Training for Personal Care Staff
in
North Carolina Licensed
Adult Care Homes -- 10A NCAC 13F
&
Family Care Homes -- 10A NCAC 13G

80-Hour Training Curriculum

Published By
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION

UPDATED JANUARY 2022
NOTE:

The Department created an updated electronic version of this training course in January 2022 which is to be used by instructors, effective March 1, 2022.

Changes to the training course were very minimal and mainly addressed outdated language and grammatical errors. No changes to course content were made.

Additionally, in response to advances in technology and the changing needs of today’s workforce, the Department has approved a plan for how training hours may be taught using virtual classrooms and some self-study hours. The Department’s approved distribution of training hours can be found in the introductory section of this manual.

Questions regarding the manual or this training should be directed to DHSR.AdultCare.Training@dhhs.nc.gov.
INTRODUCTION
Content Outline
Instructor’s Note
Course Requirements
Lesson Plan/Distribution of Hours
Expected Outcomes

SECTION I
Practical Knowledge and Skills in Adult/Family Care Home Personal Care (Total: 5 hours)

- Unit I  Introduction to Adult/Family Care Homes in North Carolina (1 hour)
- Unit II  The Role and Functions of Personal Care Staff (1.5 hours)
- Unit III Understanding Human Needs of Older and/or Disabled Adults (1 hour)
- Unit IV  Activities of Daily Living (1.5 hours)

SECTION I -- The hours in this section can be completed as self-study by the student. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.

SECTION II
Cognitive, Behavioral and Social Care including Intellectual Disabilities (Total: 8 hours)

- Unit I  Recognition of Usual Patterns of Response to Others (0.5 hour)
- Unit II  Individual Resident’s Preferences and Personality Traits (require different kinds of staff responses) (1 hour)
- Unit III Recognition of Behavior Indicating Increase Distress (1 hour)
- Unit IV  Knowledge and Techniques as Alternatives to Restraints (1.5 hours)
- Unit V Safe, Humane Management of Behavior Problems (1 hour)
- Unit VI Understanding and Working with Adults with Special Needs (1 hour)
- Unit VII Intellectual Developmental Disabilities (1 hour)
- Unit VIII Goals of Care for the Resident with Specific Disabilities (1 hour)

SECTION II -- This section can be broken out into a maximum of 4 hours of student self-study and minimum of 4 hours of live classroom instruction. "Live classroom instruction" can be in-person instruction or a virtual classroom through an online learning platform. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.
SECTION III
Residents’ Rights and Safety in the Environment (Total: 4 hours)
  Unit I   Residents’ Rights (1 hour)
  Unit II  Accident and Injury Prevention (1 hour)
  Unit III Care during Emergencies (1 hour)
  Unit IV  Infection Control and Universal Precautions (1 hour)

SECTION III -- This section can be broken out into a maximum of 2 hours of student self-study and minimum of 2 hours of live classroom instruction. "Live classroom instruction" can be in-person instruction or a virtual classroom through an online learning platform. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.

SECTION IV
Basic Nursing Skills (Total: 5 Hours)
  Unit I   Observing body functions (1 hour)
  Unit II  Care of Person Confined to Bed (2.5 hours)
  Unit III Care of the Ambulatory Person Needing Assistance with ADLs (1.5 hours)

SECTION IV -- This section can be broken out into a maximum of 2 hours of student self-study and minimum of 3 hours of live classroom instruction. "Live classroom instruction" can be in-person instruction or a virtual classroom through an online learning platform. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.

SECTION V
Basic Restorative Services (Total: 3 Hours)
  Unit I   Basic Human Need for Rehabilitation Services (1 hour)
  Unit II  Restorative Eating/ Self-Feeding Programs (1 hour)
  Unit III Basic Restorative Measures to Meet Psychosocial Needs (1 hour)

SECTION V -- Units I & II (2 hours) must be taught using live classroom instruction, which can be in-person instruction or a virtual classroom through an online learning platform. Unit III (1 hour) can be student self-study. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.
SECTION VI
Observation/Documenting Responsibilities (Total: 2 Hours)
   Unit I   Observational Skills (1 hour)
   Unit II  Reporting/Recording information (1 hour)

SECTION VI -- This section (2 hours) must be taught using live classroom instruction, which can be in-person instruction or a virtual classroom through an online learning platform. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.

SECTION VII
Basic Nursing Skills for Special Health Related Tasks (Total: 8 Hours)
   Unit I   Common Diseases and Conditions Related To “Normal” Aging (4 hour)
   Unit II  Basic Principles for Resident Care Procedures for Persons with Problems Related to Age, Disability or Common Illness (4 hour)

SECTION VII -- This section can be broken out into a maximum of 2 hours of student self-study and minimum of 2 hours of live classroom instruction. "Live classroom instruction" can be in-person instruction or a virtual classroom through an online learning platform. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.

SECTION VIII
Skills Lab: Practice of Special Health Related Personal Care Tasks (Total: 9 Hours)

SECTION VIII -- This section (9 hours) must be taught in-person in a physical classroom/skills lab setting.

SECTION IX
Application of Knowledge and Skills – The Practicum (Total: 36 hours)
   1. Orientation to Practice
   2. Clinical Outcomes
      a. Perform basic personal care tasks and provide care as described in role and responsibilities of personal care staff
      b. Perform basic nursing skills, including special health-related tasks, according to established procedures
      c. Perform personal care tasks requiring documentation of competency by a licensed professional
      d. Document observation using appropriate terms
      e. Meet the cognitive, behavioral, mental and social care needs of aging and disabled persons
      f. Provide basic restorative services for aging and disabled persons
g. Respect residents’ rights as established

**SECTION IX -- This section must be completed in-person at an adult care home facility.**

**SECTION X**
Competency Evaluation Information
- Unit I  Skill Demonstration
- Unit II  Exam

**SECTION XI**
Competency Evaluation Instruments
INSTRUCTOR’S NOTE

Exhibits, handouts and discussion questions can be added at the end of each section to assist the student to gain more depth on a specific topic. Instructors are encouraged to have small group discussions or role play with certain situations. In doing so, instructors can determine how well the student understands the content and they have greater opportunity to measure the progress and accomplishments of students. Basic nursing skills should be demonstrated by the instructor with a return demonstration by the student in a practice laboratory session prior to the field experience with residents in the adult care homes or family care homes.

Vocabulary words and a brief definition have been included in the supplemental materials. These words are intended to help the students understand medical terminology often used when describing health conditions, illnesses or chronic disease states. Students should be cautioned not to use these words inappropriately when communicating with persons to avoid confusing or alarming residents about their health status.

The competency testing and clinical skills evaluation tool list the personal care tasks and basic nursing skills that all students are expected to be able to do following the training. Often, students are uneasy about being tested; thus, instructors are encouraged to incorporate adult training principles into the classroom and clinical sections to accurately measure knowledge, skills and abilities of the student. It is essential that all students be evaluated to determine their ability to provide safe competent care. When an unsatisfactory performance level is noted with a specific skill, the student should return to the practice laboratory for additional supervised practice. If the student fails to show improvement, it should be determined that the student failed the course.

The number of students per course should be limited in size when the practice laboratory and clinical experiences are not sufficient to allow for a meaningful field experience.

The curriculum outline in this module identifies readings in a text written by Peggy A. Grubbs and Barbara A. Blasband. If alternative nurse aide training text are used, appropriate readings would need to be identified.
COURSE REQUIREMENTS

Specific course requirements should be finalized by the instructor based on his/her experiences in working with adult students who have varying educational and/or experiential backgrounds. At a minimum, attendance requirements should be set. If absences are allowed, a means to make up missed class or clinical should be determined.

Instructors should use a written or verbal means of testing students to determine their level of comprehension of the content covered in the class or assignments given for outside work (e.g., readings, alternative text, websites or selected audio visuals). Additionally, skills competency testing is required.

The skills/competency evaluation checklist can be used as the final document on which to record the student’s overall performance. This document should be kept by the students as evidence of completion of the training program.

The skills evaluation checklist identifies a S/U designation which stands for satisfactory or unsatisfactory performance. Satisfactory means: "demonstrating accurate and safe practice which is based on sound principles of care"; unsatisfactory means: "showing that one is not mindful of safe practice skills while providing care".

Each student should be allowed the opportunity to practice and repeat the skill in a classroom/lab setting. Instructors should determine at what point a failure is indicated based on the student’s ability to show improvement in a "learning situation".
Introduction to 80-Hour Curriculum

LESSON PLAN/DISTRIBUTION OF HOURS

Each section/unit in this model curriculum has a specific number of hours allocated for class/practice lab sessions. The 80-hour module has an additional practice lab for the special health related personal care. Instructors should prioritize which content to focus on within the identified time frames realizing that, as adult students, the students should be expected to continue some of this required learning outside of the designated class/lab hours. Instructors should decide which content can be most appropriately learned through readings, audio visuals or other sources and request that the student come to a class/lab prepared with some basic knowledge. All hours allocated to class and clinical practice are in accordance with the law and must always be adhered to in order to complete the 80-hour training as required by law.

Update Effective December 1, 2021:
The following table provides the Department approved distribution of hours for the 80-hour training course for personal care staff in licensed adult care homes and family care homes. Instructors are not required to offer self-study or virtual classroom instruction.

80-Hour Training for Personal Care Staff in
Adult Care Homes & Family Care Homes
Licensed Pursuant to 10A NCAC 13F and 10A NCAC 13G

Department Approved Distribution of Training Hours

Effective Date: December 1, 2021

<table>
<thead>
<tr>
<th>Section/Unit Introduction</th>
<th>Section/Unit Title</th>
<th>Total Required Hours</th>
<th>Required Live Instruction Hours</th>
<th>Maximum Approved Hours for Self-Study</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Content Outline</td>
<td></td>
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<tr>
<td></td>
<td>Instructor’s Note</td>
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<tr>
<td></td>
<td>Course Requirements</td>
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<tr>
<td></td>
<td>Lesson Plan/Distribution of Hours</td>
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<tr>
<td></td>
<td>Expected Outcomes</td>
<td></td>
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</tr>
<tr>
<td>SECTION I</td>
<td>Practical Knowledge and Skills in Adult/Family Care Home Personal Care</td>
<td>5</td>
<td>0</td>
<td>5</td>
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<td>-----------</td>
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<tr>
<td>Unit I</td>
<td>Introduction to Adult/Family Care Home Care in North Carolina</td>
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<tr>
<td>Unit II</td>
<td>The role and functions of Personal Care Staff</td>
<td>1.5</td>
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</tr>
<tr>
<td>Unit III</td>
<td>Understanding human needs of older and/or disabled adults</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Unit IV</td>
<td>Activities of Daily Living</td>
<td>1.5</td>
<td></td>
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</tbody>
</table>

SECTION I -- The hours in this section can be completed as self-study by the student. The student's knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.

<table>
<thead>
<tr>
<th>SECTION II</th>
<th>Cognitive, Behavioral and Social Care, Including Intellectual Disabilities</th>
<th>8</th>
<th>4</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Unit I</td>
<td>Recognition of usual patterns of response to others</td>
<td>0.5</td>
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<tr>
<td>Unit II</td>
<td>Individual resident's preferences and personality traits (require difference kinds of staff response)</td>
<td>1</td>
<td></td>
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<tr>
<td>Unit III</td>
<td>Recognition of distress and behavior that indicates problems</td>
<td>1</td>
<td></td>
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<tr>
<td>Unit IV</td>
<td>Knowledge and techniques as alternatives to restraints</td>
<td>1.5</td>
<td></td>
<td></td>
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<tr>
<td>Unit V</td>
<td>Safe, humane management of behavior problems</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Unit VI</td>
<td>Understanding and working with adults with special needs</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Unit VII</td>
<td>Intellectual and developmental disabilities</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Unit VIII</td>
<td>Goals of care for the resident with specific disabilities</td>
<td>1</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>SECTION III</th>
<th>Residents' Rights and Safety in the Environment</th>
<th>4</th>
<th>2</th>
<th>2</th>
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<tbody>
<tr>
<td>Unit I</td>
<td>Residents' Rights</td>
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<tr>
<td>Unit II</td>
<td>Accident and injury</td>
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<tr>
<td>Unit III</td>
<td>prevention</td>
<td>1</td>
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<tr>
<td>Unit IV</td>
<td>Care during emergencies</td>
<td>1</td>
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<tr>
<td></td>
<td>Infection control and</td>
<td>1</td>
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<td></td>
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<tr>
<td></td>
<td>universal precautions</td>
<td>1</td>
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<thead>
<tr>
<th>SECTION IV</th>
<th>Basic Nursing Skills</th>
<th>5</th>
<th>3</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td>Unit I</td>
<td>Observing body functions</td>
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<td></td>
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<tr>
<td></td>
<td>Care of a person confined to a bed</td>
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<tr>
<td>Unit II</td>
<td>Care of the ambulatory person needing assistance with ADL's</td>
<td>1.5</td>
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</tbody>
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<table>
<thead>
<tr>
<th>SECTION V</th>
<th>Basic Restorative Services</th>
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<th>2</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>Unit I</td>
<td>Basic human need for rehabilitation services</td>
<td>1</td>
<td></td>
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<tr>
<td>Unit II</td>
<td>Restorative eating/self-feeding programs</td>
<td>1</td>
<td></td>
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<tr>
<td>Unit III</td>
<td>Basic restorative measure to meet psychosocial needs</td>
<td>1</td>
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</tbody>
</table>

**SECTION V --** Units I & II (2 hours) must be taught using live classroom instruction, which can be in-person instruction or a virtual classroom through an online learning platform. Unit III (1 hour) can be student self-study. The student’s knowledge and comprehension of the material must be demonstrated by the student successfully passing a test at the end of this section.

<table>
<thead>
<tr>
<th>SECTION VI</th>
<th>Observation/Documenting Responsibilities</th>
<th>2</th>
<th>2</th>
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<tr>
<td>Unit I</td>
<td>Observational skills for the personal care aide</td>
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<tr>
<td></td>
<td>Report/record information on a person’s condition and response to care</td>
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<tr>
<td>Unit II</td>
<td></td>
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<table>
<thead>
<tr>
<th>SECTION VII</th>
<th>Basic Nursing Skills for Special Health Tasks</th>
<th>8</th>
<th>4</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit I</td>
<td>Common diseases and conditions related to normal aging</td>
<td>4</td>
<td></td>
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<tr>
<td>Unit II</td>
<td>Basic principles for resident care procedures for persons with problems related to age, disability or common illness</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>SECTION VIII</th>
<th>Skills Lab: Practice of Special Health Related Personal Care Tasks</th>
<th>9</th>
<th>9</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>SECTION VIII -- This section (9 hours) must be taught in-person in a physical classroom/skills lab setting.</td>
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<tr>
<td>SECTION IX</td>
<td>Application of Knowledge and Skills --- The Practicum</td>
<td>36</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>Orientation to practice</td>
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<tr>
<td>2</td>
<td>Clinical Outcomes</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>a. Perform basic personal care tasks and provide care as described in role and responsibilities of personal care staff</td>
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<td></td>
<td>b. Perform basic nursing skills according to established procedures</td>
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<td>c. Perform personal care tasks requiring documentation of competency by a licensed professional</td>
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<td>d. Document observations using appropriate terms</td>
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<td></td>
<td>e. Meet the cognitive, behavioral, mental and social care needs of aging and disabled persons</td>
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<td>f. Provide basic restorative services for aging and disabled persons</td>
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<td>g. Respect residents' rights as established</td>
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<tr>
<td></td>
<td>SECTION IX -- This section must be completed in-person at an adult care home facility.</td>
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<tr>
<td>SECTION X</td>
<td>Information for Using the Personal Care Staff Competency Evaluation</td>
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<tr>
<td>Unit I</td>
<td>Skill Demonstration</td>
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<tr>
<td>Unit II</td>
<td>Exam</td>
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<tr>
<td>SECTION XI</td>
<td>Competency Evaluation Instruments</td>
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<td></td>
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<tr>
<td>Unit I</td>
<td>Techniques for providing care</td>
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<tr>
<td></td>
<td>Skills/competency evaluations</td>
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### 80-Hour Training for PCAs: Breakdown of Hours

<table>
<thead>
<tr>
<th>SECTION</th>
<th>Required Minimum Live Instruction Hours</th>
<th>Maximum Approved Self-Study Hours</th>
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<tbody>
<tr>
<td>SECTION I</td>
<td>0</td>
<td>5</td>
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<tr>
<td>SECTION II</td>
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<tr>
<td>SECTION III</td>
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<tr>
<td>SECTION IV</td>
<td>3</td>
<td>2</td>
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<tr>
<td>SECTION V</td>
<td>2</td>
<td>1</td>
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<tr>
<td>SECTION VI</td>
<td>2</td>
<td>0</td>
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<tr>
<td>SECTION VII</td>
<td>4</td>
<td>4</td>
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<tr>
<td><strong>Total Hours</strong></td>
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<td><strong>18</strong></td>
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<tr>
<td>SECTION VIII (Skills Lab)</td>
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<tr>
<td>SECTION IX (Practicum)</td>
<td>36</td>
<td>0</td>
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<tr>
<td>SECTION X (Skills and Exam)</td>
<td>~</td>
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<tr>
<td>SECTION XI (Tools)</td>
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### 80-Hour Training for PCAs Totals

<table>
<thead>
<tr>
<th>Category</th>
<th>Hours</th>
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<tbody>
<tr>
<td>Live Instruction Hours (minimum)</td>
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<tr>
<td>Approved Self-Study Hours (maximum)</td>
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<tr>
<td>Skills Lab Hours</td>
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<tr>
<td>Practicum Hours</td>
<td>36</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>80</strong></td>
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</table>
EXPECTED OUTCOMES

Students will be able to do the following:

1. State the purpose and main functions of an Adult/Family Care Home (ACH/FCH) available for adults in North Carolina
2. Recognize the basic human needs of all residents served in ACH/FCH
3. Discuss the special needs of the elderly and disabled persons with functional limitations
4. Describe the different types of observations that can be made of a person’s personal care needs and patterns of behavior.
5. Describe the functions and responsibilities of a personal care aide in an ACH/FCH
6. Use safe and appropriate techniques in providing basic personal care tasks for residents in an ACH/FCH
7. Use safe and appropriate techniques in providing special health-related personal tasks
8. Record and report observations of the resident’s response to care
9. Value the need to protect residents’ rights
10. Demonstrate appropriate communication skills in interacting with residents
11. Assist residents to maintain or improve physical strength and energy and help residents with disabilities to better perform activities of daily living
12. Recognition of residents’ usual patterns of responding to other people
13. Recognition that residents’ preferences require different kinds of staff responses
14. Recognition of behaviors that indicate a resident is experiencing increase interpersonal distress and behavior problems
   a. typical/atypical behaviors
   b. interpersonal distress versus intrapersonal distress
   c. differentiate coping styles
   d. effective interventions

(continued – next page)
EXPECTED OUTCOMES

15. Knowledge of procedures for obtaining consultation and assistance regarding safe, humane management of residents’ behavioral problems
   a. facility-based policies and procedures
   b. humane management

16. Pass a competency evaluation with a satisfactory grade
### Unit I – 1 Hour
Introduction to Adult/Family Care Homes in North Carolina

