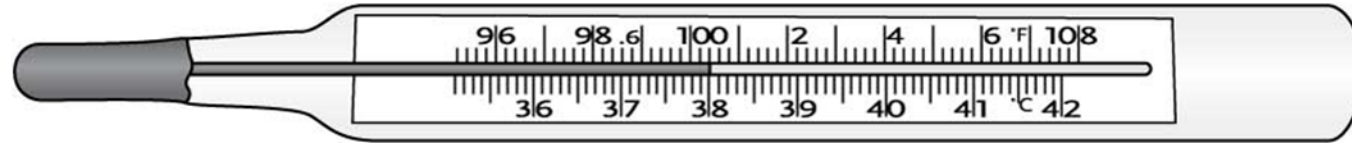
6. Reading: _____



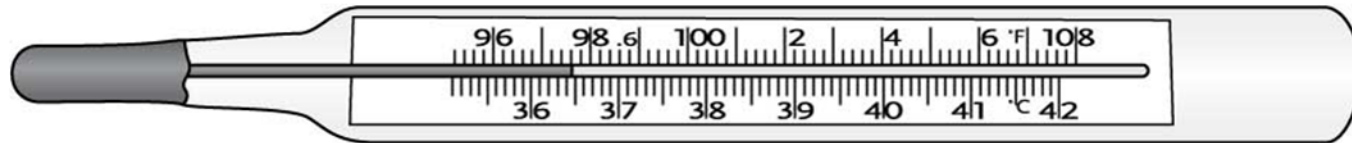
7. Reading: _____



8. Reading: _____



9. Reading: _____



10. Reading: _____

2. List three types of specimens that may be collected from a client

Define the following terms:

specimen

a sample that is used for analysis in order to try to make a diagnosis.

sputum

mucus coughed up from the lungs.

stool

feces.

hat

in health care, a collection container that is sometimes inserted into a toilet to collect and measure urine or stool.

2. List three types of specimens that may be collected from a client

Define the following terms:

routine urine specimen

a urine specimen that is collected any time a person voids.

clean-catch specimen

a urine specimen that does not include the first and last urine that is voided

24-hour urine specimen

urine specimen consisting of all urine voided in a 24-hour period.

2. List three types of specimens that may be collected from a client

HHAs should understand these points about specimens:

- Three types of specimens are sputum, stool, and urine specimens
- HHAs must wear gloves for these procedures
- Labeling and storing specimens correctly is important
- Most agencies' specimen containers have specific instructions to be followed

2. List three types of specimens that may be collected from a client

Guidelines for collecting a sputum specimen include the following:

- Proper PPE is important for this procedure, i.e. gloves and a mask
- Early morning is the best time to collect sputum
- Show a specimen kit for this procedure
- Excess sputum must be wiped from the container, especially the outside area
- Remember to wash hands

Collecting a sputum specimen

Equipment: specimen container and lid, completed label (labeled with client's name, date of birth, address, date, and time), specimen bag, tissues, gloves, N95 mask

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on the mask and gloves.
5. Stand behind the client if the client can hold the specimen container by himself. Ask the client to cough deeply, so that sputum comes up from the lungs. To prevent the spread of infectious material, give the client tissues to cover his mouth while coughing. Ask the client to spit the sputum into the specimen container.

Collecting a sputum specimen

6. When you have obtained a good sample (about two tablespoons of sputum), cover the container tightly. Wipe any sputum off the outside of the container with tissues. Discard the tissues. Apply the label, place the container in a clean specimen bag (or plastic bag), and seal the bag.
7. Remove and discard your gloves and mask.
8. Wash your hands.
9. Document the procedure.

2. List three types of specimens that may be collected from a client

Guidelines for collecting a stool specimen include the following:

- Urine and toilet paper should not be included in the sample
- Remove and discard gloves and wash hands before leaving the room. Upon return, put on clean gloves
- Perineal care may be necessary following the collection of the stool specimen
- Both the HHA and the client must wash hands after the collection
- HHAs should be familiar with what a specimen container looks like
- Remember to wash hands

Collecting a stool specimen

Equipment: specimen container and lid, completed label (labeled with client's name, date of birth, address, date, and time), specimen bag, 2 tongue blades, 2 pairs of gloves, bedpan (if client cannot use a portable commode or toilet), hat for toilet (if client uses commode or toilet), plastic bag, toilet paper, disposable wipes, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. When the client is ready to move his bowels, ask him not to urinate at the same time and not to put toilet paper in with the sample. Provide a plastic bag to discard toilet paper separately.

Collecting a stool specimen

6. Fit hat to toilet or commode, or provide client with bedpan.
7. Make sure the bed is in its lowest position. Place toilet paper, disposable wipes, and a bell or other way to call you within the client's reach. Ask client to clean his hands with a wipe when finished if he is able.
8. Remove and discard your gloves. Wash your hands. Leave the room and close the door.
9. When called by the client, return and wash your hands. Put on clean gloves. Give perineal care if help is needed.
10. Using the two tongue blades, take about two tablespoons of stool and put it in the container. Without touching the inside of the container, cover it tightly. Apply the label, place container in a clean specimen bag, and seal the bag.
11. Wrap the tongue blades in toilet paper and put them in plastic bag with used toilet paper. Discard bag in proper container.

Collecting a stool specimen

12. Empty bedpan or container into the toilet. Turn the faucet on with a paper towel. Rinse the bedpan or container with cold water first and empty it into the toilet. Flush the toilet. Then clean the bedpan or container with hot, soapy water and store. Store the equipment.
13. Store the specimen properly.
14. Remove and discard gloves.
15. Wash your hands.
16. Document the procedure. Note amount and characteristics of stool.

2. List three types of specimens that may be collected from a client

HHAs should remember these points when collecting a routine urine specimen:

- Ask clients not to put toilet paper in with the specimen
- Remove and discard gloves and wash hands before leaving the room. Upon return, wash hands and put on clean gloves
- The HHA should wipe off the outside of the container with a paper towel and label it correctly
- Be familiar with what a kit for collecting this specimen looks like; it may vary from agency to agency
- Remember to wash hands

Collecting a routine urine specimen

Equipment: specimen container and lid, completed label (labeled with client's name, date of birth, address, date, and time), specimen bag, 2 pairs of gloves, bedpan or urinal (if client cannot use a portable commode or toilet), hat for toilet (if client uses portable commode or toilet), plastic bag, toilet paper, disposable wipes, paper towels, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Fit hat to toilet or commode, or provide client with bedpan. Ask client to void into the hat, urinal, or bedpan. Ask the client not to put toilet paper in with the sample. Provide a plastic bag to discard toilet paper separately.