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Philosophy-residential social models</td>
<td>Handout: State Regulations for Licensing <a href="#">Adult Care Homes/Family Care Homes</a></td>
</tr>
<tr>
<td>Explain the purpose and main functions of Adult/Family Care Homes (ACH/FCH)</td>
<td>1. Resident preferences and needs</td>
<td></td>
</tr>
<tr>
<td>available to aging and disabled persons</td>
<td>2. Valuing human interactions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Building on residents’ strengths</td>
<td></td>
</tr>
<tr>
<td>Definition and type of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. ACH (7 or more residents)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. FCH (2 to 6 residents)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe some of the requirement to providing services</td>
<td>Meeting residents’ needs</td>
<td>Lecture: Information/class discussion</td>
</tr>
<tr>
<td></td>
<td>1. Scheduled needs</td>
<td>Read in Grubbs, Chapter 1 or alternative training text</td>
</tr>
<tr>
<td></td>
<td>2. Unscheduled needs</td>
<td></td>
</tr>
<tr>
<td>The working environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Physical environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The residents’ rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Admission, transfer and discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss the need for team building and collaboration in the Adult/Family Care</td>
<td>Care team members</td>
<td>Demonstrate beginning communication skills in role play situations</td>
</tr>
<tr>
<td>Home (ACH/FCH)</td>
<td>1. Licensed health professionals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Resident, family and personal care staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Ombudsman/advocates</td>
<td></td>
</tr>
<tr>
<td>Cooperation with care managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Helping to identify residents’ abilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Accuracy in reporting observations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Unit II – 1.5 Hours
The Role and Functions of Personal Care Staff

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Policy and procedure</td>
<td>Review of facility job description for personal care staff</td>
</tr>
<tr>
<td>Describe the ACH/FCH’s responsibility to residents and personal care staff</td>
<td>1. The purpose and importance of resident assessments and care planning 2. Job descriptions, training and supervision of personal care staff 3. Continuing staff development needs for the personal care staff 4. Stress and burnout among personal care staff 5. Improving moral and job satisfaction 6. The problems with turnover</td>
<td></td>
</tr>
<tr>
<td>Describe the personal care aide’s role and responsibilities in helping residents to accept and adjust to life in the ACH/FCH</td>
<td>Personal care staff’s job</td>
<td>Read in Grubbs, Chapters 2, 3, and 11 or alternative training text</td>
</tr>
<tr>
<td>Identify attitudes and lifestyles that promote behavioral and physical well-being during the aging process</td>
<td>Aging process</td>
<td>Have students identify their own personal feelings about older people</td>
</tr>
<tr>
<td></td>
<td>1. The myths and realities of aging 2. Perception about the frail elderly 3. Caregivers attitudes toward the elderly</td>
<td></td>
</tr>
</tbody>
</table>

(continued – next page)
## Unit II – 1.5 Hours
The Role and Functions of Personal Care Staff

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following:                     | Developmental task of aging  
1. Physical, psychological and cultural  
2. Supporting life skills, freedom of choice  
Improving quality of life  
1. Minimize physical and cognitive impairment  
2. Maintain function  
3. Encourage regular health checks  
4. Eliminate neglect and abuse  
5. Raise the standard of care  
Improve and support quality for aging in older/disabled persons  
1. Physical and mental well-being  
2. Social, recreational and diversional needs  
Life changes for older people  
1. Role and relationships with others  
2. How it feels to be aging  
3. The importance of sharing life’s experiences by reminiscing  
4. Anxieties about dying  
End of life decisions  
1. Advance directives for health care  
2. Health care power of attorney  
3. Living wills, no codes, DNRs  | Read in Grubbs, Chapters 2 and 3 or alternative training text  
View selected AVs  
Class discussion  
Read in Grubbs Chapters 10 and 25 or alternative training text  | Have students list events that occurred to family members or residents and discuss how the person reacted  
Handout: Sample Living Will  |

(continued – next page)
### Unit II – 1.5 Hours
The Role and Functions of Personal Care Staff

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Ways people communicate with each other</td>
<td>Read in Grubbs, Chapter 8 or alternative training text</td>
</tr>
<tr>
<td>Discuss basic concepts of communication</td>
<td>1. Verbal and non-verbal communication</td>
<td>Demonstrate beginning communication skills in role play situations</td>
</tr>
<tr>
<td></td>
<td>2. Reporting observations and signs of change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Guidelines on how to communicate better</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Importance of communication with resident, family and friends</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Developing people skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Managing resident disputes</td>
<td></td>
</tr>
<tr>
<td>Discuss developing communication skills with residents who have special needs</td>
<td>Working with residents who have difficulty communicating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. The resident who is aphasic</td>
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</tr>
<tr>
<td></td>
<td>2. The resident with vision problems</td>
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<tr>
<td></td>
<td>3. The resident who is deaf</td>
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<tr>
<td></td>
<td>4. The resident who is confused, demented or has garbled speech</td>
<td></td>
</tr>
<tr>
<td>List examples of barriers to good communication</td>
<td>Barriers to communication</td>
<td>Have students describe a past experience when a communication barrier caused them to end a conversation</td>
</tr>
<tr>
<td></td>
<td>1. Speaking loudly, shouting or displaying an impatient attitude</td>
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</tr>
<tr>
<td></td>
<td>2. Distractions, noisy environment</td>
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</tr>
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<td></td>
<td>3. Words with more than one meaning</td>
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<td></td>
<td>4. Different languages</td>
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<tr>
<td></td>
<td>5. Feelings such as embarrassment or inability to ask questions</td>
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</tr>
<tr>
<td></td>
<td>6. Illness or physical disability</td>
<td></td>
</tr>
</tbody>
</table>
### Unit III – 1 Hour
Understanding Human Needs of Older and/or Disabled Adults

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Basic human needs</td>
<td>Have students discuss their views on pet therapy and its value in the ACH/FCH setting</td>
</tr>
</tbody>
</table>
| Describe how the personal care staff can help individuals meet their basic needs | 1. Food and personal care needs  
2. Love and affection  
3. Security and trust  
4. Recognition and acceptance  
5. Socialization and belonging |                                                                                  |
|                                                                                 | Physical disabilities and functional limitations when basic human needs are not met (stress response)  
1. Physical ailments  
2. Psychosocial behaviors (fear, anger, anxiety, aggression, regression, discouragement) |                                                                                  |
| Describe the importance of family to aging/disabled persons                      | Individual and family differences  
1. Temperament and disposition  
2. Physical and mental capabilities  
3. Interests, motivation and values  
4. Customs, economic resources and political beliefs  
5. Religious beliefs, ethnic background and culture  
6. Support family involvement in decision making  
7. Maintain a connection with surrounding community | Have students suggest resident activities that would be of interest to family members or visitors |
## Unit IV – 1.5 Hours
### Activities of Daily Living

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following:                                               | Standard of health and hygiene  
  1. The resident's care plan as the basis for the provision of daily care  
  2. Principles of care related to personal care needs  
  3. Ethical and legal issues in providing care |
| Identify the role of the personal care staff in assisting persons with basic care tasks | Assisting with ADLs  
  1. Personal hygiene (bed, bath, tub/shower, mouth care, care of skin); dressing and undressing; grooming (hair, scalp, nail care, shaving)  
  2. Physical activity, ambulating (exercise, walking)  
  3. Turn and position, transferring (wheelchair)  
  4. Feeding, encourage and prompt with eating  
  5. Bowel and bladder continence (absorbent products, condom catheter or reducing wetness via prompted voiding, habit training and providing an odor free environment)  
  6. Perineal care | Read in Grubbs, Chapter 19 or alternative training text  
  Review selected audio visuals on basic skills |
| Demonstrate procedures for assisting persons with activities of daily living (ADL) and simple care tasks | Assisting with basic health care tasks  
  1. Taking vital signs, temperature, pulse and respiration  
  2. Measuring routine height and weight  
  3. Collecting urine and fecal specimens  
  4. Providing good skin care to avoid pressure sores  
  5. Fluid balance and measures to prevent dehydration | Evaluate students’ progress |
### Unit I – 0.5 Hour
Recognition of Usual Patterns of Response to Others

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td></td>
<td>Presentation of content by instructor with examples. Video or role play would be good here</td>
</tr>
<tr>
<td>Recognize that people have individual personality traits that affect how they respond to others</td>
<td>Traits&lt;br&gt; 1. Expressive style (quiet vs dramatic) 2. Interpersonal style (introverted vs extroverted) 3. Task style (unmotivated vs eager) 4. Emotional style (positive vs negative)</td>
<td></td>
</tr>
<tr>
<td>Recognize that students have different traits/styles</td>
<td>Students to describe their usual ways of responding to others</td>
<td>Class discussion</td>
</tr>
<tr>
<td>Recognize how students respond based on their individual styles to individuals who have different traits/styles</td>
<td>Describe how you respond to adult care home residents with whom you work. Identify the types of traits you find most difficult to work with</td>
<td>Class discussion of things that might help student recognize what a resident wants from student&lt;br&gt;Class discussion on “hot” buttons</td>
</tr>
<tr>
<td>Understand that recognizing individual preferences will help in your work</td>
<td>Preferences versus needs</td>
<td>Class discussion with examples</td>
</tr>
</tbody>
</table>
# Unit II – 1 Hour

Individual Resident’s Preferences and Personality Traits  
(require different kinds of staff responses)

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following:                                               | How to identify and interact with a resident who prefers each of the following styles: quiet, dramatic; introverted, extroverted; unmotivated, eager; positive and negative | Instructor will provide description of several residents and students will identify the resident’s preferred styles  
Role play how one might approach each preferred style at a first meeting |
| Identify the different ways individuals express themselves to others based on their personal styles and personality traits, and identify the most appropriate student interactional style for residents with these traits | Review of need for: respect; privacy/personal space; appropriate timing of activities; body language; vocal tone and other basic social skills that are valued by the resident | Instructor will provide description of situations encountered in working in an ACH/FCH  
Have students role play the resident and staff interacting in appropriate ways |
## Unit III – 1 Hour
Recognition of Behaviors Indicating Increased Distress

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognize behaviors that are typical for each individual resident</td>
<td>Describe types of behaviors both typical and atypical</td>
<td>Students will demonstrate typical and atypical behaviors through role playing</td>
</tr>
<tr>
<td>Identify internal distress and external distress</td>
<td>Review stressors both internal and external that affect distress</td>
<td>Class discussion and role playing of stressors that can contribute to increased distress</td>
</tr>
<tr>
<td>Identify residents coping styles that are effective and those that are not effective</td>
<td>Review coping styles that are effective or not effective including behaviors indicative of a pending crisis</td>
<td>Class discussion regarding styles of coping and staff thoughts/feelings about those individuals with ineffective styles vs effective styles Students will role play different styles</td>
</tr>
</tbody>
</table>
## Unit IV – 1 ½ Hours
Knowledge and Techniques as Alternatives to Restraints
(to decrease distress and behavior problems)

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Review facility restraint policy, procedure and the use and frequency of restraints</td>
<td>Class discussion of policy and procedures</td>
</tr>
<tr>
<td>Recognize the type and use of restraints currently being used within facilities including chemical restraints</td>
<td></td>
<td>Handout: Licensed Facilities Policies and Procedures and Rules 10A NCAC 13F .1501 and 13G .1301 regarding restraint use and alternatives.</td>
</tr>
<tr>
<td>Identify feelings associated with restraint use</td>
<td>Autonomy versus restraint use</td>
<td>Instructor will provide relevant scenarios for students to experience restraint use through role playing</td>
</tr>
<tr>
<td>Identify alternatives to restraints</td>
<td>Early intervention techniques that can reduce the need for restraint use</td>
<td>Readings in Gentle Teaching</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss active listening and person centeredness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice alternative interventions</td>
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<td></td>
<td></td>
<td>Handouts</td>
</tr>
</tbody>
</table>
### Unit V – 1 Hour
Safe, Humane Management of Behavioral Problems

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Review existing policy, procedures and consultation</td>
<td>Class discussion of practices in a variety of ACH/FCH settings</td>
</tr>
<tr>
<td>Identify the typical chain of command for policies and consultation</td>
<td></td>
<td>Handout: Examples of rules regarding chain of command</td>
</tr>
<tr>
<td>Identify contacts for assistance within and outside the ACH/FCH</td>
<td>Review existing resources within and outside the ACH/FCH</td>
<td>Students will discuss individual program policies and resources within and outside the ACH/FCH as/or benefits and/or problems</td>
</tr>
<tr>
<td>Identify concepts of humane management</td>
<td>Review personal and programmatic use of ethics</td>
<td>Students will establish a list of resources and how to contact them</td>
</tr>
<tr>
<td></td>
<td>Review ethics as a management technique</td>
<td>Class discussion and sharing of personal and management ethics as they pertain to attitudes</td>
</tr>
</tbody>
</table>
## Unit VI – 1 Hour
Understanding and Working with Adults with Special Needs

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Care of persons with dementia</td>
<td>Read in Grubbs, Chapter 13 or alternative training text</td>
</tr>
<tr>
<td>Describe the goals of care for assisting persons with cognitive disorders</td>
<td>1. Managing the person displaying symptoms of confusion, memory loss, agitation and disorientation</td>
<td>Have students role play their actions for a resident wearing a sweater buttoned incorrectly or had on serval layers of clothing, some of which were on backwards</td>
</tr>
<tr>
<td></td>
<td>2. Accepting and working with problem behaviors, troubled residents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. When reality orientation is an appropriate approach for the person with confusion and memory loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Environmental modifications and rechanneling energy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Helping demented persons meet their own personal care needs</td>
<td></td>
</tr>
<tr>
<td>Psychosocial needs for persons with cognitive disabilities</td>
<td>1. Providing for emotional health needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Social recreational and diversional needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Placement and adjustment problems</td>
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</tbody>
</table>
### Unit VII – 1 Hour
Intellectual Developmental Disabilities (IDD)
(Intellectual Disabilities - ID)

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Basic techniques and skills of care for persons with physical disabilities</td>
<td>Have students give examples of how they would encourage self-care for persons with severe arthritis of the hands/fingers</td>
</tr>
</tbody>
</table>
| Discuss the goals of care for assisting a person with physical disability and/or IDD | 1. Providing personal care  
2. Promoting maximum self-care and independence                                      |                                                                                                          |
|                                                                                  | Meeting the person’s needs when ID is a factor                                       |                                                                                                          |
|                                                                                  | 1. Providing personal care  
2. Establishing routines  
3. Working with behavior problems  
4. Professional services, education and training needs |                                                                                                          |
|                                                                                  | Meeting the special care needs of persons with IDD                                   | Read in Grubbs, Chapter 10 or alternative training text                                                   |
|                                                                                  | 1. Supporting appropriate behavior  
2. Helping families understand capabilities and limitations of their loved one’s disabilities  
3. The personal care staff’s responsibilities in guiding persons with disabilities to meet their basic human needs for love and affection |                                                                                                          |
### Section II – Cognitive, Behavioral and Social Care – 8 Hours

#### Unit VIII – 1 Hour
Goals of Care for the Resident with Specific Disabilities

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following: | Care requirements for persons with Alzheimer’s disease  
1. Prevent decline in ADLs  
2. Minimize disorientation  
3. Control problem behaviors and supervise personal care needs  
4. Retrain; don’t restrain  
5. Understand the “sundown” syndrome | Read in Grubbs, Chapter 13 or alternative training text |
| Discuss special skills and techniques appropriate for the personal care staff in caring for residence with Alzheimer’s disease | Environmental innovations for behavior control  
1. Provide a homelike environment  
2. Exit controls, using alarms  
3. Enclose courtyards  
4. Decrease tactile stimulation, noise control  
5. Way finding, appropriate use of cueing | Have students list ways to keep the confused or disoriented Alzheimer’s resident occupied in activities |
| Discuss the care requirements for persons with HIV and AIDS | Managing persons with HIV and AIDS  
1. Using techniques to prevent the spread of infection  
2. Meeting the social recreational and diversional needs of persons with AIDS  
3. Things to think about in working with persons with AIDS | Read in Grubbs, Chapter 5 or alternative training text |
| | | Have students discuss protective isolation and compare their feelings with the feelings the resident may be expressing |

(continued – next page)
### Unit VIII – 1 Hour
Goals of Care for the Resident with Specific Disabilities

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Assisting the persons with Cerebral Palsy to meet personal care needs</td>
<td>Have students discuss how they would communicate with residents that are unable to clearly pronounce words</td>
</tr>
<tr>
<td>Discuss special care requirements for persons with Cerebral Palsy</td>
<td>1. The effects of muscle weakness on limbs resulting in problems with walking, coordination and balance</td>
<td>Evaluate students’ progress</td>
</tr>
<tr>
<td></td>
<td>2. Using assistive devices to help in caring for the person with Cerebral Palsy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Good posture and proper body mechanics when providing care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Communication problems</td>
<td></td>
</tr>
</tbody>
</table>
### Unit I – 1 Hour
Residents’ Rights

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Residents’ Rights in ACH/FCHs</td>
<td>Handout: State Rules and Regulations G.S. 131D-21</td>
</tr>
<tr>
<td>Explain the legal and ethical responsibilities of personal care staff in protecting residents’ rights</td>
<td>1. Provision for care and services</td>
<td>Discuss examples of violations of residents’ rights that could be considered abuse, battery, invasion of privacy or neglect</td>
</tr>
<tr>
<td></td>
<td>2. Respect for individuality and the right to privacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Confidentiality of personal and medical records</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Communicating needs to staff and access to resources to facilitate communicating with family and friends</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Advocates, guardians and grievance issues</td>
<td></td>
</tr>
<tr>
<td>Expected behaviors for the personal care staff in providing care</td>
<td>Expected behaviors for the personal care staff in providing care</td>
<td>Have students review residents’ rights for ACH/FCH and compare to nursing home resident rights</td>
</tr>
<tr>
<td>1. Ensure freedom from mental and physical abuse, neglect and exploitation</td>
<td>1. Ensure freedom from mental and physical abuse, neglect and exploitation</td>
<td></td>
</tr>
<tr>
<td>2. Understand ethical standards of behavior</td>
<td>2. Understand ethical standards of behavior</td>
<td></td>
</tr>
<tr>
<td>3. Know the basic principles underlying malpractice and negligence</td>
<td>3. Know the basic principles underlying malpractice and negligence</td>
<td></td>
</tr>
</tbody>
</table>
### Unit II – 1 Hour
#### Accident and Injury Prevention

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following: | Type of accidents  
1. Falls  
2. Burns  
3. Poisons  
4. Suffocation | Read in Grubbs, Chapter 6 or alternative training text |
| Discuss the personal care staffs’ responsibilities in providing for a safe, clean environment | Factors to consider in preventing accidents or injuries  
1. Environmental considerations, safety hazards, lighting, floors, and cleanliness of surroundings  
2. Reporting faculty equipment and unsafe conditions | |
| | Physical and emotional safety concerns for the resident  
1. Confusion  
2. Medications  
3. Problems with coordination or dizziness | |
| List the guidelines for using correct body mechanics | Techniques while providing care  
1. Body mechanics and lifting injuries  
2. Cleaning injuries while working with equipment and supplies  
3. General rules of safety for bed making | Have students demonstrate correct body mechanics while doing a variety of lifting activities |

(continued – next page)
### Unit II – 1 Hour

**Accident and Injury Prevention**

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Goals for restraint reduction programs</td>
<td>View selected audio visuals</td>
</tr>
<tr>
<td>Discuss the actions personal care staff should take when supporting a restraint free environment</td>
<td>1. Provide individualized care based on patterns of behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Know the benefits of a restraint free environment for the resident and the staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Education of resident, family and staff</td>
<td></td>
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<tr>
<td></td>
<td><strong>Monitoring, if restraints must be used</strong></td>
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</tr>
<tr>
<td></td>
<td>1. Understand the purpose of protective devices and need for a physician’s order</td>
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<tr>
<td></td>
<td>2. Know alternatives to the use of mechanical or chemical restraints</td>
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</tr>
<tr>
<td></td>
<td>3. Monitor resident comfort and safety</td>
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</tr>
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<td></td>
<td>4. Meet diversional and communication needs</td>
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</tr>
<tr>
<td></td>
<td>5. Guidelines for proper use and release of restraints</td>
<td></td>
</tr>
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<td></td>
<td>6. Reporting resident response/behavior with use of restraints</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Legal issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Incident and Accident Reports</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Accuracy in reporting accidents, losses or unusual occurrences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Safety precautions to accident prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Recognizing those persons who are accident prone</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outline the procedure to follow when reporting an incident or accident in the workplace</strong></td>
<td></td>
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<tr>
<td></td>
<td>Handouts: Share samples of facility incident/accident tools and discuss whether they are complete for an accurate report</td>
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</tr>
</tbody>
</table>
## SECTION III – Residents’ Rights and Safety in the Environment – 4 Hours

### Unit III – 1 Hour
Care during Emergencies

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following: Discuss fire preventive measures to ensure safety in ACH/FCH settings</td>
<td>Fire hazards/fire safety: 1. Smoking regulations and supervision 2. Housekeeping and storage of supplies and equipment 3. Fire prevention activities 4. Types of fires and the use of extinguishers 5. Smoke detector and the fire alarm system 6. Reporting faulty equipment</td>
<td>Role play situations on how staff should respond in case of a fire</td>
</tr>
<tr>
<td>Explain the personal care staff’s responsibilities in the event of fire or disaster</td>
<td>Fire safety program 1. Training staff on policies 2. Fire drills and verifying staff response 3. Precautions to take with the use of oxygen Disaster plans 1. Natural and human disasters (power outage, weather conditions, crashing accidents) 2. Policy and procedure for responding in the event of disaster 3. Evacuation plans</td>
<td>Read in Grubbs, Chapter 6 or alternative training text View selected audio visuals</td>
</tr>
</tbody>
</table>

(continued – next page)
## Unit III – 1 Hour
Care during Emergencies

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Assisting until professional help arrives when the resident:</td>
<td>Read in Grubbs, Chapter 6 or alternative teaching text</td>
</tr>
<tr>
<td>Explain the personal care staff’s responsibilities in assisting with basic first</td>
<td>1. Is burned, cut or bruised</td>
<td></td>
</tr>
<tr>
<td>aid during emergency situations</td>
<td>2. Falls with possible fractures and swelling of the limb</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Has a drug allergy or accidental poisoning</td>
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<tr>
<td></td>
<td>4. Has a fainting spell with loss of consciousness</td>
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</tr>
<tr>
<td></td>
<td>5. Has a possible heart attack or respiratory failure</td>
<td></td>
</tr>
<tr>
<td>Explain the personal care staff’s responsibilities in assisting with basic first</td>
<td>Medical emergencies</td>
<td>Read in Grubbs, Chapter 7 or alternative teaching text</td>
</tr>
<tr>
<td>aid during emergency situations</td>
<td>1. Guidelines for response in the event of a medical emergency (the ABCs of clear air</td>
<td>Have students demonstrate procedure for Heimlich maneuver</td>
</tr>
<tr>
<td></td>
<td>way, breathing, circulation)</td>
<td>Have students discuss how they would react in certain emergency</td>
</tr>
<tr>
<td></td>
<td>2. Accessing help from EMS services</td>
<td>situations</td>
</tr>
<tr>
<td></td>
<td>3. Reporting incident to proper staff</td>
<td></td>
</tr>
<tr>
<td>Obstructed airway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Causes of choking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Coughing and clearing the airway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Heimlich maneuver of the conscious or unconscious victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsive disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Causes of seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Specific actions to be taken by the personal care staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeing a resident who may be suffering from shock or cerebral hemorrhage</td>
<td>1. Causes of shock or cerebral hemorrhage and symptoms you might see</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Specific actions to be taken by the personal care staff</td>
<td></td>
</tr>
</tbody>
</table>
### Unit IV – 1 Hour
Infection Control and Universal Precautions

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Definitions and basic principles</td>
<td>Read on Grubbs, Chapter 5 or alternative training text</td>
</tr>
<tr>
<td>Explain the principles of infection control</td>
<td>1. Infection control</td>
<td>Demonstrate good practices and technique for handwashing; cleaning and sterilizing; disposal of infected waste and handling of soiled linen</td>
</tr>
<tr>
<td></td>
<td>2. Universal precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Assisting persons to maintain high level wellness through good personal care practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disease transmission</td>
<td>Review selected audio visuals on isolation techniques</td>
</tr>
<tr>
<td></td>
<td>1. Micro-organisms that cause infection, viruses, bacteria, fungus and protozoa</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. The body’s response to infection-signs and symptoms</td>
<td>Evaluate students’ progress</td>
</tr>
<tr>
<td></td>
<td>3. Risk factors for infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workplace safety issues for the personal care staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Using protective supplies effectively</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Disposing of soiled linens, supplies, contaminated wastes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Exposure to blood borne pathogens</td>
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</tr>
</tbody>
</table>
**Unit I – 1 Hour**
Observing Body Functions

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Techniques for measuring and recording vital signs</td>
<td>Have students practice putting information on a graph sheet</td>
</tr>
<tr>
<td>Explain the way vital signs are measured and recorded</td>
<td>1. Ways to measure and record body temperature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Measuring and recording radial pulse rate</td>
<td></td>
</tr>
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<td></td>
<td>3. Measuring and recording respirations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Taking and recording blood pressures</td>
<td></td>
</tr>
<tr>
<td>Body functions that affect vital signs</td>
<td>1. Reasons for variations in temperature, pulse, respirations and blood pressure</td>
<td></td>
</tr>
<tr>
<td>Discuss the importance of knowing body weight and height</td>
<td>Reasons for obtaining height and weight</td>
<td>Have students discuss how they would weight a w/c bound resident at their facility</td>
</tr>
<tr>
<td></td>
<td>1. Baseline measurement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Indicator of health status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. As a measure in prescribing medications</td>
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</tr>
<tr>
<td>Guidelines for measuring height and weight</td>
<td>1. Frequency and method of measurement for the ambulatory person</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Modifications to accommodate persons with disabilities</td>
<td></td>
</tr>
</tbody>
</table>
## UNIT II – 2.5 Hours
Care of Person Confined to Bed

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Basic human needs</td>
<td>Read in Grubbs, Chapter 17 or alternative teaching text</td>
</tr>
<tr>
<td>Explain the fundamental concepts and goals of care for persons confined to bed</td>
<td>1. Privacy, warmth and comfort</td>
<td>Have student discuss a variety of activities that should be scheduled to keep residents alert and stimulated</td>
</tr>
<tr>
<td></td>
<td>2. Communications, social and diversional needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Emotional health and well-being</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Nutritional concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal care needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Hygiene and grooming</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Foot care</td>
<td></td>
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<td></td>
<td>3. Skin care</td>
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<td></td>
<td>4. Elimination</td>
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<tr>
<td></td>
<td>Environmental safety</td>
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<tr>
<td></td>
<td>1. Body mechanics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Moving and positioning</td>
<td></td>
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<td></td>
<td>3. Using side rails</td>
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<td></td>
<td>4. Changing bed linens</td>
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</tr>
</tbody>
</table>
UNIT III – 1.5 Hours  
Care of the Ambulatory Person Needing Assistance with ADLs

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Basic human needs</td>
<td>Have students discuss how they would help to foster independence and avoid taking over for the resident who is too slow</td>
</tr>
<tr>
<td>Discuss how to promote optimum level of functioning for persons not confined to bed</td>
<td>1. Communications, social and diversional needs</td>
<td>Utilize online resources for preventing falls</td>
</tr>
<tr>
<td></td>
<td>2. Supporting independence according to functional ability</td>
<td>Read in Grubbs, Chapter 19 or alternative teaching text</td>
</tr>
<tr>
<td></td>
<td>3. Emotional health and well-being</td>
<td>Evaluate students’ progress</td>
</tr>
<tr>
<td></td>
<td>Personal care needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Assisting with bathing; tub, shower or whirlpool</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Assisting with ADLs of dressing, grooming, feeding or toileting</td>
<td></td>
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<tr>
<td></td>
<td>3. Activity and exercise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Environmental safety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Making an unoccupied bed</td>
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</tr>
<tr>
<td></td>
<td>2. Safety when using a wheelchair</td>
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<tr>
<td></td>
<td>3. Preventing falls and fall-related injuries</td>
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</tbody>
</table>
## UNIT I – 1 Hour
Basic Human Need for Rehabilitation Services

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following: Discuss the definitions and basic principles of rehabilitation for residents in an ACH/FCH</td>
<td>Definitions 1. Rehabilitation 2. Restorative care Principles of restorative care 1. Treat the whole person 2. Start rehabilitation early 3. Stress ability not disability 4. Encourage activity 5. Maintain a restorative attitude</td>
<td>Read in Grubbs, Chapter 4 or alternative teaching text</td>
</tr>
<tr>
<td>Identify the personal care staff’s role and responsibility in assisting with rehabilitative care</td>
<td>Assisting in performing activities of daily living 1. Support independence according to functional ability 2. Assist to conserve energy 3. Assist to regain lost function or to maintain current level of functional ability 4. Assist to prevent further disability and loss of function Assisting with ambulation development 1. Assisting to dangle, stand or walk 2. Assist the person with one sided weakness 3. Using proper technique with weight bearing assistance 4. Assist with cast care or another prosthetic device</td>
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</tbody>
</table>
### UNIT I – 1 Hour
Basic Human Need for Rehabilitation Services

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Assisting with transfer techniques</td>
<td>Have students demonstrate how to transfer from bed to wheelchair</td>
</tr>
<tr>
<td>Identify the personal care staff’s role and responsibility in assisting with</td>
<td>1. Assisting in transfer from bed to chair and chair to bed</td>
<td></td>
</tr>
<tr>
<td>rehabilitative care</td>
<td>2. Assisting in transfer using a mechanical lift</td>
<td></td>
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<tr>
<td></td>
<td>3. Other assistive devices, canes, walkers, crutches</td>
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<td></td>
<td>4. Helping to use the bedside commode</td>
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<td></td>
<td>5. Preventing back strain for the personal care staff</td>
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</table>
### UNIT II – 1 Hour

Restorative Eating/Self Feeding Programs

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Promoting optimum function</td>
<td>Have students observe a resident’s eating habits for several meals and report back for class discussion</td>
</tr>
<tr>
<td>Define the personal care staff’s responsibilities with helping residents who are not able to eat independently</td>
<td>1. Encourage self-feeding</td>
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<td></td>
<td>2. Understand how food contributes to physical, social and emotional well being</td>
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<td></td>
<td>3. Use of adaptive equipment for eating</td>
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<td></td>
<td>4. Provide mouth care to the functionally disabled after feeding</td>
<td></td>
</tr>
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<td></td>
<td>5. Report amount of food eaten/refused</td>
<td></td>
</tr>
<tr>
<td>Understanding digestive problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Changes due to aging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Common medical problems affecting eating</td>
<td></td>
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</tr>
<tr>
<td>Discuss proper nutritional requirements for older residents and residents with cognitive or physical disabilities or nutritional disorders</td>
<td>Understanding the basic of a well-balanced diet</td>
<td>Have students give examples of residents who would benefit from supplemental nourishment</td>
</tr>
<tr>
<td></td>
<td>1. The food guide pyramid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Types of diets, regular or mechanical</td>
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<td></td>
<td>Understanding the importance of special diets and therapeutic diets</td>
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### UNIT II – 1 Hour
Restorative Eating/Self Feeding Programs

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Maintaining adequate food and fluid intake</td>
<td>Have students make a list of all foods they consume within the last 24 hours and discuss whether it was healthy</td>
</tr>
<tr>
<td>List the most important ways to maintain adequate food and fluid intake</td>
<td>1. Feeding residents who cannot feed themselves</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Serving between meal snacks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Providing supplemental fluids/nourishment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Modifying or changing poor eating habits</td>
<td></td>
</tr>
<tr>
<td>Discuss factors that affect the dining experience</td>
<td>Methods to assist persons to accept food</td>
<td>View selected audio visuals</td>
</tr>
<tr>
<td></td>
<td>1. Increase activity level prior to mealtime</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Consider environment and attractiveness in arranging and serving food</td>
<td></td>
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<tr>
<td></td>
<td>3. Consider food preparation, consistency of food and temperature of food</td>
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<td></td>
<td>4. Respect individual differences – likes and dislikes</td>
<td></td>
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<tr>
<td></td>
<td>5. Know the meaning of food – cultural, moral and religious values</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Remember functional limitations and vision problems</td>
<td></td>
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<tr>
<td></td>
<td>7. Consider medications or response to pain</td>
<td></td>
</tr>
</tbody>
</table>
UNIT III – 1 Hour  
Basic Restorative Measures to Meet Psychosocial Needs

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following: | Improving self-esteem and self-care skills  
1. Balance exercise, relaxation and sleep  
2. Adhere to values and beliefs  
3. Hold onto an inner life of spiritual satisfaction  
Facilitating the potential for healing  
1. Coping with illness, loss, anxiety and/or depression  
2. Supporting independence in performing activities of daily living  
3. Encouraging performance at optimal levels of functioning  
4. Support restorative goals and minimize custodial care  
Support interrelationships of various dimensions  
1. Encouraging family support in a meaningful way  
2. Develop a sense of community with other residents, friends and staff  
3. Listen and allow free expression of feelings about moving from private home to an ACH/FCH | Have students list some of the little extra things they could do to promote a healthier environment for the resident |
| Describe restorative measures to follow to meet psychosocial needs in helping residents to become healthier | | Evaluate students’ progress |


## UNIT I – 1 Hour
Observational Skills

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Observing through the use of the physical senses</td>
<td>Read in Grubbs, Chapter 4 or alternative teaching text</td>
</tr>
<tr>
<td>Describe ways people make observations and report facts</td>
<td>1. <strong>Sight</strong>: rash, skin color, swelling, slow movement, grimacing, temperature readings, checking height and weight</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. <strong>Hearing</strong>: coughing, wheezing, moans, cries, blood pressure</td>
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<td></td>
<td>3. <strong>Touch</strong>: lump, perspiration, change in pulse</td>
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</tr>
<tr>
<td></td>
<td>4. <strong>Smell</strong>: odor of breath, order of wounds, fumes, burning</td>
<td></td>
</tr>
<tr>
<td>Using verbal and non-verbal skills of communication</td>
<td>1. Remaining objective versus personal interpretation; facts not opinions</td>
<td>Have students role play examples of body language that differs from the verbal message that is being sent</td>
</tr>
<tr>
<td></td>
<td>2. Asking questions; speaking clearly and learning to listen</td>
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<tr>
<td></td>
<td>3. Keeping good eye contact</td>
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<tr>
<td>Working with persons who have difficulty communicating</td>
<td>1. Find alternative/creative ways to communicate</td>
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<tr>
<td></td>
<td>2. Talk slowly pronouncing words or allow time for lip reading</td>
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<td></td>
<td>3. Use of interpreters or sign language as a means of communication</td>
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</tr>
</tbody>
</table>

(continued – next page)
### UNIT I – 1 Hour
Observational Skills

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Reporting observations and signs of change</td>
<td>Read in Grubbs, Chapter 4 or alternative teaching text</td>
</tr>
<tr>
<td>Describe the personal care staff’s responsibilities in reporting facts to other staff</td>
<td>1. Keeping notes</td>
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<td></td>
<td>2. Reporting what has been seen and heard and resident’s response to care</td>
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<td>3. Report anything unusual</td>
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<td></td>
<td>4. Learn meanings of new words</td>
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</tr>
<tr>
<td>Observational reporting</td>
<td>1. Sharing samples of “note taking” documents</td>
<td></td>
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<tr>
<td></td>
<td>2. Verbal reports to facility staff on a resident’s condition and response to care</td>
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</tr>
</tbody>
</table>


### Expected Outcomes
The student will do the following:

- Discuss the importance of medical records and medical language in reporting/recording observations

### Instructional Content

- Medical records and care plans
  1. Doctor’s orders, admission note and FL-2
  2. Resident assessment/reassessments
  3. Resident care plans
  4. Personal care flow sheets

- Written communications
  1. Guidelines on how to report/record observations
  2. Knowing how to spell words and use accepted abbreviations
  3. Using resources to help in writing information

- Charting policies and procedures in ACH/FCH
- Legal responsibilities of different staff in charting
  1. Personal care staff’s responsibilities
  2. Respect confidentiality of a legal record

- Written documentation by the personal care staff
  1. Sharing samples of record keeping tools
  2. Sharing samples of written progress notes

### Teaching/Learning Evaluation Activities

- Read in Grubbs, Chapters 8 and 9 or alternative teaching text
- Review facility policy and procedure for record keeping tools
- Evaluate students’ progress
## UNIT I – 4 Hours
Common Diseases and Conditions Related to “Normal” Aging

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following: Define the responsibilities of the personal care staff in assisting to promote wellness for “normal” aging resident | Maintaining and improving existing health or wellness  
1. Basic normal changes in older persons  
2. Nutritional factors effecting health promotion of older persons  
3. Functional changes of the eyes and ears of older residence  
4. Changes in sleep/rest patterns  
5. Change in activity levels | Read in Grubbs, Chapters 4 or alternative teaching text |
| Understanding risks factors that contribute to illness  
1. Injuries/accidents related to activities of daily living in later adulthood  
2. The five leading causes of death among older residence  
3. Lifestyle problems affecting older residents; substance use, diet and exercise  
4. Dysfunctional change caused by external factors; flu, TB, medications | Have students list basic needs of a resident they believe are not being met |
| Learning to respond to the body’s messages  
1. Paying attention to signals such as headache, sore throat, shortness of breath  
2. Accepting loss and adjustment to declining functional ability in a positive way  
3. Lessening dysfunctional disabilities from disorders that cause dementia/depression | Brainstorm ways to see what could be done |
UNIT II – 4 Hours
Basic Principles for Resident Care Procedures for Persons with Problems Related to Age, Disability or Common Illness

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will do the following:</td>
<td>Physical care requirements related to:</td>
<td>Have students discuss their feelings if someone had to do an invasive procedure on them. Knowing their own feelings, discuss how they could make it easier for the resident</td>
</tr>
<tr>
<td>Identify basic principles necessary to support safe and competent practice when performing resident care procedures</td>
<td>Gastrointestinal tract 1. Feeding when there are swallowing difficulties 2. Administering enemas 3. Restorative bowel training/retraining 4. Testing fecal specimens</td>
<td>Review reference section in Grubbs, pages 398-409</td>
</tr>
<tr>
<td></td>
<td>Neuro muscular system 1. Assisting with gait training using assistive devices 2. Assisting with or performing range of motion exercises 3. Applying heat therapy</td>
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</tbody>
</table>