Collecting a routine urine specimen

6. Make sure the bed is in its lowest position. Place toilet paper, disposable wipes, and a bell or other way to call you within the client's reach. . Ask client to clean his hands with a wipe when finished if he is able.
7. Remove and discard gloves. Wash your hands. Leave the room and close the door.
8. When called, return and wash your hands. Put on clean gloves. Give perineal care if help is needed.
9. Take bedpan, urinal, or hat to the bathroom.
10. Pour urine into the specimen container. Specimen container should be at least half full.
11. Cover the urine container with its lid. Do not touch the inside of container. Wipe off the outside with a paper towel and discard the paper towel.
12. Apply the label, place the container in a clean specimen bag, and seal the bag.

Collecting a routine urine specimen

13. Discard extra urine in the toilet. Turn the faucet on with a paper towel. Rinse the bedpan, urinal, or hat with cold water and empty it into the toilet. Flush the toilet. Store equipment.
14. Remove and discard your gloves.
15. Wash your hands.
16. Document the procedure. Note amount and characteristics of urine.

2. List three types of specimens that may be collected from a client

HHAs should remember these points when collecting a clean-catch (midstream) urine specimen:

- The labia of the female client or the penis of the male client must be cleaned before collecting this specimen
- The client must start to urinate, stop midstream, and then start again so the urine collected is not the first urine voided at that time
- When the container is half full, the specimen is completed and the lid is placed on it

2. List three types of specimens that may be collected from a client

Collecting a clean-catch (midstream) urine specimen (cont'd):

- Wipe off the outside of the container with a paper towel and label it correctly
- Be familiar with what a kit for collecting this specimen looks like; it may vary from agency to agency
- Remember to wash hands

Collecting a clean-catch (midstream) urine specimen

Equipment: specimen kit with container and lid (labeled with client's name, date of birth, address, date, and time), specimen bag, cleansing wipes, gloves, bedpan or urinal (if client cannot use a portable commode or toilet), plastic bag, toilet paper, disposable wipes, paper towels, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Open the specimen kit. Do not touch the inside of the container or the inside of the lid.

Collecting a clean-catch (midstream) urine specimen

6. If client cannot clean his perineal area, you will do it. Use the cleansing wipes to do this. Be sure to use a clean area of the wipe or a clean wipe for each stroke. See bed bath procedure in Chapter 13 for a reminder on how to give perineal care.
7. Ask the client to urinate a small amount into the bedpan, urinal, or toilet, and to stop before urination is complete.
8. Place the container under the urine stream and have the client start urinating again. Fill the container at least half full. Ask the client to stop urinating and remove the container. Have the client finish urinating in bedpan, urinal, or toilet.
9. After urination, provide a plastic bag so that the client can discard the toilet paper. Give perineal care if help is needed. Ask the client to clean his hands with a wipe if he is able.

Collecting a clean-catch (midstream) urine specimen

10. Cover the urine container with its lid. Do not touch the inside of container. Wipe off the outside with a paper towel and discard.
11. Apply label, place the container in a clean specimen bag, and seal the bag.
12. If using a bedpan or urinal, discard extra urine in toilet. Turn the faucet on with a paper towel. Rinse the bedpan or urinal with cold water and empty it into the toilet. Flush the toilet. Store equipment.
13. Remove and discard your gloves.
14. Wash your hands.
15. Document the procedure. Note amount and characteristics of urine.

2. List three types of specimens that may be collected from a client

HHAs should remember these points when collecting a 24-hour urine specimen:

- The label must include the beginning and ending times of collection of the specimen
- The specimen may need to be kept cold at all times during the 24 hours of the collection process
- The urine from the first morning urination is discarded. The 24 hours begins after that voiding and ends 24 hours later after the early morning urination

2. List three types of specimens that may be collected from a client

Collecting a 24-hour urine specimen (cont'd):

- The specimens may be kept at room temperature, in a special refrigerator, or on ice
- The client and family must be carefully instructed not to not discard any urine during the collection period, or the entire 24-hour collection will have to be started again
- Remember to wash hands

Collecting a 24-hour urine specimen

Equipment: 24-hour specimen container with lid, completed label (labeled with client's name, date of birth, address, date, and time), bedpan or urinal (for clients confined to bed), hat for toilet (if client can use portable commode or toilet), bucket of ice (if the urine must be kept cold; a clearly-marked container may also be able to be put in the refrigerator), funnel (if the container opening is small), gloves, toilet paper, disposable wipes, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. When beginning the collection, have the client completely empty his bladder. Discard the urine and note the exact time of this voiding. The collection will run until the same time the next day.

Collecting a 24-hour urine specimen

5. Wash hands and put on gloves each time the client voids.
6. Ask the client not to put toilet paper in with the sample each time the client voids. Pour urine from the bedpan, urinal, or hat into the container, using the funnel as needed. Container may be stored at room temperature, on ice, or in the refrigerator. Follow the supervisor's instructions.
7. After each voiding, help as necessary with perineal care. Ask the client to clean his hands with a wipe after each voiding if he is able.
8. Be sure the client or family member understands that all urine is to be saved, even when you are gone. Demonstrate how to pour the urine into the container. Remind them to store the container properly (room temperature, in the bucket of ice, or in the refrigerator if ordered).
9. Clean equipment after each voiding.

Collecting a 24-hour urine specimen

10. Remove and discard gloves.
11. Wash your hands.
12. Document the time of the last void before the 24-hour collection period began, and the last void of the 24-hour collection period.

2. List three types of specimens that may be collected from a client

Review these facts about urine straining:

- Process of pouring urine through a fine filter to catch particles that are present to diagnose kidney stones
- Stones can be tiny or large.
- Any particles that are found are sent to the laboratory in a clean specimen bag.
- A routine urine specimen is needed, then the HHA pours it through the strainer or gauze.

3. Describe the importance of fluid balance and explain intake and output (I&O)

Define the following terms:

intake, or input

the fluid a person consumes.

output

fluid that is eliminated from the body through urine, feces, and vomitus, as well as perspiration and moisture that is exhaled into the air; also includes wound drainage.

fluid balance

taking in and eliminating equal amounts of fluid.

emesis

the act of vomiting, or ejecting stomach contents through the mouth and/or nose.

3. Describe the importance of fluid balance and explain intake and output (I&O)

Remember:

To maintain health, the body must take in a certain amount of fluid each day. Generally, a healthy person needs to take in about 64 ounces of fluid each day. The fluid a person consumes is called intake, or input. If a person's intake is not in a healthy range, he or she can become dehydrated.

3. Describe the importance of fluid balance and explain intake and output (I&O)

Remember:

All fluid taken in each day cannot remain in the body. It must be eliminated as output. Output includes urine, feces (including diarrhea), and vomitus, as well as perspiration and moisture in the air that a person exhales.

If a person's intake exceeds his or her output, fluid builds up in body tissues. This fluid retention can cause medical problems and discomfort.

Key Material: 14-2: Conversion Table

One ounce equals 30 milliliters. To convert ounces to milliliters, multiply the number of ounces by 30.

1 oz. = 30 mL

2 oz. = 60 mL

3 oz. = 90 mL

4 oz. = 120 mL

5 oz. = 150 mL

6 oz. = 180 mL

7 oz. = 210 mL

8 oz. = 240 mL

1 tsp. = 5 mL

1 tbsp. = 15 mL

2 tbsp. = 1 oz. = 30 mL

$\frac{1}{4}$ cup = 2 oz. = 60 mL

$\frac{1}{2}$ cup = 4 oz. = 120 mL

1 cup = 8 oz. = 240 mL



Activity

Find a partner. Each write an intake problem for different liquids in ounces and create a different I&O sheet with it. Exchange your sheet with your partner and convert your partner's problem from ounces to milliliters (mL). Pass the problem back to the partner who wrote it to check the conversions.

3. Describe the importance of fluid balance and explain intake and output (I&O)

HHAs should remember these points when measuring and recording intake and output:

- Measuring containers are necessary for this procedure. There are different types of measuring items, including some that are marked in ounces and milliliters (mL)
- Measuring containers should be placed on a flat surface, and the urine should be measured at eye level
- It is important not to splash urine when emptying graduate

Measuring and recording intake and output

Equipment: I&O sheet, graduate (measuring container), pen and paper

Measure intake first.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Using the graduate, measure the amount of fluid a client is served. Note the amount on paper, not in the visit notes. (if the amount is between measurement lines you may need to round up to the nearest 25 mL. Follow policy.)

Measuring and recording intake and output

5. When client has finished a meal or snack, measure any leftover fluids. Note this amount on paper.
6. Subtract the leftover amount from the amount served. If you have measured in ounces, convert to milliliters (mL) by multiplying by 30.
7. Document the amount of fluid consumed (in mL) in the visit notes and/or in the input column of I&O record, as well as the time and type of fluid consumed. Report anything unusual, such as the client refuses to drink, drinks very little, is nauseated, etc.
8. Wash your hands.

Measuring and recording intake and output

Measuring output is the other half of monitoring fluid balance.

Equipment: I&O sheet, graduate, gloves, pen and paper

1. Wash your hands.
2. Put on gloves before handling a bedpan or urinal.
3. Pour the contents of the bedpan or urinal into the graduate. Do not spill or splash any of the urine.
4. Place graduate on a flat surface. Measure the amount of urine at eye level. Keep the container level. Note the amount on paper, converting to mL if necessary. (If the amount is between measurement lines, you may need to round up to the nearest 25 mL. Follow policy.)



Measuring and recording intake and output

5. After measuring urine, empty graduate into toilet without splashing.
6. Turn the faucet on with a paper towel. Rinse graduate with cold water and pour rinse water into the toilet.
7. Rinse bedpan/urinal with cold water and pour rinse water into the toilet. Flush the toilet. Clean and store equipment.
8. Remove and discard gloves.
9. Wash your hands before recording output.
10. Immediately document the time and amount of urine in output column on sheet. For example: 1545 hours 200 mL urine.

To measure vomitus, pour from basin into measuring container, then discard in the toilet. If client vomits on the bed or floor, estimate the amount. Document emesis (EM-e-sis, or vomiting) and amount in the visit notes and/or in input column of I&O sheet.

3. Describe the importance of fluid balance and explain intake and output (I&O)

HHAs should remember these points when observing, reporting, and documenting emesis:

- It is important to offer the client comfort measures, wear gloves, remove soiled linens, and offer a drink or toothbrush afterwards
- The client should have privacy if possible. Clients may be very sensitive about vomiting in front of others
- The basin should be covered with a paper towel as quickly as possible

Observing, reporting and documenting emesis

Equipment: emesis basin, 2 pairs of gloves, pen and paper or I&O sheet, supplies for oral care

1. Put on gloves.
2. Make sure the head is up or turned to one side. Place an emesis basin under the chin. Remove it when vomiting has stopped.
3. Remove soiled linens or clothes. Set aside for laundering. Replace with fresh linens or clothes.
4. If client's I&O is being monitored, measure and note amount of vomitus.
5. Flush vomit down the toilet unless vomit is red, has blood in it, or looks like wet coffee grounds. If these symptoms are observed, call your supervisor before disposing of the vomit. After disposing of vomit, wash and store basin.
6. Remove and discard gloves.
7. Wash your hands.
8. Put on clean gloves.

Observing, reporting and documenting emesis

9. Provide comfort to client: wipe face and mouth, position comfortably, and offer a drink of water or oral care. Oral care helps get rid of the taste of vomit in the mouth.
10. Launder soiled linens and clothes promptly in hot water.
11. Remove and discard gloves.
12. Wash your hands again.



Observing, reporting and documenting emesis

13. Document time, amount, color, and consistency of vomitus.
14. Report to your supervisor immediately and get instructions for diet.

4. Describe the guidelines for catheter care

Define the following terms:

catheter

a thin tube inserted into the body that is used to drain fluids or inject fluids.

urinary catheter

a catheter that is used to drain urine from the bladder

straight catheter

a catheter that does not remain inside the person; it is removed immediately after urine is drained or collected.

4. Describe the guidelines for catheter care

Define the following terms:

indwelling catheter

a type of catheter that remains inside the bladder for a period of time; urine drains into a bag also called *Foley catheter*.

condom catheter

catheter that has an attachment on the end that fits onto the penis; also called an *external* or *Texas catheter*.

4. Describe the guidelines for catheter care

Remember:

HHAs should never insert, irrigate or remove catheters.

4. Describe the guidelines for catheter care

HHAs should understand these guidelines about catheter care:

- It is important to wash hands thoroughly before giving catheter care
- Keep genital area clean
- Keep drainage bag lower than the client's hips or bladder to prevent infection and let gravity allow drainage
- Keep drainage bag off the floor
- Prevent kinks, twists, and pressure on tubing
- Report bloody urine, stoppage of urine, bag filling suddenly, bag being out of place, leakage, client discomfort, and odor
- Collect urine specimens directly from the catheter, not the bag

4. Describe the guidelines for catheter care

Remember:

Urine is infectious waste matter and must be handled with gloves on and disinfected with solutions of bleach and water.