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UNIT II – 4 Hours
Basic Principles for Resident Care Procedures for Persons with Problems Related to Age, Disability or Common Illness

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
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<th>Teaching/Learning Evaluation Activities</th>
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<tbody>
<tr>
<td>The student will do the following:</td>
<td>Physical care requirements related to:</td>
<td>Have students discuss their feelings if someone had to do an invasive procedure on them. Knowing their own feelings, discuss how they could make it easier for the resident</td>
</tr>
</tbody>
</table>
| Identify basic principles necessary to support safe and competent practice when performing resident care procedures | Cardio-vascular illness  
1. Exercise/activity requirements  
2. Diet restrictions; low fat, low cholesterol, low salt diets  
3. Maintaining body warmth for older residence  
4. The use of medications (diuretics) and their effects on other body functions  
5. The use of TEDs to improve circulation | Review reference section in Grubbs, pages 398-409                                                          |
|                                                                                   | Wounds of the skin  
1. Non-sterile dressing procedures  
2. Care of non-infected pressure ulcers  
3. Using ace bandages or binder to protect wounds | Evaluate students’ progress                                                                                  |
|                                                                                   | Chemical or mechanical devices are used  
1. Chemical or mechanical devices to restrict activity  
2. Physical restraints to enhance functional ability |                                                                                                           |
## UNIT I – 9 Hours
Skill Lab Practice of Special Health Related Personal Care Tasks

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Instructional Content</th>
<th>Teaching/Learning Evaluation Activities</th>
</tr>
</thead>
</table>
| The student will do the following: Discuss principles of safe practice when performing special health related personal care tasks | Special health related personal care tasks  
1. Feed a resident with swallowing difficulty  
2. Assist with gait training using assistive devices  
3. Assist with range of motion exercises  
4. Empty and record drainage from a catheter bag  
5. Administer enemas  
6. Bowel and bladder training to regain continence  
7. Procedure to follow when testing urine or fecal specimens  
8. Correctly apply physical or mechanical restraints to restrict movement or enhance functional ability  
9. Non-sterile dressing procedures  
10. Maintaining fluid balance, forcing or restricting fluids  
11. Apply heat therapy  
12. Caring for non-infected pressure ulcers  
13. Administering a vaginal irrigation | Have students demonstrate safe and competent practice with special health related personal care tasks in a “skills lab” setting  
Observe and supervise safe practice with skills in the practice setting of the ACH/FCH  
Read in Grubb’s, Chapter 23 and 24 or alternative teaching text |
SECTION IX – The Practicum – 36 Hours

The Practicum – 36 Hours
Application of Knowledge and Skills

1. Orientation to practice setting
2. Clinical outcomes
   a. Perform basic personal care tasks and provide care as described in role and responsibilities of personal care staff
   b. Perform basic nursing skills, including special health-related tasks, according to established procedures
   c. Perform personal care tasks requiring documentation of competency by a licensed professional
   d. Document observations using appropriate terms
   e. Meet the cognitive, behavioral, and social care needs of aging and disabled persons
   f. Provide basic restorative services for aging and disabled persons
   g. Respect of residents’ rights as established
INFORMATION FOR USING
COMPETENCY EVALUATION INSTRUMENT

Introduction

Competency testing is done to evaluate whether a student has acquired the basic knowledge, skills and abilities to provide safe care. Competency testing, for clinical (practical) knowledge, is usually measured by observing a person's psychomotor skills when carrying out procedures. Additional information about the person's cognitive understanding of the procedure, the reason for doing the procedure and the expected outcomes, can also be measured by asking questions either verbally or in writing. Verbal questioning, however, should not occur during the actual skills demonstration (testing) since this may distract/disrupt the student's performance. Further, no advice or prompting should be given by the instructor during the skills testing period.

Skills testing usually occurs in a classroom laboratory, simulated to resemble the actual practice setting, where needed equipment and supplies are available. Skills are performed on a model (mannequin) using a case situation/resident condition similar to the actual practical setting. Skills testing is a required component of the 80-hour training program for personal care staff training. Written exams may be used in combination with the skills performance testing but may not be a substitute for and the only means of competency testing. Since students must demonstrate competency in all basic skills specified in law, instructors will be using a variety of testing methods that include skills, performance, written or oral exams and observations of performance in clinical settings and classroom discussion/role play situations.

Unit I – Skill Demonstration

The tools in this section of the module can be used to test and document student competence in delivering personal care to residents in Adult/Family Care Home (ACH/FCH) settings. Instructors teaching the 80-hour training programs may use the tools to determine if the personal care staff has adequate skills and knowledge to safely perform individual tasks assigned. Each tool, which tests competency in carrying out procedures, includes “demonstrated skills”. The steps of the procedure are listed in logical order and should be performed in proper sequence.

Students must demonstrate competency in all basic skills specified in law. It is up to the instructor to determine whether a student’s performance on the skills test demonstrates competence. To make this decision, the instructor must determine which of the steps (demonstrated skill and/or area of knowledge) are critical to the competent “safe” performance of the procedure to meet the care needs of the resident.

Clearly, all steps that relate to safety ought to be designated as critical when performing skills. There should be relative smoothness and efficiency in carrying out the procedure;
competence is usually determined when the student can complete the entire skill unassisted without missing critical steps. Instructors should watch for left-handed students and make provisions for them in the skills demonstration when handling equipment and manual dexterity are being evaluated.

When observing the student’s performance, the competency tools serve as a checklist with a clear set of criteria for the task. A comment section allows the instructor to cite the variations from procedure and performance weaknesses. These tools may be kept as evidence of the student’s knowledge, skills and abilities; however, a less cumbersome documentation method is to keep a final record similar to the “Personal Care Aide Skills/Competency Evaluation” tool which is included in the 80-hour curriculum modules. An asterisk (*) in the competency/skills column of the course outline, indicates a need for the instructor to develop a written evaluation of the test item.

Expected outcomes for student performance are comparable, regardless of setting, with respect to the procedures for providing personal care. Likewise, the underlying scientific principles for the procedures are similar. Standards, against which the quality of the performance can be measured, have been determined for the practice setting. To ensure consistency in competency testing, the competency tools and knowledge questions in this module were adapted from the tools and questions used to verify competency of the ACH/FCH. The original content of the individual skills verified through a review of professional publications and by the expertise of home care professionals, serving on an advisory committee, who field tested the Competency Testing Tools to correspond to the four levels of the In-Home Aide Services standards. The NC DHHS Divisions participating in this endeavor were: Division of Aging, Division of Medical Assistance, Division of Social Service, and the Division of Services to the Blind.

(Note: For a student to become competent in performing some tasks, such as taking and recording vital signs or documenting observations, the student must be able to read and write at a level necessary to carry out these assigned tasks properly)

**Unit II - Exams**

Related knowledge questions, written or oral responses to inquiry, can also be used to evaluate competency. These questions may not be used in lieu of skills demonstration; however, they may be used to supplement performance testing by providing the instructor with additional understanding of the student's acquisition of knowledge, attitude or behavior. This is particularly important, at this time, if written or oral exams were not used during the classroom training session.

(continued – next page)
Knowledge questions determine the student's general knowledge of issues and content information related to the procedure. If an oral examination is given, instructors should read from a prepared test in a neutral manner. (Reading prepared questions avoids the tendency to paraphrase and get the answer you want or to provide clues to the answer.) An alternate method to reading questions is the use of audio tapes.

Exam questions require that the student have ability in reading, writing and visual acuity. If using this form of competency evaluation, it is most important that the questions be carefully constructed. Multiple choice questions are the most commonly used forms since they allow analysis. However, written exams are one of the most intimidating forms of testing for the adult student. Thus, instructors are cautioned to adhere to the basic principles of test construction such as: (1) ensuring the intent of questions does not trick the student; (2) only one correct answer is listed in the multiple options; (3) double negatives are not used.

The instructor may also pose questions and expect the student to respond. Questioning a person orally has value in that it provides opportunity to evaluate verbal and non-verbal responses thus testing both the cognitive and affective domains. This method can be used simultaneously during a practice session for skills demonstration, yet, it should not be used during actual testing since it may be disruptive to one's thought process. Questions can elicit whether the student has knowledge of facts. (What is happening? How, when and where does it happen?) Questions are also helpful to get information on how well the student understands. (Why does this happen? What are the variations?) Questions help to determine level of safety and the student’s ability to apply learned knowledge to other situations. (What does this mean? How do you explain it? In what other situations would this apply?)
### SECTION XI  Competency Evaluation Instruments

#### Personal Care Aide Training Skills/Competency Evaluation
(Initialed and dated by person supervising)

<table>
<thead>
<tr>
<th>Date of Observation</th>
<th>Knowledge/Experience</th>
<th>In Lab</th>
<th>In Clinical</th>
<th>S</th>
<th>U</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Nursing Skills</strong></td>
<td>1. Understands procedures and accurately takes/records vital signs:</td>
<td></td>
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<tr>
<td></td>
<td>a. taking body temp</td>
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<tr>
<td></td>
<td>b. taking pulse and respiration</td>
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<td></td>
<td>c. taking blood pressure</td>
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<td></td>
<td>2. Understands procedure and accurately measures/records height and weight</td>
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<td></td>
<td>3. Properly collects urine and fecal specimens</td>
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<td>4. Aware of universal precautions and uses procedures to prevent the spread of infection when:</td>
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<tr>
<td></td>
<td>a. handwashing</td>
<td></td>
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<td></td>
<td>b. changing bed linen</td>
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<td></td>
<td>c. disposing of contaminated wastes</td>
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<td></td>
<td>d. providing personal care (uses gloves when needed)</td>
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</tbody>
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(continued – next page)
### Personal Care Aide Training Skills/Competency Evaluation
(Initialed and dated by person supervising)

<table>
<thead>
<tr>
<th>Date of Observation</th>
<th>Knowledge/Experience</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Provides personal hygiene and grooming needs according to functional ability:</td>
</tr>
<tr>
<td></td>
<td>a. toileting and maintenance of bowel and bladder continence</td>
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<tr>
<td></td>
<td>b. mouth care, care of dentures</td>
</tr>
<tr>
<td></td>
<td>c. bathing, bed bath, tub/shower or whirlpool</td>
</tr>
<tr>
<td></td>
<td>d. perineal care daily with each change of wet clothing or soiled linens</td>
</tr>
<tr>
<td></td>
<td>e. shaving</td>
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<tr>
<td></td>
<td>f. hair and scalp grooming including shampooing</td>
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<tr>
<td></td>
<td>g. proving special foot care/nail care for non-diabetic or non-peripheral vascular disease care of fingernails</td>
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<td></td>
<td>h. correctly applies condom catheter</td>
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<tr>
<td></td>
<td>6. Personal care, exercise, transfer, ambulation/locomotion:</td>
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<tr>
<td></td>
<td>a. encourages physical activity</td>
</tr>
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<td></td>
<td>b. assists with mobility/walking</td>
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<td></td>
<td>c. correctly uses assistive devices</td>
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</tbody>
</table>

(continued – next page)
## Personal Care Aide Training Skills/Competency Evaluation

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<table>
<thead>
<tr>
<th>Knowledge/Experience</th>
<th>In Lab</th>
<th>In Clinical</th>
<th>S</th>
<th>U</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Personal care, exercise, transfer, ambulation/locomotion (continued)</td>
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<tr>
<td>d. correctly transfers bed/chair</td>
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<tr>
<td>e. correctly uses mechanical lift</td>
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<td>7. Assists with dressing, undressing</td>
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<td>8. Personal care, resident in bed:</td>
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<tr>
<td>a. properly positions/turns</td>
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<tr>
<td>b. gives a back rub</td>
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<td>c. preventing pressure sores including care of normal unbroken skin</td>
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<tr>
<td>d. makes an occupied bed, ensuring safety to the resident</td>
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<td>9. Applies or assists with applying ace bandages, TEDs, binders</td>
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<tr>
<td>10. Apply or removes or assist with applying/removing prosthetic devices</td>
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<td>11. Personal care, safety needs:</td>
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<tr>
<td>a. provides for safe environment</td>
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<td>b. emphasizes safety principles</td>
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### Personal Care Aide Training Skills/Competency Evaluation

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<tr>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Personal care, safety needs: (continued)</td>
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<td></td>
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<tr>
<td>c. explains responsibility with respect to basic first aid in emergency situations</td>
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<td>d. monitors resident for safety when restraints are used</td>
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<td>12. Shows correct procedure with Heimlich maneuver</td>
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<tr>
<td>13. Behavioral Needs:</td>
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<tr>
<td>a. recognizes differences in behavior of resident with ID, IDD or physical illness and responds appropriately</td>
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<td>b. can identify some of the ways residents and families react to illness and disability</td>
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<td>c. assists residents to adjust to living arrangement in ACH/FCH</td>
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<td>d. can identify the needs of the dying resident and show respect and support for end-of-life decisions</td>
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</thead>
<tbody>
<tr>
<td><strong>14. Nutrition Needs:</strong></td>
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<tr>
<td>a. assists with feeding/drinking</td>
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<tr>
<td>b. provides additional nourishment, supplements</td>
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<tr>
<td>c. has a working knowledge of most common special diets</td>
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<tr>
<td><strong>15. Communication:</strong></td>
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<tr>
<td>a. can describe special needs and problems of elderly/disabled</td>
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<tr>
<td>b. responds appropriately to resident’s needs; is supportive of independence according to functional ability</td>
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<td>c. respects residents’ rights, freedom of choice</td>
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<td>d. is aware of and correctly uses the language of medicine when appropriate</td>
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<td>e. communicates effectively with residents and co-workers</td>
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<td>f. uses appropriate language at all times when at work</td>
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<td>g. gives correct information to families who ask questions about their relative</td>
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<td>h. accurately reports observation and changes in resident’s condition to supervisor</td>
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(continued – next page)
### Personal Care Aide Training Skills/Competency Evaluation

*(Initialed and dated by person supervising)*

<table>
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<tr>
<th>Knowledge/Experience</th>
<th>Date of Observation</th>
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<th>In Clinical</th>
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<tr>
<td>16. Personal Care/Special Health Related Skills:</td>
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<tr>
<td>a. Correctly feeds resident with swallowing difficulty</td>
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<td>b. Assists with gait training using assistive devices</td>
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<td>c. Assists with or performs range of motion exercise</td>
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<td>d. Empty and record drainage from cath bag</td>
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<td>e. Administer enema</td>
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<td>f. Bowel and bladder retraining to regain continence</td>
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<td>g. Test urine or fecal specimens</td>
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<td>h. Correctly use physical or mechanical devices to restrain or enable functional ability</td>
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<td>i. Non-sterile dressing procedures done correctly</td>
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<td>j. Knows correct way to force or restrict fluids</td>
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<td>k. Correctly applies heat therapy</td>
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<td>l. Correctly care for noninfected pressure ulcers</td>
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17. Personal Care Staff Roles and Responsibilities:

<table>
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<th>Knowledge/Experience</th>
<th>Date of Observation</th>
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<th>In Clinical</th>
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<tbody>
<tr>
<td>a. can identify tasks &amp; functions of personal care staff</td>
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### Personal Care Aide Training Skills/Competency Evaluation

(Initialed and dated by person supervising)

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<tr>
<td>b. is aware of the limitations of role in practice setting</td>
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<td>c. is friendly, courteous and respectful of other’s lifestyles</td>
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<td>d. respects resident’s rights for privacy and confidentiality</td>
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<td>e. avoids self-injury by using good body mechanics when providing care</td>
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<td>f. personal demeanor, character and attributed are appropriate</td>
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<td>g. adheres to assigned schedule and assigned duties</td>
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<td>h. carries out goals and follows policies of the ACH/FCH</td>
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<td>i. is a good team member in the ACH/FCH</td>
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SECTION XI – Competency Evaluation Instruments

Techniques for Providing Care Outline

1. Using Proper Body Mechanics
2. Bed Making
   a. unoccupied bed
   b. occupied bed
3. Safety Precautions
   a. preventing falls/accidents; arranging furniture, wiping up spills
   b. using the senses; checking sound, smells and room temperature
   c. safe use of restraints
   d. basic fire safety; observing smoking rules, reporting faulty equipment, use or fire extinguishers, participation in drills
   e. evacuation procedures; lifts and carriers
4. Using Effective Communication Skills
   a. speaking skills, listening skills
   b. non-verbal communication
   c. interpersonal skills with residents, other staff
5. Infection Control Measures
   a. standard precautions: handwashing; handling linen; cleaning equipment
   b. transmission-based precautions: handwashing and gloving; protective apparel; linen and laundry; waste disposal
   c. handwashing
6. Respecting Residents' Rights
   a. right to privacy
   b. right to confidentiality
   c. freedom from restraints
   d. free from abuse, neglect or exploitation
7. Observations
   a. routine skin checks
   b. watching for signs of depression
   c. how well the resident eats; foods/fluid taken by mouth
   d. watching the wanderer
8. Reporting and Recording Observations
   a. oral reports of resident’s behavior and response to care
   b. accident/incident reports
9. Giving Backrubs
10. Assisting Residents with Emotional Problems
    a. maintaining/regaining self-esteem
    b. helping confused and/or disoriented residents
    c. coping with anxiety
    d. managing the combative resident
    e. watching the wanderer
11. Interpersonal Skills and Behavioral Interventions
    a. recognizes unusual patterns of response
    b. preferences and personality traits
    c. distress and behavior problems
    d. alternatives to the use of restraints
    e. safe, humane management of behavior problems
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Using Proper Body Mechanics

Demonstration:

_____ 1. Used proper technique for lifting
   a. Carried heavy objects close to body
   b. Broadened base of equilibrium by placing feet apart when carrying heavy objects
   c. Assumed squatting position, with back straight, and lifts heavy object(s) using
      strongest and longest muscles of body (legs, hips and arms)
   d. Kept hips and knees slightly bent when carrying heavy objects
   e. Used portable cart to move objects that are bulky or too heavy for one person to carry
   f. When necessary, pushed, pulled or rolled heavy objects rather than lifting

_____ 2. Faced work area, with all needed equipment accessible to the reach, rather than
   twisting to reach equipment/supplies

_____ 3. Adjusted the work area, when possible, to a comfortable height

_____ 4. When moving a resident’s body unassisted, moved torso in segments rather than
   trying to move entire body

_____ 5. Avoided jerky or twisting movements when performing duties

_____ 6. Maintained good posture when walking, standing or sitting

_____ 7. Sought help to move heavy objects/person(s)

_____ 8. Used a back support brace (waist belt) while moving or lifting objects/residence

Pass: ___________  More Practice: ___________

Comments: __________________________________________________________________________

____________________________________________________________________________________

Signature of Instructor __________________________ Date ___________

Signature of Personal Care Staff ______________________ Date ___________
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