4. Describe the guidelines for catheter care

Think about this question:

Why is it important to offer fluids to clients who have catheters in place?

4. Describe the guidelines for catheter care

Remember:

Wear gloves and wash your hands when providing any type of catheter care.

4. Describe the guidelines for catheter care

HHAs should remember these points when providing catheter care:

- Be familiar with what an actual catheter, tubing, and drainage bag look like
- Use soap and water or antiseptic wipes
- Always wipe down the tubing away from the body
- Wipe once and use a new wipe or clean area of a washcloth each time. This will lower the risk of introducing bacteria into the urethral opening
- It is important to wear gloves and wash hands

Providing catheter care

Equipment: bath blanket, disposable bed protector, bath basin with warm water, soap, 2-4 washcloths or disposable wipes, towel, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe level, usually waist high. If bed is movable, lock the bed wheels.
5. Lower the head of the bed. Position client lying flat on her back.
6. Remove or fold back top bedding, keeping client covered with bath blanket.

Providing catheter care

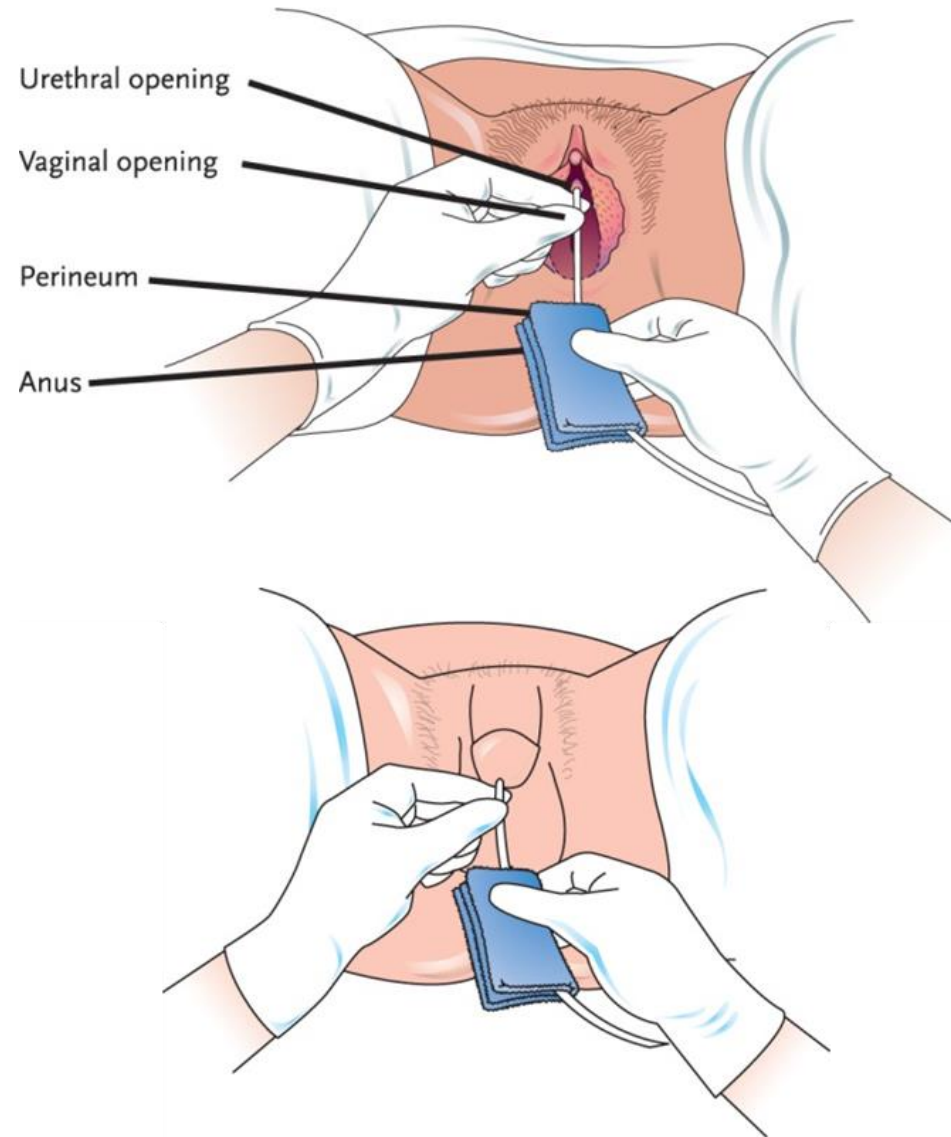
7. Test the water temperature against the inside of your wrist. Water temperature should be no higher than 105°F. Have the client check the temperature to see if it is comfortable. Adjust if necessary.
8. Put on gloves.
9. Ask the client to flex her knees and raise her buttocks off the bed by pushing against the mattress with her feet. Place a clean bed protector under her buttocks.
10. Expose only the area necessary to clean the catheter. Avoid overexposing the client.
11. Place towel under catheter tubing before washing.
12. Wet washcloth in the basin. Apply soap to the washcloth. Clean area around the meatus. Use a clean area of the washcloth for each stroke.

Providing catheter care

13. Hold catheter near the meatus. Avoid tugging the catheter throughout the procedure.
14. Clean at least four inches of catheter nearest the meatus. Move in only one direction, away from the meatus. Use a clean area of the washcloth for each stroke.
15. Dip a clean washcloth in the water. Rinse the area around the meatus, using a clean area of washcloth for each stroke. With the towel, dry the area around the meatus.

Providing catheter care

16. Dip a clean washcloth in the water. Rinse at least four inches of catheter nearest the meatus. Move in only one direction, away from the meatus. Use a clean area of the washcloth for each stroke.
17. With the towel, dry at least four inches of the catheter nearest the meatus. Move in only one direction, away from the meatus. Do not tug the catheter.
18. Remove the bed protector from under the client and discard. Remove towel from under the catheter tubing and place it in the proper container.



Providing catheter care

19. Place linen and used washcloths in proper containers. Empty the basin into the toilet and flush toilet. Clean and store the basin.
20. Remove and discard gloves.
21. Wash your hands.
22. Replace top covers and remove bath blanket and place it in the proper container.
23. If you raised an adjustable bed, return it to its lowest position.
24. Help the client dress. Arrange the covers. Check that the catheter tubing is free from kinks and twists and that it is securely taped to the leg.
25. Wash your hands again.
26. Document procedure and any observations.