**Bed Making**
(making an unoccupied bed)

**Demonstration:**

___ 1. If hi-low bed, adjusted bed to an elevated level to avoid back strain, returned bed to low position when task completed
___ 2. Put on gloves (if linens soiled with urine, feces or other body fluid)
___ 3. Watched for lost or misplace articles caught within soiled linens
___ 4. Removed dirty linen (rolled linens away from self, avoided shaking dirty linens to avoid spread of bacteria through the air)
___ 5. Immediately placed linen in receptacle (did not place linens on floor)
___ 6. Removed gloves (disposed per facility policy)
___ 7. Had clean linen available:
   a. blanket
   b. bottom sheet
   c. draw sheet, as needed
   d. mattress pad, as needed
   e. pillow cases
   f. spread
   g. top sheet
___ 8. Spread bottom sheet over mattress (pad)
___ 9. Placed draw sheet on bed, if needed
___ 10. Spread top sheet over bottom sheet (hem even with head of bed)
___ 11. Placed blanket evenly on bed
___ 12. Made mitered (hospital) corners or tucked according to resident’s instruction
___ 13. Placed blanket/spread on top of bed linens, if needed
___ 14. Put pillowcases on pillows
___ 15. Fan-folded top sheet and blanket to the foot of the bed
   OR
___ 16. Pulled spread, sheet and blanket over pillow
___ 17. Washed hands after competing task and moving on to another resident

Pass:__________ More Practice:__________

Comments: ____________________________________________________________________________________________

_____________________________________________________________________________________________________

Signature of Instructor Date

_____________________________________________________________________________________________________

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

**Bed Making**
(making an occupied bed)

**Demonstration:**

1. If hi-low bed, adjusted bed to an elevated level to avoid back strain
2. Washed hands prior to providing care to resident
3. Put on gloves, if needed
4. Collected the following linen:
   a. blanket and/or bedspread
   b. bottom sheet
   c. draw sheet, if needed
d. mattress pad, if needed
   e. pillowcases
   f. plastic draw sheet
g. top sheet
5. Loosened top linens at foot of bed
6. Removed top covers except for top sheet
7. Placed the clean sheet over top sheet. Had the resident hold the top edge of the clean sheet, if able. Slid the soiled sheet out, from top to bottom, and put it in hamper (did not place soiled linen on floor)
8. Instructed or turned resident onto left side of bed taking adequate precautionary measures to prevent resident from rolling off bed (e.g., side rails, another person supporting resident on left side of bed, etc.)
9. Adjusted pillow under head for comfort of resident
10. Loosened bottom linens from the head to the foot of the bed
11. Fan-folded soiled bottom linens one at a time toward the resident (fan-folded mattress pad if needed to be changed)
12. Placed the bottom sheet on the mattress pad lengthwise so the center is in the middle of the bed. Fan folded the top part toward the resident
13. Made a mitered comer at the head of the bed. Tucked the sheet under the mattress from the head to the foot of the bed. (If using a fitted sheet, adequately secured each comer and fan-folded sheet towards center of bed)
14. Placed a draw sheet on the bottom sheet. Fan-folded the top part toward the resident. Tucked the excess draw sheet under the mattress
15. Instructed or turned resident to the right side of bed. (Followed safety precautions)
16. Readjusts pillow under head for comfort of resident
17. Loosened bottom linens. Removed each piece of used linen (watched for lost or misplaced articles caught in linens; did not place soiled linens on floor)
18. Straightened and smoothed the mattress pad
19. Pulled the clean bottom sheet toward the aide. Made a mitered corner at the head of the bed. Tucked the sheet under the mattress from the head to the foot of the bed (adapted, if used fitted sheet)

(continued – next page)
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

**Bed Making**
(making an occupied bed)

**Demonstration:**

20. Pulled the draw sheet tight and tucked under mattress
21. Asked resident to move or turned resident to the center of the bed
22. Readjusted pillow for comfort
23. Put the top sheet on the bed (hem stitching on the outside)
24. Asked the resident to hold top sheet (if able). Removed blanket or top sheet covering resident
25. Placed the blanket on the bed over resident. The upper hem was 6 to 8 inches from the top of the mattress
26. Placed the bedspread on the bed. Covered the resident
27. Brought the top sheet down over the bedspread to form a cuff
28. At the foot of the bed, lifted the mattress corner with one arm. Tucked the top sheet, blanket, and bedspread under the mattress together. Made a mitered corner. (Loosened linen to allow for movement of resident's feet)
29. Followed procedure, as described in step #28, on other side of bed
30. Changed the pillowcases
31. Asked resident if bed is comfortable, returned bed to low position for resident safety
32. Removed dirty linens from the room
33. Removed and disposed of gloves properly
34. Washed hands

Pass: _________  More Practice: _________

Comments: __________________________________________________________

________________________________________  _______________________
Signature of Instructor                                   Date

________________________________________  _______________________
Signature of Personal Care Staff                          Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Safety Precautions
(preventing falls/accidents)

Demonstration:

1. Checked to see that tub and shower floors are equipped with nonslip mats
2. Encouraged the use of grab bars when using tub or toilet
3. Kept floors free of spills or dust
4. Kept traffic areas free of clutter
5. Safety hazards such as scatter rugs, objects with sharp edges and unstable chairs are removed from resident areas
6. Objects are arranged to minimize the resident's need to reach or bend
7. Reports faulty equipment and/or inadequate lighting
8. Adjusts bed to the proper height to aid in transfers
9. Locked wheelchair brakes to prevent falls when transferring (unlocks brakes, when appropriate, to allow motion, self-moving by the resident)

Pass: __________  More Practice: __________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date

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SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Safety Precautions
(using the senses)

Demonstration:

__1. Avoids contributing to sensory overload when providing care

__2. Watched resident for signs and symptoms of possible visual problems such as: bumping into objects, missing a step, increased squinting or inability to read printed material

__3. Used effective communication skills with residents with hearing disabilities

__4. Carefully handled a resident's hearing aid or glasses to avoid damage and/or loss

__5. Observed resident's skin routinely to check for reddened areas, pressure sores, bruises or skin tears

__6. Provided activity and/or turns bedridden residents according to plan of care to decrease the possibility of pressure sores

__7. Checked temperature of bath water to avoid skin burns

__8. Checked room temperature to avoid chilling environment

__9. Assisted residents to assure adequate food intake by making certain the appearance, temperature and texture of foods are pleasing when serving and/or feeding

__10. Avoided unpleasant odors by keeping the residents and the environment clean; reports unpleasant odors immediately

Pass: __________ More Practice: __________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date

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SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Safety Precautions
(safe use of restraints)

Demonstration:

___ 1. Demonstrated knowledge of the rules for the safe use of any kind of restraint that restricts movement/mobility (e.g., side rails, geri-chair, tray tables, waist or belt restraints, vest jacket, wrist, ankle or mitt restraints)
___ 2. Used restraints for the proper reason and not for the convenience of staff
___ 3. Demonstrated an understanding of alternatives to the use of restraints
___ 4. Applied restraints properly and only in accordance with the plan of care; checks skin frequently for proper circulation
___ 5. Correctly monitored and visually checked the restrained resident according to facility policy
___ 6. Removed the restraints every 2 hours, or more frequently if needed, and provides adequate exercise/mobility
___ 7. Met the personal care needs of residents who are restrained (communicates with, offers liquids and toilets the resident on schedule, or more often as needed)

Pass: __________ More Practice: __________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

**Safety Precautions**
(fire and evacuation)

**Demonstration:**

1. Demonstrated knowledge of basic fire safety rules
2. Listed proper information to provide to the telephone operator when reporting a fire
3. Knew the location of fire alarms and extinguishing devices
4. Discussed the meaning of the word RACE with respect to the steps to take in case of fire (rescue, alert, confine and extinguish)
5. Identified safety precautions to take when using electrical appliances/equipment
6. Cautious when oxygen is in use
7. Reported safety hazards that could contribute to accidents
8. Supported enforcement of smoking rules (smoke free environment or smoking only in designated areas)
9. Monitored smoking among residents who require supervision
10. Discussed the fire safety and evacuation route for exiting the facility in case of emergency
11. Explained how and when to use these three basic body carries when responding to an emergency
   a. bedding lift
   b. cradle drop
   c. two-person extremity carry

Pass: __________  More Practice: __________

Comments: ________________________________________________________________

_________________________  _______________________
Signature of Instructor                  Date

_________________________  _______________________
Signature of Personal Care Staff          Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Communication Skills

Demonstration:

___ 1. Uses effective speaking and listening skills with residents and other staff
   a. spoke clearly in an un rushed manner
   b. spoke loud enough to be heard but avoids yelling
   c. conveyed specificity with spoken messages
   d. did not interrupt or talk at the same time as others
   e. maintained eye contact when speaking with others

___ 2. Responded to a resident's emotional and physical needs in a timely manner
   a. used touch appropriately in a comforting supportive manner

___ 3. Avoided using inappropriate verbal or language or tone of voice when interacting with residents

___ 4. Avoided using other verbal or nonverbal blocks to communication
   a. avoided use of body language which can be perceived as disrespectful (gestures, movements or mannerisms)
   b. avoided use of condescending or patronizing salutations
      (i.e., "dearie", "sweetie" or "honey")
   c. does not verbally abuse residents at any time

___ 5. Described ways to communicate with residents with vision or hearing problems

___ 6. Described ways to communicate with cognitively impaired residents

___ 7. Used effective reporting skills
   a. openly shared information about residents' condition and response to care
   b. communicated regularly, according to facility policy, with supervisor and the personal care staff going off or coming on duty
   c. reviewed the plan of care for additional information on the resident's condition

___ 8. Visited assigned residents, on a regular basis, during the course of the day to check on their present condition

___ 9. Used appropriate behavior to assist with the management of a resident who is communicating in an unacceptable way

___ 10. Recognized and adapts to the differences and values in communication styles/patterns of other cultures

Pass:__________  More Practice:__________

Comments: __________________________________________________________

____________________________________________________________________
Signature of Instructor Date

____________________________________________________________________
Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

**Infection Control Measures**

*(transmission-based procedures)*

### Demonstration:

1. **Safe practice:**
   - a. aware of workplace policy and procedure for universal precautions that promote safety for self and resident
   - b. reported exposure, illness and injury immediately
   - c. aware of need to attend training and retraining sessions on infection control regulations

2. **Demonstrated good personal hygiene technique with handwashing**
   - a. washed hands before/after touching resident or resident's food
   - b. washed hands after putting hand to mouth while coughing or sneezing
   - c. washed hands after using the bathroom
   - d. washed hands after cleaning bedpans/urinals
   - e. washed hands after touching soiled linen

3. **Wore disposable gloves as directed and according to facility policy and procedure:**
   - a. when changing soiled linen
   - b. when cleaning bedpans, urinals
   - c. when in contact with body fluids or blood
   - d. when bathing or feeding a resident with a known infection
   - e. when aide has skin breakdown on hands

4. **Demonstrated proper glove technique:**
   - a. washed hands before putting on gloves
   - b. inspected and notes any cuts or rashes on hands
   - c. put on gloves; checked and replaced gloves that are broken or damaged
   - d. removed gloves without touching skin to outside of gloves
   - e. threw gloves into plastic trash bag (or otherwise disposes of per facility policy)

5. **Demonstrated proper use of protective clothing**
   - a. washed hands before putting on gown
   - b. if needed, wears protective equipment mask or goggles. (Follows facility policy and procedures)
   - c. was aware of biohazard bags for disposal of contaminated materials as directed in facility policy and procedures

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Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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_____________________________________________________________________________
Signature of Instructor Date
_____________________________________________________________________________
Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Infection Control Measure
(handwashing)

Demonstration:

1. Turned on water, water should run entire time hands are being washed
2. Turned faucet on and off using a paper towel (if policy of facility)
3. Pushed wristwatch 4-5" above hand
4. Stood far enough away from sink so clothes did not touch sink
5. Adjusted water until it warm and a comfortable temperature
6. Wet wrists and hands thoroughly under running water
7. Kept hands lower than level of elbows throughout the procedure
8. Worked up good lather by rubbing palms together
9. Washed each hand and wrist thoroughly and cleaned well between fingers
10. Cleaned well under fingernails by rubbing tips of fingers against palms
11. Continued washing for 10 to 15 seconds
12. Used nail file to clean under nails (optional)
13. Rinsed wrists and hands well under running water
14. Dried wrists and hands with paper towel
15. Correctly used an alternative method of handwashing (per policy of facility)

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Signature of Instructor  Date

Signature of Personal Care Staff  Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Respecting Residents’ Rights

Demonstration:

1. Provided safe quality care to residents under their care
   a. treated the residents with respect, consideration dignity and full recognition of his or her individuality
   b. ensured resident’s right to privacy
   c. kept information about the resident confidential

2. Responded, without delay, to resident’s requests for care

3. Avoided using physical restraints for convenience
   a. used the restraint only with authorized permission of the physician according to clear and indicated medical reason
   b. followed guidelines for applying restraints and checked residents according to facility policy

4. Ensured the resident is free of mental and physical abuse; neglect and exploitation

5. Supported the residents wish for privacy when meeting with family or friends when using the phone to communicate

6. Assisted the resident with the resident’s requests for writing materials including helping resident to get postage. Helped resident to send and receive mail promptly

7. Respected resident’s right of freedom to make complaints without fear of coercion or retaliation

8. Helped residents to have access to their personal possessions and to have access to lockable space to secure their personal valuables

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Signature of Instructor  Date
_____________________________________________________________________________

Signature of Personal Care Staff  Date

SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care
Observations

Demonstration:

1. Observed the resident's functional status and reports any changes in physical ability to perform ADLs
2. Took the time to observe and respond to the resident's verbal and non-verbal communications and reported unusual responses
3. Watched for signs of depression such as withdrawal from social contact
4. Knew that medications may affect a resident's health status and watches for and reports on any changes that are unusual in ability or behavior
5. Observed the condition of the skin when giving personal care such as a bath or backrub and reports on any redness, skin breaks or bruises that are noted
6. Observed changes in speech, eating habits, elimination patterns, weight or other vital signs and reports these changes to the supervisor immediately
7. Observed the resident who is a wanderer and follows facility policy with routine checks

Pass:__________ More Practice:__________

Comments: ___________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Reporting and Recording Observations

Demonstration:

1. Obtained a report on the residents from the previous staff members prior to giving care.
2. Reported “off” to the oncoming staff about the residents under their care during the course of the day.
3. Immediately reported anything out of the ordinary about the resident to the supervisor.
4. Immediately told the supervisor of any changes in the resident’s vital signs, complaints of illness, chest pain or feelings of faintness or dizziness.
5. Listened to the resident’s concerns about their health and reports symptoms that the resident may describe to the supervisor.
6. Wrote down observations and/or vital signs about the residents under their care to assist in charting accurately.
7. Accurately reported/recorded personal care and treatments on each resident under their care using facility approved forms and charting methods.
8. Made all recordings of observations or care provided on the resident’s chart in a timely fashion.
9. Entries made on the resident’s chart of the facility flow sheet are completely honest and factual.
10. Entries on the resident’s chart were signed using first initial, last name and title.
11. Entries on facility flow sheets were initialed according to policy.

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
_____________________________________________________________________________

Signature of Instructor Date
_____________________________________________________________________________

Signature of Personal Care Staff Date
Giving a Backrub

Demonstration:

___ 1. Offered backrub as part of daily morning, afternoon and evening care or at other times as necessary to stimulate circulation to pressure areas of the back
___ 2. Assembled equipment
   a. lotion
   b. towels
___ 3. Asked resident to turn on side or abdomen; use side most comfortable for resident. (Back should be turned toward the aide)
___ 4. Side rail was up on the far side of the bed to prevent falls. When no rails were used, student checked to ensure resident was not on the edge of the bed to prevent falls
___ 5. Placed towel under resident's exposed back to prevent getting lotion on clothing or bed linens
___ 6. Lotion was warmed by placing container under running warm water prior to the backrub or by placing a small amount in the palm of the hands and using friction to warm the lotion
___ 7. Student elevated bed to a comfortable working position, if able, and kept knees bent to avoid straining back
___ 8. Applied lotion to entire back with palms of hands using firm, long strokes from buttocks to shoulders and back of neck
___ 9. Used gentle pressure on downward stroke from shoulders to buttocks
___10. Used circular motion on each bony area
___11. Rhythmic rubbing motion was continuous for 2 to 3 minutes
___12. Dried residents back with towel and straightens gown/clothes and bed linens
___13. Returned resident to a comfortable position and lowers bed for safety
___14. If resident was confined to bed, used bedrails as ordered or appropriate
___15. Replaced equipment in drawer of bedside table
___16. Washed hands
___17. Immediately reports any areas of redness, skin tears or unusual skin marks
___18. Reported how the resident tolerated the procedure and in particular, any unusual response to the care

Pass: __________  More Practice: __________

Comments: ____________________________

________________________________________
Signature of Instructor  Date

________________________________________
Signature of Personal Care Staff  Date
Assisting Residents with Emotional Problems
(maintaining/regaining self-esteem)

Demonstration:

___ 1. Encouraged and praises residents for doing as much as they are capable of doing
___ 2. Allowed residents to make meaningful choices in their course of care
___ 3. Included residents in any decision making regarding their care
___ 4. Allowed residents to express their feelings
___ 5. Was kind to residents, and if they express anger, does not take it personally
___ 6. Showed residents they are respected, appreciated and valued as an individual
___ 7. Assisted residents to adjust to the facility by encouraging them to place personal possessions such as family pictures, special belongings, plants or favorite blankets in their room
___ 8. Encouraged residents to remain mobile and to participate in a variety of activities
___ 9. Helped residents to keep in touch with family and friends
___10. Helped residents to keep up with current events through TV, newspapers, magazines, radio and internet
___11. Took time to talk with the resident on a personal level as they perform tasks for them

Pass:__________  More Practice:__________

Comments: ____________________________________________________________

_____________________________________________________________________
Signature of Instructor Date

_____________________________________________________________________
Signature of Personal Care Staff Date
Assisting Residents with Emotional Problems
(confused/disoriented)

Demonstration:

1. Assisted in decorating the resident’s room with personal belongings
2. Kept to a daily routine the resident can follow
3. Assisted to keep the resident active to avoid boredom
4. Introduced self to the resident as often as needed to help the resident remember
5. Kept a calendar and clock in a visible place and frequently referred to the time and date
6. Encouraged the resident to talk about his or her family and past experiences
7. Kept cueing signs visible to help the resident find the toilet or their room
8. Did not avoid a confused resident or laugh at the confused responses of the resident

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date
_____________________________________________________________________________
Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Assisting Residents with Emotional Problems
(coping with anxiety)

Demonstration:

___ 1. Recognized the symptoms of anxiety such as irritability, restlessness, sleeplessness and reports them immediately to the supervisor
___ 2. Remained calm and comforted the anxious resident who had physical symptoms such as trembling, headaches, palpitations and dizziness
___ 3. Tried to decrease the resident's anxiety by using relaxation exercises such as deep breathing or physical activity such as walking with the resident
___ 4. Tried to keep the resident's mind off their anxiety by planning simple activities
___ 5. Decreased stimuli by turning off the radio, lowering the lights or bringing the resident to a room where they could be alone and quieted
___ 6. Did not ask the anxious resident to make decisions
___ 7. Provided positive reinforcement to the resident when they were able to cope with anxiety in adaptive ways such as talking about it
___ 8. Talked with the resident about what causes the anxiety and what relieves it

Pass:__________  More Practice:__________

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Signature of Instructor Date