4. Describe the guidelines for catheter care

HHAs should remember these points when emptying the catheter drainage bag:

- The drainage system is a closed system so that no infection can enter. It must remain a closed system, even when being emptied
- The drain spout should be cleaned with alcohol every time it is emptied, and the spout and clamp should not touch the graduate
- Urine color, smell, clarity, and amount should be observed
- It is important to wear gloves and wash hands

Emptying the catheter drainage bag

Equipment: graduate (measuring container), alcohol wipes, paper towels, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Place a paper towel on the floor under the drainage bag. Place the graduate on the paper towel.

Emptying the catheter drainage bag

6. Open the clamp on the drainage bag so that urine flows out of the bag and into the graduate. Do not let spout or clamp touch the graduate.
7. When urine has drained out of the bag, close the clamp. Using alcohol wipes, clean the drain spout. Replace the drain spout in its holder on the bag.
8. Go into the bathroom. Place graduate on a flat surface and measure at eye level. Note the amount and the appearance of the urine. Empty into toilet and flush toilet.



Emptying the catheter drainage bag

9. Clean and store graduate. Discard paper towels.
10. Remove and discard your gloves.
11. Wash your hands.
12. Document procedure and amount of urine.

4. Describe the guidelines for catheter care

HHAs should remember these points when changing a condom catheter:

- There should be space between drainage tip and glans of penis
- Condom catheter is secured to penis with special tape applied in a spiral manner
- It is important to wear gloves and wash hands

Changing a condom catheter

Equipment: condom catheter and collection bag, catheter tape, gloves, plastic bag, bath blanket, disposable bed protector, gloves, supplies for perineal care

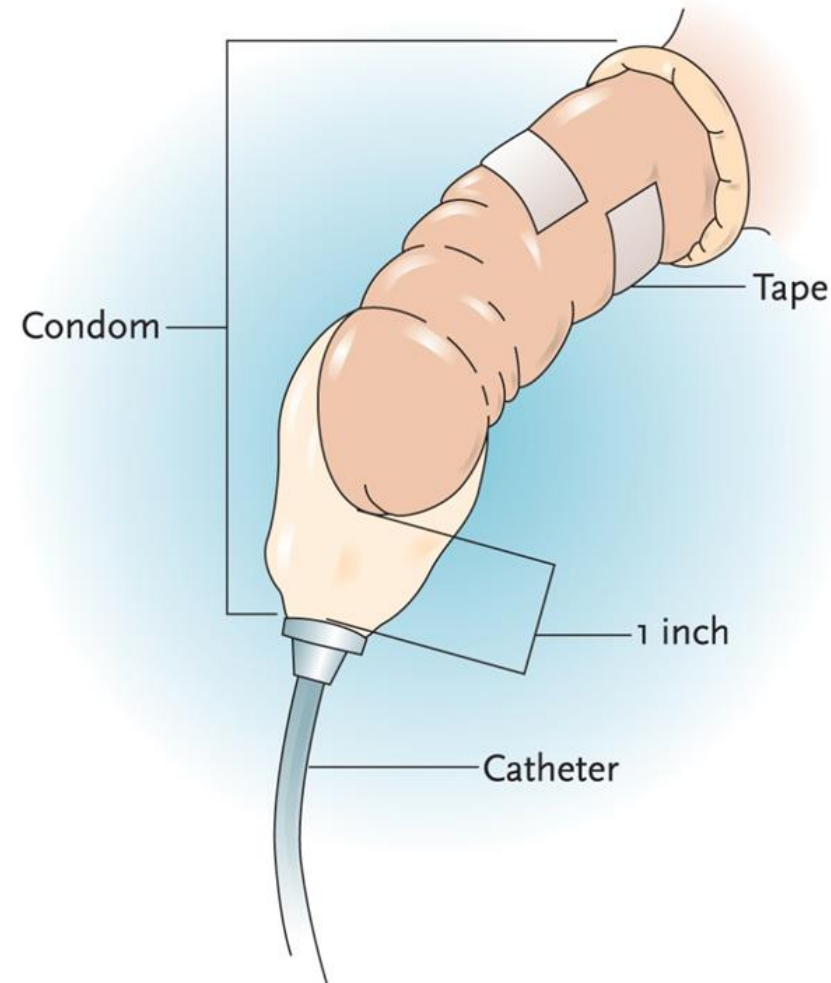
1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If bed is movable, lock bed wheels.
5. Lower head of bed. Position client lying flat on his back.
6. Remove or fold back top bedding, keeping client covered with bath blanket.
7. Put on gloves.
8. Place a clean bed protector under his perineal area including his buttocks.

Changing a condom catheter

9. Adjust bath blanket to only expose genital area.
10. Gently remove condom catheter. Place condom and tape in the plastic bag.
11. Assist as necessary with perineal care.
12. Move pubic hair away from the penis so it does not get rolled into the condom.

Changing a condom catheter

13. Hold penis firmly. Place condom at tip of penis and roll toward base of penis. Leave space (at least one inch) between the drainage tip and glans of penis to prevent irritation. If client is not circumcised, be sure that the foreskin is in normal position.
14. Secure condom to penis with special tape provided. Apply tape in a spiral manner. Never wrap tape all the way around penis because it can impair circulation.



Changing a condom catheter

15. Connect catheter tip to drainage tubing. Do not touch the tip to any object but the drainage tubing. Make sure tubing is not twisted or kinked.
16. Check to see if collection bag is secured to leg. Make sure drain is closed.
17. Remove and discard bed protector. Discard used supplies in plastic bag. Place soiled clothing and linens in proper containers. Clean and store supplies.
18. Remove and discard your gloves.
19. Wash your hands.
20. Replace top covers. Remove bath blanket and place it in the proper container. Make sure the client is comfortable. Make sure the client is comfortable. If you raised an adjustable bed, return it to its lowest position.
21. Wash your hands again.
22. Document procedure and any observations.

5. Explain the benefits of warm and cold applications

The following are important points about warm and cold applications:

- Heat relieves pain, reduces swelling, elevates temperature in the tissues, and increases blood flow, bringing more oxygen and nutrients to tissues
- Cold stops bleeding, prevents swelling, relieves pain, and brings down high fevers
- It is important to observe area for redness, pain, blisters, or numbness

Key Material 14-3: Warm and Cold Applications

Application	Temperature	Timing	Special Considerations
Warm compresses	No higher than 105° F	Remove after 20 minutes.	Cover with plastic wrap.
Warm soaks	No higher than 105° F	Check temperature every five minutes.	Observe for redness. Soak 15–20 minutes.
Hot water bottles	No higher than 105° F or 98° F for infants, small children, and older adults	20 minutes only	Fill 2/3 full. Provide privacy.
Sitz baths	No higher than 105° F	20 minutes only	Fill 2/3 full. Provide privacy.
Ice packs	Ice	Check after five minutes. Remove after 20 minutes.	Fill bag 2/3 full of ice. Cover bag; watch for blisters, redness, and white or pale color.
Cold compresses	Cold water with ice	Check after five minutes. Remove after 20 minutes.	Check for blisters, redness, and white or gray skin.

5. Explain the benefits of warm and cold applications

HHAs should remember these points when applying warm compresses:

- Be familiar with commercial-type warm compresses
- Plastic wrap can keep compresses warm and wet longer and to prevent getting the bed or client's bedclothes wet

Applying warm compresses

Equipment: washcloth or compress, plastic wrap, towel, basin

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill basin one-half to two-thirds full with warm water. Test water temperature against the inside of your wrist to ensure it is safe. Water temperature should be no higher than 105°F. Have client check water temperature. Adjust if necessary.

Applying warm compresses

5. Soak the washcloth in the water and wring it out. Immediately apply it to the area. Note the time. Quickly cover the washcloth with plastic wrap and a towel to keep it warm.



Applying warm compresses

6. Check the area every five minutes. Remove the compress if the area is red or numb or if the client complains of pain or discomfort. Change the compress if cooling occurs. Remove the compress after 20 minutes.
7. Discard plastic wrap. Empty basin in the toilet. Rinse basin and pour rinse water in the toilet. Flush the toilet. Clean and store basin and other supplies. Put laundry in hamper.
8. Wash your hands.
9. Document the time, length, site of procedure, and any observations.

5. Explain the benefits of warm and cold applications

HHAs should remember these points when administering warm soaks:

- Understand the importance of using the correct temperature (no higher than 105°F) and amount of time (15 to 20 min)
- Client may feel chilled, so use a bath blanket
- Carefully add warm water to basin periodically to keep water continuously warm

Administering warm soaks

Equipment: basin or bathtub (depending on the area to be soaked), bath blanket, towel, disposable absorbent pad

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill the basin or tub half full of warm water. Test water temperature against the inside of your wrist to ensure it is safe. Water temperature should be no higher than 105°F. Have client check water temperature. Adjust if necessary.
5. Place basin on a disposable absorbent pad (protective barrier), in a comfortable position for the client.

Administering warm soaks

6. Immerse the body part in the basin or help the client into the tub. Pad the edge of the basin with a towel if needed. Use a bath blanket to cover the rest of the client, if needed, for extra warmth.



Administering warm soaks

7. Check water temperature every five minutes. Add hot water as needed to maintain the temperature. Never add water hotter than 105°F to avoid burns. To prevent burns, ask the client not to add hot water. Observe the area for redness. Discontinue the soak if the client complains of pain or discomfort.
8. Soak for 15–20 minutes or as ordered in the care plan.
9. Remove basin or help the client out of the tub. Use the towel to dry client.
10. Drain the tub or empty basin in the toilet. Rinse basin and pour rinse water in the toilet. Flush the toilet. Clean and store basin and other supplies. Put laundry in hamper.
11. Wash your hands.
12. Document the time, length, and site of procedure. Report the client's response and any of your observations about the skin.

5. Explain the benefits of warm and cold applications

HHAs should remember these points when using a hot water bottle:

- Understand that temperature (different for adults and children) and amount of time are very important for this procedure
- Always cover water bottle and check skin every five minutes
- It is a good idea to practice filling the bottle and pressing out the excess air

Using a hot water bottle

Equipment: hot water bottle, cloth cover or towel

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill the bottle half full with warm water (no higher than 105°F, or 98°F for infants and small children or older adults).
5. Press out excess air and seal the bottle.
6. Dry the bottle and check for leaks. Cover with a cloth cover or towel.
7. Apply the bottle to the area ordered. Check skin every five minutes for redness or pain. If redness or pain are present, add cold water to the bottle to reduce the temperature.

Using a hot water bottle

8. Remove the bottle after 20 minutes or as ordered in the care plan.
9. Empty the hot water bottle. Wash and store supplies.
10. Wash your hands.
11. Document the time, length, and site of procedure. Document the client's response and any of your observations about the skin.

5. Explain the benefits of warm and cold applications

Define the following term:

sitz bath

a warm soak of the perineal area to clean perineal wounds and reduce inflammation and pain.

5. Explain the benefits of warm and cold applications

HHAs should remember these points when assisting with a sitz bath:

- The procedure given here is for the use of a disposable commercial-type sitz basin that sits on the commode. There is also a sitz chair that is used in facilities. In addition, sometimes the client is simply placed into a bathtub of water
- Gloves must be worn for this procedure. The client must be checked every five minutes and not left in the water for longer than 20 minutes. It is important to be familiar with the type of equipment used for this procedure

Assisting with a sitz bath

Equipment: disposable sitz bath, towels, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Fill the sitz bath two-thirds full with warm water. Place the disposable sitz bath on the toilet seat. Check the water temperature. Normally water temperature should be no higher than 105°F.
6. Help the client undress and sit on the sitz bath. A valve on the tubing connected to the bag allows the client or you to refill the water in the sitz bath with warm water.

Assisting with a sitz bath

7. You may be required to stay with the client for safety reasons. If you leave the room, check on the client every five minutes to make sure he or she is not dizzy or weak. Stay with a client who seems unsteady.
8. Help the client off of the sitz bath after 20 minutes. Provide towels and help with dressing if needed.
9. Clean and store supplies. Put laundry in hamper.
10. Remove and discard your gloves.
11. Wash your hands.
12. Document the procedure, including the time and length of procedure, the client's response, and the water temperature.

5. Explain the benefits of warm and cold applications

HHAs should remember these points when applying ice packs:

- The ice bag is only filled 2/3 full, excess air is removed, and it is always covered
- The area must be checked after five minutes and observed for blisters, paleness, and white or gray skin
- The client may feel chilled, so a blanket should be offered. The ice bag is removed after 20 minutes
- It is a good idea to practice and demonstrate this procedure on other students

Applying ice packs

Equipment: cold pack or sealable plastic bag and crushed ice, towel to cover pack or bag

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill plastic bag or ice pack one-half to two-thirds full with ice. Seal bag. Remove excess air. Cover bag or ice pack with towel.



Applying ice packs

5. Apply bag or pack to the area as ordered. Note the time. Use another towel to cover bag if it is too cold.
6. Check the area after five minutes for blisters, pale, white, or gray skin. Stop treatment if client complains of numbness or pain.
7. Remove ice after 20 minutes or as ordered in the care plan.
8. Return ice bag or pack to freezer. Put laundry in hamper.
9. Wash your hands.
10. Document the time, length, and site of procedure. Report the client's response and any of your observations about the skin.

5. Explain the benefits of warm and cold applications

HHAs should remember these points when applying cold compresses:

- Ice may be added to the water to keep it cold, but offer the client a blanket
- Cold compresses increase the risk for blisters, so the client must be checked every five minutes
- Two washcloths are used so that one can be soaking while the other is applied to the skin

Applying cold compresses

Equipment: basin filled with water and ice, 2 washcloths, protective pad, towels

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.

Applying cold compresses

4. Place bed protector under area to be treated. Rinse washcloth in basin and wring out. Cover the area to be treated with a towel. Apply cold washcloth to the area as directed. Change washcloths often to keep area cold.
5. Check the area after five minutes for blisters, pale, white, or gray skin. Stop treatment if client complains of numbness or pain.



Applying cold compresses

6. Remove compresses after 20 minutes or as ordered in the care plan. Give client towels as needed to dry the area.
7. Clean and store basin. Put laundry in hamper.
8. Wash your hands.
9. Document the time, length, and site of procedure. Report the client's response and any observations about the skin.

6. Explain how to apply nonsterile dressings

HHAs should remember these points when changing a dry dressing using nonsterile technique:

- HHAs do not usually work with sterile dressings
- Lift dressing off the wound; do not drag it over wound
- Change gloves after old dressing is removed
- Always observe dressing and wound for odor, amount and color of drainage, and any redness or swelling
- Only touch outer edges of the dressing when applying it
- Remember to wash hands

Changing a dry dressing using nonsterile technique

Equipment: package of square gauze dressings, adhesive tape, scissors, 2 pairs of gloves, plastic bag

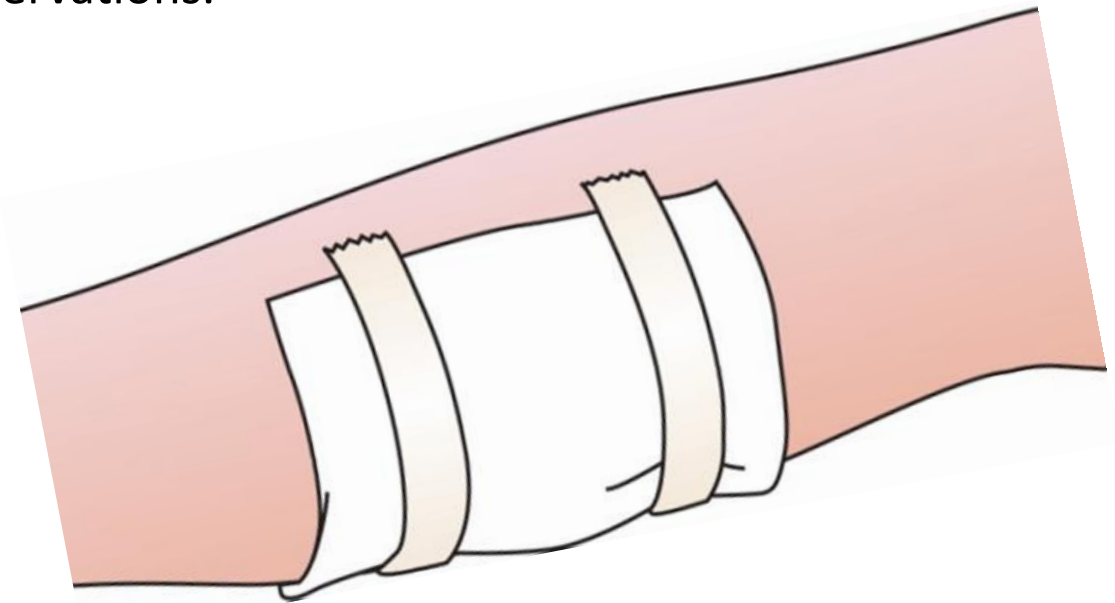
1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. With scissors, cut pieces of tape long enough to secure the dressing. Hang tape on the edge of a table within reach. Open the four-inch gauze square package without touching the gauze. Place the opened package on a flat surface.
5. Put on gloves.

Changing a dry dressing using nonsterile technique

6. Remove soiled dressing by gently peeling tape toward the wound. Lift dressing off the wound. Do not drag it over the wound. Observe the dressing for odor or drainage. Notice the color and size of the wound. Dispose of used dressing in the waste bag.
7. Remove gloves. Discard in the waste bag. Wash your hands.

Changing a dry dressing using nonsterile technique

8. Put on clean gloves. Touching only outer edges of new four-inch gauze, remove it from package. Apply it to the wound. Tape gauze in place. Secure it firmly.
9. Discard supplies.
10. Remove and discard gloves.
11. Wash your hands.
12. Document the procedure and your observations.



7. Describe the purpose of elastic stockings and how to apply them

Remember:

Antiembotic stockings (elastic stockings, compression stockings, TED hose) may prevent swelling and blood clots and promote circulation in the feet and hands.

Putting elastic stocking on a client

Equipment: elastic stockings

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. The client should be in the supine position (on her back) in bed. With client lying down, remove her socks, shoes, or slippers, and expose one leg. Expose no more than one leg at a time.

Putting elastic stocking on a client

5. Take one stocking and turn it inside out at least to the heel area.



Putting elastic stocking on a client

6. Gently place the foot of the stocking over toes, foot, and heel. Make sure the heel is in the right place (heel of foot should be in heel of stocking).



Putting elastic stocking on a client

7. Gently pull the top of stocking over foot, heel, and leg.
8. Make sure that there are no twists and wrinkles in the stocking after it is applied. It must fit smoothly. Make sure the heel of stocking is over the heel of foot. If the stocking has an opening in the toe area, make sure the opening is either over or under the toe area, depending upon the manufacturer's instructions.



Putting elastic stocking on a client

9. Repeat steps 5 through 8 for the other leg.
10. Wash your hands.
11. Document the procedure and your observations. How did the skin appear? Were there any changes in color or temperature? Were there any sores or swelling on the legs? If the client complains of pain, numbness, or tingling, remove the stockings and contact your supervisor.

8. Define *ostomy* and list care guidelines

Define the following terms:

ostomy

surgical creation of an opening from an area inside the body to the outside.

stoma

an artificial opening in the body.

colostomy

surgically created opening into the large intestine to allow stool to be expelled.

ileostomy

surgically created opening into the end of the small intestine to allow stool to be expelled.

8. Define *ostomy* and list care guidelines

Think about this question:

Why is care of the skin and the stoma so important?

8. Define *ostomy* and list care guidelines

Remember:

It is important to be familiar with the different types of commercially sold ostomy appliances and equipment and to know which types are most appropriate for certain ostomies.

8. Define *ostomy* and list care guidelines

HHAs should know these guidelines for caring for an ostomy:

- Wash hands carefully and wear gloves
- Clients should also wash hands properly; HHAs should assist as needed
- Careful observation for changes in skin is important to prevent skin breakdown
- Empty and clean ostomy pouch whenever stool is eliminated
- Skin barriers may be used
- Food blockage can occur if large amounts of high-fiber food are ingested and if food is not chewed well. Follow diet instructions
- Encourage fluids and proper diets

8. Define *ostomy* and list care guidelines

Guidelines for caring for an ostomy (cont'd):

- Some clients are embarrassed about having an ostomy; the HHA should allow for privacy and behave professionally
- Report odors
- Report emotional or physical problems with adjusting to the ostomy
- Follow agency's policies
- Report changes in color, amount, frequency, or odor of stool; skin changes; leaking stool; absence of stool; watery stool with green, stringy material; abdominal cramps; and vomiting
- In many cases, the client is very experienced using the ostomy equipment and will teach the aide about the products

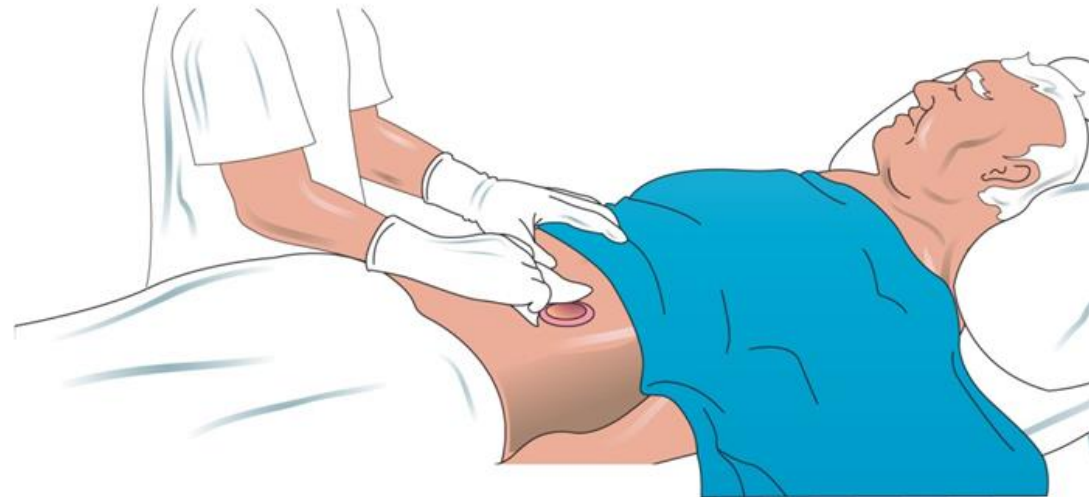
Caring for an ostomy

Equipment: disposable bed protector, bath blanket, clean ostomy pouching system, belt (if needed), disposable wipes (made for ostomy care), basin of warm water, washcloth, 2 towels, plastic bag, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If bed is movable, lock bed wheels.
5. Put on gloves.
6. Place bed protector under client. Cover client with a bath blanket. Pull down the top sheet and blankets. Expose only the ostomy site. Offer client a towel to keep clothing dry.

Caring for an ostomy

7. Undo the ostomy belt if used. Remove ostomy pouch carefully. Place it in the plastic bag. Note the color, odor, consistency, and amount of stool in the pouch.
8. Wipe the area around the stoma with disposable wipes for ostomy care. Discard wipes in plastic bag.
9. Using a washcloth and warm water, wash the area in one direction, away from the stoma. Rinse. Pat dry with another towel.



Caring for an ostomy

10. Place the clean ostomy drainage pouch on the client, following your supervisor's instructions. Hold in place and seal securely. Make sure the bottom of the pouch is clamped.
11. Remove disposable bed protector and discard. Place soiled linens in proper containers. Discard the plastic bag properly.
12. Remove and discard gloves.
13. Wash your hands.
14. Return bed to lowest position if adjusted.
15. Document procedure and any observations. Note any changes to the stoma and surrounding area. A normal stoma is red and moist, and looks like the lining of the mouth. Call your supervisor if stoma appears very red or blue or if swelling or bleeding is present. Report any sign of skin breakdown around the stoma.

9. Describe how to assist with an elastic bandage

Remember:

Elastic (nonsterile, ACE) bandages hold dressings in place, secure splints, support and protect body parts, and may decrease swelling.

9. Describe how to assist with an elastic bandage

HHA duties may include the following:

- Bringing bandage to client
- Positioning client to apply bandage
- Washing and storing bandage
- Documenting observations
- Note: Some HHAs may be allowed to apply and remove these bandages

9. Describe how to assist with an elastic bandage

HHAs should understand these safety guidelines with elastic bandages:

- Keep area clean and dry
- Apply bandage snugly but not too tight
- Wrap bandage evenly
- Do not tie bandage
- Remove bandage as indicated in care plan
- Check bandage often
- Check on client 10-15 minutes after bandage is applied. Note swelling; cyanotic skin; shiny, tight skin; cold skin; sores; numbness; tingling; and pain or discomfort

Critical Thinking: Case Study

Your client has an indwelling catheter in place. Discuss these questions with a partner:

What daily care would most likely be included in the care plan?

What would you observe about the urine in the bag?

What would you do if, when you arrived, you discovered that the catheter had fallen out during the night?

If the client complains of pain in the bladder area, what could this mean and what action should you take?

Name that procedure activity

Choose a procedure from Chapter 13 or Chapter 14. Write down the name of the procedure and a clue that is one of the most important points about that particular procedure. The clues could be about special equipment required or a step that makes it different from other procedures.

We will divide into two teams and the teams will take turns giving their clues and asking the other team to *Name That Procedure*.



Hartman