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Signature of Personal Care Staff Date
Recognize Unusual Patterns of Response
(to others)

Demonstration:

___ 1. Recognized that residents have individual personality traits that effect how they respond to others

___ 2. Recognized their own usual style/personality traits

___ 3. Demonstrated appropriate interaction to resident whose personality traits and usual pattern of responding differ from that of the aide

Pass: ________  More Practice: ________

Comments: __________________________________________________________

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Signature of Instructor ___________________________ Date ________

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Signature of Personal Care Staff _______________________ Date ________
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Preferences and Personality Traits
(individual residents require different kinds of staff responses)

Demonstration:

_____ 1. Identified appropriate interaction with a resident who prefers each of the following styles: quiet, dramatic; introverted, extroverted; unmotivated, eager; positive and negative

_____ 2. Demonstrated appropriate interactions with residents that show respect for the individual

_____ 3. Demonstrated appropriate interaction with residents that match the resident’s need for privacy and personal space

_____ 4. Demonstrated appropriate interactions with residents that match the resident’s preference about timing of activities and tasks

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Techniques for Providing Care

Recognition of Behaviors Indicating Increased Distress

Demonstration:

1. Recognized behaviors that are unique to the individual
2. Was able to recognize changing behaviors due to stressors
3. Identified coping styles and their effectiveness
4. Related effective interventions for coping with various stressors

Pass:__________ More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date
alternatives to the use of restraints
(to decrease distress & behavior problems)

Knowledge of and use of techniques, as alternatives to the use of restraints, to decrease intrapersonal and interpersonal distress and behavior problems

Demonstration:

____ 1. Related type, use and frequency of restraints
____ 2. Identified personal feelings as they related to the use of restraints
____ 3. Identified five (5) interventions that provided alternatives to restraints

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Safe Humane Management of Residents’ Behavioral Problems

Knowledge of procedures for obtaining consultation and assistance regarding safe, humane management of residents’ behavior problems

Demonstration:

___ 1. Related in-house chain of command for restraint policy and consultation
___ 2. Identified in-house and out of facility contracts for consultation
___ 3. Explained how personal ethics impact humane management

Pass:__________  More Practice:__________

Comments: ____________________________________________________________

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Signature of Instructor  Date

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Signature of Personal Care Staff  Date
Basic Nursing Skills Outline
Assisting with ADLs/Personal Care Tasks

Unit No./ Title
1. Feeding residents unable to feed themselves (blind; physically/emotionally/mentally disabled; needing special supplements, extra nourishment)
   a. ambulatory resident
   b. resident confined to bed/chair
2. Positioning resident in bed
   a. positioning on side – turning towards you
   b. moving resident up – using turning sheet
3. Transferring resident to/from bed to chair
   a. mechanical lift
   b. gait (transfer) belt
4. Assisting with walking
5. Personal hygiene
   a. mouth care; brushing the teeth
   b. denture care
   c. hair and scalp care; combing/brushing and trimming
   d. hair and scalp care; chair shampoo
   e. hair and scalp care; bed shampoo
   f. care of fingernails
   g. assisting with bath/shower
   h. giving bed bath
   i. shaving resident; (A) safety razor, (B) electric razor
   j. shaving resident with skin disorders
6. Assisting with toileting/maintaining continence
   a. adult briefs
   b. using the bedpan
   c. offering the urinal
   d. bedside commode
   e. condom catheter
   d. offering bedside commode
7. Collecting specimen
   a. urine specs
   b. fecal specs
8. Giving perineal care
   a. Female
   b. Male
9. Care for normal, unbroken skin
(continued – next page)
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills Outline

Basic Nursing Skills
Assisting with ADLs/Personal Care Tasks

10. Take and record vital signs
   a. temperature: oral, axillary
   b. temperature: rectal
   c. radial pulse
   d. respiration
   e. blood pressure *
11. Take and record routine height and weight
   a. height
   b. weight
12. Prosthetic devices
   a. apply and remove or
   b. assist with applying/removing
13. Applying ace (elastic) bandages
14. Applying elastic stockings (TEDs)
15. Applying binders *
16. Assist with dressing/undressing
17. Assist limited function resident with dressing/undressing
18. Emergency Care
   a. choking; Heimlich maneuver for conscious resident
   b. choking; Heimlich maneuver for unconscious resident
   c. bleeding; cuts, nosebleeds, hemorrhage
   d. seizures
   e. burns
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Feeding Residents with Special Conditions
(ambulatory residents – problems not related to swallowing difficulties)

Demonstration:

____ 1. Washed hands
____ 2. Helped resident sit comfortably
____ 3. Placed food on the table in front of resident
____ 4. Offered napkin to resident
____ 5. Seasoned and cut up food (if needed) according to resident's direction
____ 6. Identified position of food on plate (if necessary)
____ 7. Assisted resident in using utensils, as needed; did not rush resident
____ 8. Offered a straw for liquids (if available)
____ 9. Conversed with resident in a pleasant manner
____ 10. Removed dishes from table when resident had finished eating
____ 11. Noted how much and what foods resident ingested
____ 12. Washed hands
____ 13. Reported to supervisor any problems associated with resident's food intake

Pass: __________ More Practice: __________

Comments: ________________________________________________________________

_____________________________  Date
Signature of Instructor

_____________________________  Date
Signature of Personal Care Staff
SECTION XI - Competency Evaluation Instruments, Basic Nursing Skills

Feeding Residents with Special Conditions
(resident confined to bed/chair)

Demonstration:

1. Washed hands
2. Offered comfort measures to the resident, as needed, before feeding:
   a. offered opportunity to use toilet
   b. offered washcloths, for face and hands
   c. if needed, offered oral hygiene care before meal, (assisted with oral hygiene after meal)
3. Removed unnecessary articles and cleaned surface where food is to be placed
4. Positioned resident in chair or in high Fowler's position in the bed with head slightly bent forward
5. Placed napkin under resident's chin
6. Placed food on table in front of resident, (if appropriate-described the food served)
7. Buttered bread and cut meat, if this is the help needed
8. Placed hot beverages away from resident until they were ready for it
9. Used different drinking straws for each liquid or used a cup
10. Held spoon at a right angle
    a. tested hot foods by dropping a small amount on the inside of wrist before feeding food to the resident
    b. described or showed resident each food given
    c. gave solid foods from point of spoon
    d. alternated solids and liquids
    e. if resident has had a stroke, offered food to the unaffected side and checked for food stored in the mouth
11. Allowed resident to assist with eating according to the plan of care, (e.g., holding bread, eating finger food, etc.)
12. Used napkin to wipe resident's mouth as often as necessary
13. Removed dishes as soon as resident was finished
14. Washed resident's hands and face
15. Removed any spilled food from clothing and bed linen, etc.
16. Offered oral hygiene care
17. Washed hands
18. Documented time, amount and type of food and liquids consumed and resident's reaction (according to the plan of care)

Pass:__________  More Practice:__________

Comments: __________________________________________________________

__________________________________  ________________
Signature of Instructor                  Date

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Signature of Personal Care Staff       Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Position Resident in Bed
(positioning on side – turning resident towards you)

Demonstration:

___ 1. Washed hands
___ 2. Put on gloves (if possible contact with blood or body fluids)
___ 3. Provided privacy
___ 4. Explained procedure to resident
___ 5. Starting with resident on back, crossed the resident's far leg over the other leg
___ 6. Crossed the far arm over the resident's chest, bent the near arm at the elbow, bringing the hand toward the head of the bed
___ 7. Placed hand nearest the head of the bed on the resident's far shoulder. Placed other hand on the resident's hip on the far side. Braced thighs against the side of the bed
___ 8. Slowly rolled resident toward you, bending knee of upper leg slightly
___ 9. Pulled the side rail (if applicable) or otherwise secured resident's safety before going to other side of bed
___ 10. After moving to the other side of bed, placed hands under the resident's shoulders and then the hips. Pulled resident toward the center of the bed
___ 11. Made sure that the resident's body was properly aligned and safely positioned
___ 12. Placed a pillow behind the resident's back. Secured it by pushing the near side under the resident to form a roll
___ 13. Positioned the legs, supporting them with pillows between the knees and ankles
   (If resident has an indwelling catheter, made sure the tubing was not between the legs)
___ 14. Checked to see that resident was comfortable
___ 15. Removed gloved, if applicable, and washed hands
___ 16. Documented time, position changed, and resident's response to procedure

Pass:__________  More Practice:__________

Comments: _______________________________________________________________________

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Signature of Instructor Date

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Signature of Personal Care Staff Date

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Position Resident in Bed
(moving resident up – using turning sheet)

Demonstration:
____ 1. Obtained assistance from a person approved (by supervisor) to help
____ 2. Washed hands
____ 3. Put on gloves (if possible contact with blood or body fluids)
____ 4. Provided privacy
____ 5. Explained procedure to resident
____ 6. Raised bed to a level appropriate for proper body mechanics and locked wheels (if applicable)
____ 7. Lowered head of bed to level appropriate for resident (if applicable)
____ 8. Placed pillow against headboard
____ 9. Stationed self on one side of bed, helper on other side (For steps 10-15)
____ 10. Lowered side rails (if applicable)
____ 11. Assumed a broad stance with feet about 12" apart. Pointed foot closest to the head of the bed toward the head of the bed and faced that direction
____ 12. Rolled sides up turning sheet up close to the resident's body
____ 13. Grasped rolled-up turning sheet firmly near shoulders and buttocks
____ 14. While using proper body mechanics (hips and knees bent, back straight), slid resident up in bed on count of three
____ 15. Unrolled turning sheet
____ 16. Placed pillow under resident's head and shoulders. Straightened linens
____ 17. Made sure resident was comfortable and in good body alignment
____ 18. Raised side rails, lowered bed to lowest horizontal level and elevated head of bed to level appropriate for resident (if applicable)
____ 19. Removed gloves (if applicable)
____ 20. Washed hands

Pass: __________ More Practice: __________

Comments: ___________________________________________________________

_____________________________________________________________________
Signature of Instructor Date

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Signature of Personal Care Staff Date

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Transferring Resident from Bed to Chair
(using a mechanical lift)

Demonstration:

1. Obtained assistance from a person approved (by supervisor) to help with the lifting and transferring of the resident using a mechanical lift
2. Washed hands
3. Put on gloves (if possible contact with blood or body fluids)
4. Provided privacy
5. Explained procedure to resident
6. Checked mechanical lift, sling, straps and chains for frayed areas or poorly closing clasps. Did not use defective equipment and reported this to the supervisor
7. Placed a chair at right angles to the foot of the bed, facing the head (if using wheelchair, locked wheels)
8. Elevated the bed (if possible) to a comfortable working height. Locked the wheels of the bed. Lowered the nearest side rail. Rolled the resident toward assistant
9. Positioned sling(s) beneath the resident's body behind the shoulder, thighs and buttocks, smoothing sling while positioning it under resident
10. Rolled the resident back onto the sling and positioned properly under shoulders and hips
11. Positioned the lift frame over the bed with legs in maximum open position and locked
12. Attached suspension straps to sling. Checked fasteners for security
13. Attached suspension straps to the frame. Positioned the resident's arms inside the straps
14. Secured restraint straps, if needed
15. Talked to the resident while slowly lifting the resident free from the bed
16. Gently guided resident's legs and shoulders until resident was in a sitting position
17. Guided the lift away from the bed
18. Positioned the resident close to the chair
19. The second assistant held the sling and helped lower the resident slowly into the chair.
20. Made sure that resident's hands and feet were in proper positioning
21. Unhooked suspension straps and removed lift
22. Positioned resident comfortably and safely in chair, providing protector pads at pressure points on body
23. Removed gloves, if applicable, and washed hands
24. Documented time and resident's response to procedure

Pass: ___________ More Practice: ___________

Comments: __________________________________________________________________________

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Signature of Instructor Date

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Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Transferring Resident from Bed to Chair
(using a gait “transfer” belt)

Demonstration:

____ 1. Washed hands
____ 2. Put on gloves (if possible contact with blood or body fluids)
____ 3. Provided privacy
____ 4. Explained procedure to resident
____ 5. Placed chair beside bed facing foot of bed on same side as resident's strongest side
____ 6. Used gait belt of the proper size
____ 7. Assisted resident into a sitting position by placing assistant's arm closest to the head of the bed around the resident's shoulders, and the other arm under the resident's knees
____ 8. Slowly and smoothly pivoted the resident toward the side of the bed to a sitting position. Remained facing the resident to prevent a fall
____ 9. Placed gait belt around resident's waist. Slipped end of belt through serrated portion of clasp and then through metal buckle
____ 10. Pulled belt through entirely and checked to be sure that belt was smooth and snug
____ 11. Tested the tip of the belt by inserting fingers between belt and patient. (If putting gait belt around female resident, checked to be sure that the belt was around the waist and not around the breasts)
____ 12. Put on resident's slippers or shoes
____ 13. Assisted the resident to stand by grasping the gait belt on either side as the resident puts hands on the shoulders or upper arms of the assistant
____ 14. Kept back straight and base of support broad while assisting resident to a standing position
____ 15. Pivoted resident toward chair, checking the security of belt
____ 16. Continued to grasp belt as resident sits. (If assisting resident to ambulate, held firmly to gait belt with an underhand grasp)
____ 17. Positioned resident comfortably and safely in chair
____ 18. Removed gloves (if applicable) and washed hands
____ 19. Documented time of transfer (and/or ambulation) and resident's response to procedure

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Assisting with Walking

Demonstration:

___ 1. Made sure bed was in lowest horizontal position. Assured that bed/chair would not slide
___ 2. Assisted resident to sit at edge of bed/chair
___ 3. Offered appropriate footwear and assistive equipment
___ 4. Stood at resident’s side while resident gained balance. Gently supported arm (if necessary).
   Did not rush resident
___ 5. Encouraged resident to stand as straight as possible
___ 6. Walked at resident’s side and offered support, if needed
___ 7. Encouraged resident to follow through with exercise routine (if able)
___ 8. Assisted resident to return to bed/chair

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor  Date
_____________________________________________________________________________
Signature of Personal Care Staff  Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(mouth care – brushing teeth)

Demonstration:

____ 1. Washed hands
____ 2. Collected equipment as directed by resident's needs:
   a. Basin, if needed
   b. denture container, if needed
   c. mouth wash
   d. tooth brush and toothpaste
   e. towel
   f. water glass
____ 3. Placed equipment within resident's reach on overhead table or counter near sink
____ 4. Provided chair for resident, if needed
____ 5. Encouraged resident to brush teeth/gums and rinse mouth. Assisted according to the plan of care (used disposable gloves)
____ 6. Assisted with cleaning dentures (used disposable gloves)
____ 7. Assured that dentures were properly stored or that the dentures were properly replaced in the resident's mouth
____ 8. Returned equipment to area designated by the resident
____ 9. Wiped off table or counter
____ 10. Washed hands

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
___________________________________________________________________________

Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Personal Hygiene**
(mouth care – cleaning dentures)

**Demonstration:**

___ 1. Washed hands and puts on gloves, if needed
___ 2. Gathered equipment:
   a. disposable denture cup
   b. emesis basin
   c. mouthwash
   d. paper towel
   e. toothbrush or denture brush
   f. toothpaste or denture cleaner
___ 3. Assisted the resident to clean their dentures, if able
___ 4. When assisting the resident, provides privacy
___ 5. Positioned the bed to a comfortable working position, if bed can be elevated and resident requires assistance while in bed
___ 6. Positioned resident to a sitting position
___ 7. Spread towel across the resident's chest to protect clothing and sheets
___ 8. Asked resident to remove dentures and receives them on a paper towel; assists the resident who is unable
___ 9. Took the dentures to the sink for cleaning being sure there was a washcloth that had been placed on the bottom of the sink to safeguard against breaking the dentures if accidentally dropped
___ 10. With dentures in the palm of the hand, placed toothpaste or denture cleaner on the dentures and brushed cleaning all surfaces until they were clean
___ 11. Rinsed the dentures thoroughly under cool running water
___ 12. Filled the denture cup with cool water, mouthwash and water or denture solution and allowed the dentures to scale until the resident was ready to place them back in their mouth or for overnight soaking
___ 13. Insured the denture cup was properly labeled to avoid loss of the resident's dentures
___ 14. Assisted the resident to rinse their mouth with water or mouthwash
___ 15. Reported observations that were unusual such as improperly fitting dentures or mouth sores

Pass:__________  More Practice:__________

Comments: __________________________________________________________________________
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Signature of Instructor Date

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Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Personal Hygiene**
(hair/scalp care – combing/brushing/trimming)

**Demonstration:**

___ 1. Washed hands
___ 2. Collected equipment:
   a. comb and brush
   b. other needed toilet articles
___ 3. Brushed hair by starting at scalp and brushed toward hair ends
___ 4. Styled or trimmed hair as directed by resident. (Trimmed with "stylists" scissors and uses electric trimmer to remove hair from nape of neck; hair should be clean before trimming; hair can be moistened by spraying with water from a spray bottle)
___ 5. Uses mirror to show resident how new style/cut looks
___ 6. Washed hands following procedure
___ 7. Reported any hair or scalp problems to supervisor

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor  Date

Signature of Personal Care Staff  Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(hair/scalp care – hair shampoo)

Demonstration:

___ 1. Washed hands
___ 2. Collected equipment:
   - comb and brush
   - face towel or washcloth folded lengthwise
   - hair conditioner, if requested
   - hair dryer (if available)
   - pitcher or hand-held nozzle
   - shampoo
   - two bath towels
___ 3. Put on gloves (according to facility policy)
___ 4. Arranged the equipment in a convenient location
___ 5. Positioned the resident in front of the sink
___ 6. Placed a bath towel across the shoulders or across pillow under resident's head
___ 7. Brushed and combed hair thoroughly to remove snarls and tangles
___ 8. Obtained supply of warm water or used sink faucet/hose
___ 9. Asked resident to hold the face towel or washcloth over the eyes
___ 10. Applied water to hair until it was completely wet. Used pitcher or nozzle
___ 11. Applied a small amount of shampoo
___ 12. Worked up a lather with both hands. Started at the hairline and worked toward the back of head
___ 13. Massaged the scalp by applying pressure with fingertips
___ 14. Rinsed the hair with water
___ 15. Repeated steps 11-13
___ 16. Rinsed the hair thoroughly
___ 17. Applied conditioner, if desired, and rinsed as directed on the container
___ 18. Wrapped the resident's head with a bath towel
___ 19. Dried his or her face with the towel or washcloth used to protect eyes
___ 20. Helped the resident raise head (if appropriate).
___ 21. Rubbed the hair and scalp with the towel. Used two towels, if needed
___ 22. Combed the hair to remove snarls and tangles
___ 23. Dried hair as quickly as possible
___ 24. Assisted resident to desired location
___ 25. Cleaned and returned equipment to its proper place
___ 26. Cleaned and returned equipment to its proper place
___ 27. Recorded date, time, & place where the shampoo was given (sink, shower, tub, etc)
___ 28. Reported to supervisor, as soon as possible, any problems noted regarding resident's tolerance of the procedure and/or scalp problem

Pass:__________  More Practice:__________

Comments: __________________________________________________________________________
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Signature of Instructor  Date

Signature of Personal Care Staff  Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(hair and scalp care – bed shampoo)

Demonstration:

1. Washed hands

2. Assembled equipment:
   a. 3 bath towels hairbrush and comb
   b. bath blanket
   c. hairbrush and comb
   d. hair dryer (if available)
   e. large basin to collect used water
   f. large pitcher of water (115 degree F)
   g. shampoo
   h. shampoo tray
   i. small empty pitcher or cup
   j. safety pin
   k. washcloths
   l. waterproof covering for pillow
   (if regular tray not available, uses plastic sheeting with top and two sides rolled to form a drain)

3. Put on gloves (according to facility policy)

4. Placed large, empty basin on floor under spout of shampoo tray

5. Arranged on bedside table within easy reach:
   a. 2 bath clothes
   b. empty pitcher
   c. pitcher of water (115 degrees F)
   d. shampoo
   e. washcloth

6. Replaced top bedding with a washable (bath) blanket

7. Safely positioned resident at side of bed

8. Replaced pillowcase with waterproof covering

9. Covered head of the bed with bed protector. (Protector was placed under shoulders of resident)

10. Loosened clothing around neck

11. Placed towel under resident's head and shoulders. Brushed hair free of tangles, working snarls out carefully

12. Moved towel down around resident's neck and shoulders and pinned. Positioned pillow under shoulders so that head is tilted slightly backward

13. Raised bed to high horizontal position, if applicable

14. Raised resident's head and positioned shampoo tray so that drain is over the edge of bed directly above basin

15. Gave resident washcloth to cover eyes

16. Using the small pitcher, poured a small amount of water over hair until thoroughly wet

17. Used one hand to help direct the flow away from the face and ears

(continued – next page)
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(hair and scalp care – bed shampoo)

___ 18. Applied a small amount of shampoo, working up a lather. Worked from scalp to hair ends
___ 19. Massaged scalp with tips of fingers. Did not use fingernails
___ 20. Rinsed thoroughly, pouring from hairline to hair tips. Directed flow into drain. Used water from pitcher, checking water temperature before using
___ 21. Repeated the procedure a second time
___ 22. Lifted resident's head. Removed tray and bed protector. Adjusted pillow and slipped a dry bath towel underneath head
___ 23. Placed tray on basin. Wrapped hair in towel. Dried face, neck, and ears as needed.
___ 24. Dried hair with towel. (May use a portable hair dryer if available. If hair dryer used, did not put it too close to the resident's hair)
___ 25. Combed hair appropriately. Removed protective pillow cover. Replaced with cloth cover.
___ 26. Replaced bedding as needed. Removed washable (bath) blanket
___ 27. Lowered height of bed (if applicable)
___ 28. Helped resident assume a comfortable position
___ 29. Cleaned and returned equipment to its proper place
___ 30. Removed gloves and washed hands according to facility policy
___ 31. Recorded date, time, and place where the shampoo was given, and resident's tolerance of procedure
___ 32. Reported to supervisor, as soon as possible, any problems noted regarding resident's tolerance of the procedure or any scalp problems noted

Pass: __________  More Practice: __________

Comments: ____________________________________________________________________________
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_____________________________________________________________________________________

Signature of Instructor  Date

_____________________________________________________________________________________

Signature of Personal Care Staff  Date

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(care of fingernails)

Demonstration:

1. Checked plan of care to determine if this is an allowable task to provide for the resident
2. Washed hands. (Put on gloves, if appropriate)
3. Collected equipment:
   a. basin
   b. file, clippers, etc.
   c. plastic sheeting
   d. towel
4. Placed plastic sheeting and towel on table under basin
5. Soaked one hand in basin half filled with warm water
6. Removed hand from basin, placed on towel, and manicured fingernails
7. Soaked opposite hand
8. Manicured fingernails of other hand
9. Cleaned around nails carefully with cotton swab
10. Applied lotion to nail area
11. Cleaned and returned equipment to designated area
12. Discarded disposable equipment
13. Washed hands
14. Reported any hand or nail problems to supervisor

Pass:__________  More Practice:__________

Comments: ____________________________________________

_____________________________________________________________________________
Signature of Instructor Date

_____________________________________________________________________________
Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(bathing – bath/shower)

Demonstration:

____ 1. Washed hands
____ 2. Collected equipment:
   a. deodorant
   b. other toilet articles as requested by resident
   c. gown, pajamas, or clean clothes
   d. soap
   e. tub/shower equipment
   f. washcloth and bath towels
____ 3. Put on gloves
____ 4. Cleaned tub/shower
____ 5. Placed a rubber bath mat on the bottom of the tub/shower. Arranged equipment for resident's convenience
____ 6. Placed bath mat on floor in front of tub/shower
____ 7. Turned on and adjusted water temperature according to resident's direction
____ 8. Assisted resident to the tub/shower
____ 9. Assisted the resident to undress (as needed)
____10. Assisted resident into the tub/shower (as needed)
____11. Assisted with non-prescription shampooing/bathing according to plan of care
____12. Stayed nearby and had resident call when needing assistance or finished bathing
____13. Checked on resident frequently. (Provided privacy to the degree possible)
____14. Assisted the resident out of the tub/shower (as needed)
____15. Assisted the resident to dry off (as needed)
____16. Assisted the resident to dress (as needed)
____17. Assisted the resident out of bathroom
____18. Made sure resident was safe and comfortable in chair, bed, etc.
____19. Cleaned tub/shower
____20. Removed supplies to appropriate place
____21. Took soiled linen/clothing to the laundry
____22. Removed and discarded gloves appropriately
____23. Washed hands

Pass:__________ More Practice:__________

Comments: _______________________________________________________________________
________________________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Personal Hygiene**
(bathing – bed bath)

**Demonstration:**

1. Washed hands
2. Put on gloves
3. Assembled equipment needed:
   - a. bath basin
   - b. bath blanket
   - c. bath towel; washcloth
   - d. bed linen
   - e. brush and comb
   - f. laundry bag or hamper
   - g. lotion, powder
   - h. nail brush, emery board, orangewood stick
   - i. oral hygiene equipment
   - j. resident's clothing or pajamas
   - k. soap and soap dish
4. Assured that there were no drafts from windows, fans, etc. (to prevent chilling the resident)
5. Put linen on chair in order of use. Placed hamper or laundry basket nearby
6. Offered bedpan or urinal. Empty and cleaned before proceeding with bath. Washed hands and replaced gloves
7. Raised bed to highest level (if using a hospital bed) to avoid back strain. Kept resident in a comfortable position; lowered the side rails (if permitted)
8. Loosened top bed linen. Removed and folded blanket and bedspread. Placed washable (bath) blanket over top sheet, and removed sheet by sliding it out from under the washable (bath) blanket
9. Left one pillow under resident's head
10. Removed resident's clothes/pajamas and placed in laundry basket or hamper. (Assured that resident remained covered with bath blanket)
11. Filled bath basin two-thirds full and tested that it is no more than 105 degrees F
    - a. (If did not use bath thermometer, described method used to determine proper water temperature e.g., poured water over wrist)
12. Assisted resident to move to the side of the bed nearest the aide
13. Formed a mitten by folding washcloth around hand
14. Washed eyes as follows:
    - a. wet washcloth
    - b. used separate corners of washcloth for each eye
    - c. wiped from inside to outside corners of eyes. (Did not use soap around eyes)
15. Used soap on areas of the body per resident’s request
16. Did not leave soap in water
17. Washed and rinsed resident's face, ears, and neck. Used towel to dry
18. Placed towel underneath one arm. Washed, rinsed and dried axilla, arm and hand. Repeat procedure for other arm
19. Cleaned resident's hands and nails as follows (or according to the care plan, if there are special instructions):
    - a. put hands in basin of water
    - b. washed and dried each hand, gently pushing back cuticles with towel while drying fingers
    - c. cleaned under nails with orangewood stick. Shaped with emery board
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(bathing – bed bath)

d. trimmed fingernails according to the plan of care (informed supervisor of needed attention. (Did not cut fingernails if resident is a diabetic)

20. Proceeded with the bath, by exposing, washing, rinsing and drying one area of the body at a time in the following sequence:

a. the chest: for female resident, dried folds under breasts and applied powder or other skin breakdown prevention care as directed by the plan of care or according to facility policy

b. the abdomen: did not expose pubic area

c. the thigh, leg and foot: had resident flex knee, if possible, placed towel under leg and foot, placed foot in basin of water, washed thigh, leg and foot while properly supporting the leg. Dried well between toes. Repeated process with other leg

d. the toenails: cared for nails according to plan of care. (Did not cut nails if resident was diabetic). Changed bath water checking for proper water temperature (water changed, as needed, if water became too cool or too soapy)

e. the neck, back, and buttocks: assisted resident to turn on side, placed towel lengthwise on bed along back and buttocks. Washed back with long, firm strokes, rinsed, dried, and provided a backrub

f. the genitalia: assisted resident to turn on back. Placed towel under buttocks and thighs. Provided resident with clean warm water and wash cloth, and allowed resident to complete their bath, assisting as needed, ensuring that:

   (1) for female resident, washed from front to back, and (2) for male resident, the penis, scrotum, and groin area were washed and dried thoroughly

21. Reported to supervisor any difficulties the resident had during the bath

22. Applied deodorant and powder per resident's request or as directed by the resident's plan of care

23. Carried out Range of Motion exercises if included in the care plan for special health related personal care

24. Covered pillow with towel. Combed or brushed hair

25. Placed towels and washcloths in dirty laundry basket or hamper

26. Dressed resident with clean clothing

27. Cleaned and stored equipment according to facility policy

28. Changed the bed linens (made occupied bed or assisted resident into a chair)

29. Removed gloves and washed hands

30. Reported how resident tolerated bath, or any reddened areas or open skin lesions

Pass: __________  More Practice: __________

Comments: ____________________________________________

__________________________ __________________________
Signature of Instructor Date

__________________________ __________________________
Signature of Personal Care Staff Date

105
Personal Hygiene
(shaving a resident)

(A) Demonstration with a Safety Razor

Competency may be met by demonstrating (A) or (B)

**Demonstration (A):**

- 1. Washed hands
- 2. Placed towel on work area. Arranged the following on the work area:
  - a. aftershave lotion
  - b. mirror
  - c. safety razor
  - d. shaving brush
  - e. shaving brush
  - f. shaving cream or soap
  - g. tissue
  - h. towel and washcloth
  - i. wash basin
- 3. Put on gloves
- 4. Filled the wash basin/sink with warm water
- 5. Appropriately placed another towel to wipe area to be shaved or to collect moisture
- 6. Softened area to be shaved with warm water and applied shaving cream or other lubricant, as directed by resident
- 7. Held the skin taut with hand
- 8. Shaved in the direction of hair growth
- 9. Rinsed razor often
- 10. Applied direct pressure to any bleeding area
- 11. Washed off remaining shaving lubricant; dried with towel
- 12. Cleaned and returned equipment and supplies to their proper place. Wiped off work area
- 13. \[\text{Work area}\]
- 14. Removed and discarded gloves appropriately
- 15. Washed hands

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Personal Hygiene**
(shaving a resident)

(B) **Demonstration with an Electric Razor**

Competency may be met by demonstrating (A) or (B)

**Demonstration (B):**

____ 1. Washed hands
____ 2. Puts on gloves
____ 3. Followed precautions for use of any electrical equipment
   (e.g., no oxygen in use; equipment away from water; cord not frayed)
____ 4. Checked for skin rash or abrasions on area to be shaved. Avoided these areas in shaving
____ 5. Used scissors to trim any long hairs on the area to be shaved
____ 6. Shaved areas according to the resident's direction
____ 7. Cleaned razor after use as directed by resident
____ 8. Stored razor as directed by resident
____ 9. Removed and discarded gloves appropriately
____ 10. Washed hands

Pass:__________  More Practice:__________

Comments:  
______________________________________________________________________________
______________________________________________________________________________

Signature of Instructor  Date

Signature of Personal Care Staff  Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(shaving resident with skin disorders)

Demonstration:

1. Washed hands
2. Placed towel on work area and assembled the following equipment:
   a. aftershave lotion (as prescribed)
   b. basin with water
   c. mirror
   d. safety razor
   e. shaving brush (if needed)
   f. shaving cream or soap
   g. tissues
   h. towel and washcloth
3. Puts on gloves
4. Inspected for skin dryness, rashes, redness, bruising, raised areas, or tenderness. Noted any drainage from surgical incisions, lacerations or abrasions
5. Reported to supervisor before proceeding, if any of the above conditions are recent or have changed since last visited resident. (Supervisor may want to assess condition before resident is shaved)
6. Gently proceeded with shaving resident, according to the plan of care, if resident's chronic skin condition(s) has been assessed previously
7. Placed face towel across resident's chest
8. Moistened face and applied lather
9. Started in front of the ear:
   a. held skin taut
   b. brought razor down over cheek toward chin
   c. repeated until lather on cheek is removed and area has been shaved
   d. repeated on other cheek
   e. shaved chin carefully. (Had the resident tense the area to smooth out the tissue)
   f. asked resident to raise chin. Lathered and shaved neck area on each side, bringing razor up toward chin
   g. used firm, short strokes. Avoided any injury to the skin
11. Applied aftershave lotion or powder if resident requested and if not contraindicated for resident's skin disorder
12. Followed the plan of care for care of the resident's skin disorder
13. If the skin was nicked:
   a. applied pressure directly over the area
   b. applied an antiseptic
   c. reported incident to supervisor

(continued – next page)
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Personal Hygiene
(shaving resident with skin disorders)

**Demonstration:**

1. Cleaned equipment and stored in proper place
2. Disposed of gloves according to facility policy
3. Washed hands
4. Recorded date, time, condition of area shaved and resident's reaction to procedure according to facility policy

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Signature of Instructor  Date

Signature of Personal Care Staff  Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Toileting/Maintaining Continence**  
(adult briefs)

**Demonstration:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>___1.</td>
<td>Washed hands</td>
</tr>
<tr>
<td>___2.</td>
<td>Puts on gloves, if needed, to assist with removing clothing, undergarments</td>
</tr>
<tr>
<td>___3.</td>
<td>Assisted resident, as needed, with balance while getting seated on the toilet</td>
</tr>
<tr>
<td>___4.</td>
<td>Placed toilet tissue within reach; asked resident to call when through</td>
</tr>
<tr>
<td>___5.</td>
<td>Helped resident to wipe areas they were unable to reach (wore disposable gloves)</td>
</tr>
<tr>
<td>___6.</td>
<td>Assisted resident to clean up other parts of body, as necessary</td>
</tr>
<tr>
<td>___7.</td>
<td>Assisted resident to get up from toilet, as needed</td>
</tr>
<tr>
<td>___8.</td>
<td>Assisted resident with using adult (disposable) briefs, sanitary pads, etc. and/or adjusting clothing, as necessary</td>
</tr>
<tr>
<td>___9.</td>
<td>Disposed of briefs, etc. properly. Removed and disposed of gloves</td>
</tr>
<tr>
<td>___10.</td>
<td>Helped resident to wash hands</td>
</tr>
<tr>
<td>___11.</td>
<td>Washed hands</td>
</tr>
<tr>
<td>___12.</td>
<td>For resident with dementia, reminded resident of steps in toileting process, one at a time, until the process was completed</td>
</tr>
</tbody>
</table>

Pass: __________  More Practice: __________

Comments: __________________________________________________________________________________________
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Signature of Instructor  Date

Signature of Personal Care Staff  Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Toileting/Maintaining Continence
(offering the bedpan)

Demonstration:

____ 1. Assembled equipment
   a. bedpan & cover or fracture pan & cover
   b. disposable bed protector
   c. disposable gloves
   d. soap
   e. toilet tissue
   f. towels and washcloth
   g. washbasin

____ 2. Promptly responded to the resident's request to use bedpan

____ 3. Washed hands and puts on gloves

____ 4. Provided privacy

____ 5. Raised bed to a comfortable working position

____ 6. Warmed bedpan, if necessary, by running warm water inside and along the rim

____ 7. Dried outside of the bedpan with paper towels and puts powder on the pan to decrease friction

____ 8. Removed clothing/undergarments but keeps lower part of the body covered

____ 9. Asked resident to bend knees, place feet flat on mattress and raise hips, if able

____ 10. Placed protective padding on mattress and then placed bedpan under the resident (if fracture pan is used, places flat end under back)

____ 11. If resident is unable to assist, had resident turn on side with back toward aide, put pan in place and assisted resident to turn back onto the bedpan

____ 12. Covered the resident and raise the backrest; raise side rails

____ 13. Disposed of gloves, wash hands and left room to provide privacy

____ 14. When resident signals, returned immediately to remove the resident from the bedpan

____ 15. Washed hands, puts on gloves and assists the resident to get off the bedpan

____ 16. Covered the bedpan with paper towel/disposable pad and set pan on footstool or chair until removed to the resident's bathroom

____ 17. Assisted the resident to clean; turned resident on side and cleaned anal area with toilet tissue and warm washcloth; assisted with replacing undergarments

____ 18. Took bedpan to resident's bathroom

____ 19. If specimen is required, collected at this time

____ 20. Measured urine at this time if on I & O

____ 21. Reported if specimen collected, anything unusual about feces or urine; I & O if required and how resident tolerated being placed on toilet

Pass:__________  More Practice:__________  

Comments: ___________________________________________________________________
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_____________________________________________________________________________

Signature of Instructor Date

Signature of Personal Care Staff Date
Toileting/Maintaining Continence
(offering the urinal)

Demonstration:

___ 1. Washed hands and put on gloves
___ 2. Gathered equipment
   a. disposal gloves
   b. soap
   c. towel
   d. urinal and cover
   e. warm water
___ 3. Gave urinal to the resident; assured urinal was correctly placed, if resident was unable
___ 4. Provided privacy
___ 5. Responded to the resident's signal when done
___ 6. Put on disposable gloves and carefully removed the urinal
___ 7. Provided personal hygiene as needed; assisted the resident to wash their hands
___ 8. Measured urine and collected specimen, if needed

Pass:__________ More Practice:__________

Comments: ________________________________________________________________

_____________________________ ________________________________
Signature of Instructor Date

_____________________________ ________________________________
Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Toileting/Maintaining Continence
(portable bedside commode)

Demonstration:

___ 1. Washed hands and put on gloves
___ 2. Gathered equipment:
   a. basin warm water
   b. bedpan and cover
   c. disposable gloves
   d. portable commode
   e. soap
   f. toilet tissue
   g. towels
___ 3. Assisted the resident in transfer to the commode, if needed
___ 4. Placed bedpan under toilet seat of commode if it did not have a pan
___ 5. Assisted the resident to put on slippers/shoes and then helped resident out of bed onto the commode
___ 6. Placed toilet tissue within reach; assured resident has a way of signaling for assistance when finished
___ 7. Provided privacy
___ 8. Responded to residents call when done
___ 9. Assisted the resident to wipe with toilet tissue; provided personal hygiene as needed
___ 10. Assisted the resident to wash their hands
___ 11. Assisted the resident back to bed, if needed

Pass:__________ More Practice:__________

Comments:__________________________________________________________________________
____________________________________________________________________________________

_________________________________________ Date
Signature of Instructor

_________________________________________ Date
Signature of Personal Care Staff
Toileting/Maintaining Continence
(remove and apply condom catheter)

Demonstration:

____ 1. Explained procedure
____ 2. Washed hands and puts on gloves
____ 3. Collected equipment:
   a. basin of warm water  f. plastic bag
   b. bath towel  g. tincture of benzoin
   c. bed protector  h. washable (bath) blanket
   d. condom with drainage tip  i. washcloth
   e. paper towels
____ 4. Arranged equipment on table
____ 5. Provided privacy
____ 6. Raised bed to level appropriate for good body mechanics and assured resident's safety with proper use of side rails (if available)
____ 7. Covered resident with washable (bath) blanket and fan folded bedding to foot of bed Placed bed protector under resident's hips
____ 8. Adjusted washable (bath) blanket to expose genitals only
____ 9. Removed condom (sheath) by rolling toward tip of penis. Placed in plastic bag, if disposable. Placed on paper towels to be washed and dried, if reusable
____ 10. Carefully washed and dried penis. Observed for signs of irritation. Checked to see if condom has a "ready stick" surface
   a. if not, sprayed a thin coat of tincture of benzoin to penis (according to service plan)
   b. did not spray on head of penis
   c. let dry
____ 11. Applied fresh condom and drainage tip to penis by rolling it toward base of penis. If the resident was uncircumcised, was careful that the foreskin remained in good position
____ 12. Reconnected drainage system
____ 13. Removed and discarded gloves
____ 14. Adjusted bedding and positioned resident for comfort
____ 15. Washed hands
____ 16. Reported and recorded date, time, and observations to supervisor according to facility policy

Pass:__________  More Practice:__________

Comments: ____________________________________________________________

_____________________________________________________________________

Signature of Instructor                   Date

_____________________________________________________________________

Signature of Personal Care Staff         Date
Giving Perineal Care
(female)

Demonstration:

1. Explained procedure
2. Washed hands and puts on gloves
3. Collected equipment:
   a. basin with warm water (100-105 degrees F)
   b. bed protector
   c. bedpan and cover, if used by resident
   d. disposable bag
   e. disposable gloves
   f. liquid soap or soap dish with soap
   g. towel
   h. washable (bath) blanket
   i. washcloth (cotton balls)
4. Arranged equipment on table
5. Provided privacy
6. Raised bed to level appropriate for good body mechanics, if able. Assured safety of resident with proper use of side rails (if available)
7. Covered resident with washable (bath) blanket
8. Positioned resident on back with bed protector under buttocks
9. Offered bedpan to resident. If used, removed the bedpan, covered, and placed on chair
10. Draped resident:
    a. positioned washable (bath) blanket with one corner between resident's legs
    b. wrapped washable (bath) blanket around the resident's far leg
11. Helped resident flex knees and spread legs
12. Folded corner of washable (bath) blanket between resident's legs onto abdomen
13. Applied soap to washcloth
14. Separated labia. Cleaned downward from front to back with one stroke
15. Repeated steps 13 and 14 until area was cleaned
16. Rinsed perineum with a washcloth or cotton balls. Separated labia. Stroked downward from front to back. Discarded washcloth or cotton balls. Patted area dry with towel
17. Folded center corner of blanket back between resident's legs
18. Helped resident lower her legs and turn onto her side away from aide. Applied soap to a washcloth
19. Cleaned rectal area by washing from vagina to anus with one stroke
20. Discarded washcloth
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Giving Perineal Care
(female)

Demonstration:

____ 22. Positioned resident so she was comfortable. Assured resident's safety with side rails up and bed in lowest position (if applicable)
____ 23. Removed and discarded gloves
____ 24. Returned top lines to proper position
____ 25. Washed hands
____ 26. Recorded and reported date, time and observation to supervisor according to facility

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
______________________________________________________________________________

______________________________________________________________________________
Signature of Instructor Date

______________________________________________________________________________
Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Giving Perineal Care
(male)

Demonstration:

___ 1.  Explained procedure
___ 2.  Washed hands and put on gloves
___ 3.  Collected equipment:
   a. basin with warm water (100-105 degrees F)
   b. bath towel
   c. bed protector
   d. urinal (if used by resident)
   e. disposable bag
   f. disposable gloves
   g. liquid soap or soap dish with soap
   h. washable (bath) blanket
   i. washcloth (cotton balls)
___ 4.  Arranged equipment on table
___ 5.  Provided privacy
___ 6.  Raised bed to level appropriate for good body mechanics and assured safety of resident with proper use of side rails, if available
___ 7.  Covered resident with washable (bath) blanket
___ 8.  Positioned resident on back with bed protector under buttocks
___ 9.  Offered urinal (or bedpan) to resident. If used, removed the bedpan, covered, and placed on chair
___10. Draped resident:
      a. positioned washable (bath) blanket with one corner between resident's legs
      b. wrapped washable (bath) blanket around the resident's far leg. Drape near leg in same manner (not in other text)
___11. Helped resident flex knees and spread legs
___12. Folded corner of washable (bath) blanket between resident's legs onto abdomen
___13. Applied soap to washcloth (cotton balls)
___14. Retracted foreskin if resident was uncircumcised. Grasped the penis
___15. Cleaned tip of penis using a circular motion. Started at urethral opening and worked outward. Discarded washcloth (cotton balls)
___16. Rinsed area with another washcloth (cotton balls). Returned foreskin the natural position if resident was uncircumcised
___17. Cleaned shaft of penis with firm downward stroked. Rinsed area
___18. Helped resident flex legs and spread knees
___19. Cleaned scrotum and rinsed well. Patted dry penis and scrotum
___20. Folded center corner of blanket back between resident's legs
___21. Helped resident lower his legs and turn onto her side away from aide

(continued – next page)
SECTION XI– Competency Evaluation Instruments, Basic Nursing Skills

Giving Perineal Care
(male)

Demonstration:

____ 22. Cleaned rectal area. Rinsed area and dried well
____ 23. Discard washcloth
____ 24. Positioned resident so he was comfortable. Assured resident's safety with side rails up and bed in lowest position, if applicable
____ 25. Cleaned and stored equipment appropriately. Wash off table
____ 26. Removed and discarded gloves
____ 27. Returned top lines to proper position
____ 28. Washed hands
____ 29. Recorded and reported date, time and observation to supervisor according to facility

Pass:__________ More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Collecting Specimen
(urine)

Demonstration:

___ 1. Explained procedure
___ 2. Washed hands and put on gloves
___ 3. Collected equipment:
   a. clean bedpan, urinal, or specimen pan
   b. specimen container and lid
   c. label
___ 4. Wrote resident's name and other identifying information on label and placed label on container
___ 5. Provided privacy. Asked resident to cleanse area before voiding
___ 6. Asked resident to urinate in appropriate receptacle. Cautioned resident not to put toilet tissue in bedpan or specimen pan
___ 7. Poured urine into specimen container until it was about three-fourths full. Disposed of excess urine
___ 8. Placed lid on specimen container
___ 9. Cleaned specimen pan or bedpan
___10. Helped resident to wash hands

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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______________________________________________________________________________
Signature of Instructor Date

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Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Collecting Specimen**
(fecal “stool”)

**Demonstration:**

1. Explained procedure
2. Washed hands and puts on gloves
3. Collected equipment:
   a. bedpan and cover
   b. disposable bag
   c. label
   d. specimen container and lid
   e. specimen pan, if resident can use the commode
4. Labeled container with resident's name and other identifying information required
5. Provided privacy
6. Offered bedpan, urinal or commode if resident has to void first. Discarded urine and reposition resident on bedpan or commode
7. If resident can use the commode, placed specimen pan in toilet under seat
8. Asked resident not to put toilet tissue in the bedpan, commode, or specimen pan
9. Removed gloves, washed hands and left room
10. Returned to room when resident requested
11. Washed hands and put on gloves
12. Used tongue blade to take out 2 T. of feces from bedpan or specimen pan and put in specimen container
13. Put lid on specimen container. Did not touch inside of lid or container
14. Did not contaminate outside of container with stool
15. Emptied, cleaned, and disinfected bedpan or specimen pan. Helped resident wash hands
16. Removed and discarded gloves and washed hands
17. Made sure resident was comfortable
18. Placed specimen container in disposable bag (if policy of facility) and took or sent specimen to laboratory promptly
19. Reported and recorded observations to supervisor according to facility policy

Pass:__________ More Practice:__________

Comments: ______________________________________________________________________

________________________________________________________________________________

Signature of Instructor Date

Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Care for Normal Unbroken Skin

Demonstration:

___ 1. Assured that skin was clean and not wet
___ 2. Inspected skin for dryness, redness, abrasions, bruising. Reported changes in condition of resident’s skin to supervisor
___ 3. Gently applied lotion to skin and reddened areas (elbows, knees, heels) as directed by resident and/or according to plan of care
___ 4. Gave back rub as directed by resident
___ 5. Placed cushions or pads to protect bony prominences as directed by resident and/or according to plan of care

Pass:__________  More Practice:__________

Comments: __________________________________________

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Signature of Instructor __________________ Date __________

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Signature of Personal Care Staff __________________ Date __________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Take and Record Vital Signs
(monitoring of temperature – Oral or Axillary)

Demonstration: (glass thermometer)

____ 1. Washed hands
____ 2. Used disposable gloves, if needed
____ 3. Collected equipment:
   a. thermometer
   b. tissue or cotton balls
   c. rubbing alcohol or hydrogen peroxide
____ 4. Washed the thermometer with cold water and wiped with rubbing alcohol or hydrogen peroxide
____ 5. Checked thermometer for cracks
____ 6. Shook down the thermometer below 96 degrees Fahrenheit
____ 7. Placed the bulb end of the thermometer under the tongue (oral) or under the arm (axillary)
____ 8. Left the thermometer under the tongue (3 minutes) or axilla (5 minutes)
____ 9. Removed the thermometer. Wiped thermometer with a tissue or a cotton ball from stem to bulb
____ 10. Read the thermometer correctly, (one-tenth to two-tenths degree discrepancy allowed)
    a. reported temperature to resident, if appropriate
    b. reported elevated temperature to supervisor
    c. recorded temperature (date & time) on appropriate flow charts
____ 11. Shook down the thermometer
____ 12. Washed the thermometer (using hydrogen peroxide or rubbing alcohol) and returned thermometer to a safe place
____ 13. Washed hands

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

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Signature of Personal Care Staff Date
SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Take and Record Vital Signs
(rectal temperature)

Demonstration:

___ 1. Washed hands
___ 2. Provided privacy
___ 3. Assembled equipment:
   a. container with disinfectant
   b. disposable gloves
   c. lubricant
   d. pad and pencil
   e. rectal thermometer with container
   f. tissues
   g. watch with second hand
___ 4. Assisted resident to turn on side, assuring resident safety at all times
___ 5. Placed small amount of lubricant on tissue
___ 6. Put on gloves. Removed thermometer from container by holding stem end. Read mercury column. Checked thermometer for cracks and that it read below 96 degrees F
___ 7. Applied small amount of lubricant to bulb with tissue
___ 8. Folded the top bedclothes back to expose anal area
___ 9. Separated buttocks with one hand
   a. inserted thermometer gently into rectum 1-1/2 inches. Held in place
   b. replaced bedclothes as soon as thermometer was inserted
___ 10. Thermometer remained inserted for five (5) minutes
___ 11. Removed thermometer, holding by stem. Wiped from stem toward bulb end
___ 12. Discarded tissue in proper container
___ 13. Read thermometer accurately. Recorded reading on pad
___ 14. Wiped lubricant from resident's buttocks. Discarded tissue in proper container
___ 15. Washed thermometer in cold water and soap. Rinsed, dried and returned it to container with disinfectant
___ 16. Removed and disposed of gloves in proper container
___ 17. Reported/recorded temperature on flow chart according to plan of care

Pass:__________ More Practice:__________

Comments:______________________________________________________________________________

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Signature of Instructor Date

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Take and Record Vital Signs
(radial pulse)

Demonstration:

1. Washed hands
2. Collected equipment:
   a. paper and pen
   b. watch with second hand
3. Located the radial pulse with middle three fingers
4. Counted radial pulse for 30 seconds or for one full minute, if pulse was irregular
5. Multiplied number counted by two, if pulse was taken for 30 seconds
6. Reported pulse rate to resident, if appropriate
7. Reported pulse immediately to supervisor, (if pulse different than usual)

Pass:__________ More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Take and Record Vital Signs
(respirations)

Demonstration:

1. Continued to hold resident's wrist after taking radial pulse. Kept stethoscope to chest if apical pulse was taken
2. Did not tell resident respirations were being counted
3. Began counting when chest rose. Counted each rise and fall of chest as one respiration
4. Observed if respirations were regular and equal. Noted depth and if resident had any pain or difficulty in breathing
5. Counted respirations for 30 seconds. Multiplied by two
6. Counted for one (1) full minute if respirations are abnormal or irregular
7. Made sure resident was comfortable
8. Washed hands
9. Reported to supervisor (as soon as possible) if:
   a. respiration rate was outside of rates outlined in the plan of care
   b. respirations were unequal, shallow, etc.
   c. respirations were regular or irregular
   d. resident had any pain or difficulty breathing
   e. any respiratory noises
   f. any abnormal patterns
10. Reported/recorded respiratory rate according to plan of care

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Take and Record Vital Signs
(monitored by monitoring of blood pressure)

Demonstration:

1. Washed hands
2. Collected equipment:
   a. alcohol wipes
   b. blood pressure cuff
   c. stethoscope
3. Cleaned earpiece and diaphragm of the stethoscope with alcohol wipes
4. Positioned resident's arm so that it was at the level of the resident's heart
5. Exposed the upper arm
6. Squeezed the cuff to expel any remaining air. Closed the thumb valve
7. Located the brachial artery
8. Placed the arrow marking on the cuff over the brachial artery. Wrapped the cuff around the arm at least one inch above the elbow
9. Placed the manometer on a flat surface, or attached to hook on cuff
10. Placed the earpieces in ears
11. Placed the diaphragm of the stethoscope over the brachial artery
12. Inflated the cuff until gauge registered 180 mm/Hg or 20 mm/Hg above palpated systolic pressure
13. Deflated the cuff slowly
   a. noted the calibration that the pointer passed as the first sound is heard, this is the systolic pressure
   b. continued deflating the cuff slowly. When the sound changed to a softer and faster thud or disappeared, noted the calibration. This is the diastolic pressure
14. Deflated the cuff completely. Removed the stethoscope from ears. Cleaned earpieces and bell of stethoscope with alcohol wipes
15. Waited at least one (1) minute if it was necessary to repeat the procedure on the same arm
16. Told resident the blood pressure reading, if appropriate
17. Returned equipment to designated place
18. Washed hands
19. Recorded and reported blood pressure according to facility policy or plan of care

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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SECTION XI– Competency Evaluation Instruments, Basic Nursing Skills

Take/Record Height and Weight
(heighgt)

Demonstration:

1. Washed hands
2. Collected equipment:
   a. paper and pen
   b. paper towels
   c. portable height measurement rod
3. Placed paper towels on floor or scale platform
4. Asked resident to remove shoes. Provided assistance
5. Raised height measurement rod
6. Assisted resident to stand on paper towels
7. Assisted resident to stand very straight
8. Lowered height measurement rod until it rested on resident’s head
9. Recorded height on paper
10. Helped resident to put on shoes
11. Made sure resident was comfortable
12. Washed hands
13. Recorded height according to facility policy or plan of care

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Take/Record Weight
(weight)

Demonstration:

1. Washed hands
2. Collected equipment
   a. paper and pen
   b. portable scale
3. Provided privacy
4. Asked resident to remove any heavy clothing and shoes
5. Assisted resident to stand on scale platform, placed paper towel on platform if scales are used by others). Had resident stand with arms at sides
6. Viewed weight reading
7. Recorded weight reading on appropriate flow chart
8. Assisted resident to redress
9. Washed hands
10. Reported weight changes to supervisor according to facility policy or plan of care

Pass:__________ More Practice:__________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Prosthetic Devices**
(assisting with applying and removing)

**Demonstration:**

___ 1. Prosthetic device applied:
   - a. leg brace
   - b. leg splints
   - c. prosthetic limb
   - d. eye prosthesis
   - e. other ______________

___ 2. Assisted resident with skin care according to the plan of care

___ 3. Assisted in applying wraps according to the plan of care

___ 4. Assisted the resident with proper positioning and securing of prosthetic device according to the plan of care

___ 5. Laundered soiled wraps per resident’s directions or by manufacturer’s instruction

___ 6. Assisted resident with cleaning and inserting eye prosthesis, as directed by the resident’s plan of care (if applicable)

___ 7. Observed and reported skin changes to resident and supervisor as soon as possible

Pass:__________  More Practice:__________

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Signature of Personal Care Staff Date
Appling Ace “Elastic” Bandages

Demonstration:

1. Washed hands
2. Collected equipment:
   a. Elastic bandage (size of ace bandage listed on plan of care)
   b. Taped, metal clips, or safety pins
3. Assisted resident to comfortable position; exposed extremity to be bandaged (elevated extremity, if needed)
4. Made sure area was clean and dry
5. Held bandage so that roll was up and loose end on the bottom
6. Applied bandage to smallest part of extremity to be bandaged first
7. Made two (2) circular turns around the part to be bandaged
8. Made overlapping spiral turns in an upward direction. (Each turn should overlap about two-thirds of the previous turn)
9. Applied bandage smoothly with firm, even pressure (bandage should not be tight)
10. Pinned, taped, or clipped the end of bandage to hold it in place
11. Checked fingers if hand/arm (or toes, if foot/leg) is extremity bandaged, for coldness or discoloration. Also checked for complaints of pain, numbness, or tingling (Removed bandage if any of these were noted). Reported observations to supervisor
12. Washed hands

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Applying Elastic Stockings (TEDs)

Demonstration:

1. Washed hands
2. Assisted resident to lie down
3. Gathered up the stocking in hands
4. Supported the resident’s foot at the heel. Slipped the foot of the stocking over the resident’s toes, foot, and heel
5. Pulled the stocking smoothly up over the leg
6. Repeated procedure to other leg
7. Checked proper fit of stocking
8. Checked for discoloration or coolness of toes. (Removed stocking if symptoms appear or resident complained of discomfort)
9. Reported/recorded date, time, problems and interventions according to facility policy
   reported problems to supervisor as soon as possible

Pass:__________  More Practice:__________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

**Apply Binders**

**Demonstration:**

1. Washed hands
2. Used disposable gloves, if applicable
3. Applied the binder so that firm, even pressure is exerted over the area
4. Kept the body in good alignment
5. Reapplied binder if loose, wrinkled, out of position, or causing discomfort
6. Did not fasten pins or Velcro over incision
7. Changed binders that were moist or soiled
8. Removed binder at resident’s request; reported (as soon as possible) to supervisor if resident refuses to wear binder
9. Recorded, when applicable, procedure according to facility policy

Pass:__________ More Practice:__________

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Signature of Instructor ___________________________ Date ___________________________

Signature of Personal Care Staff ___________________________ Date ___________________________
SECTION X – Competency Evaluation Instruments, Basic Nursing Skills

Assisting with Dressing/Undressing

Demonstration:

1. Washed hands prior to assisting resident to dress/undress
2. Allowed resident to choose clothing to be worn
3. Noted whether resident's clothing was appropriate for the weather, temperature and occasion
4. If clothing not appropriate, helped resident review clothing options and make a more appropriate choice. (Add or delete items of clothing as weather/occasion demanded)
5. Praised suitable choices and appropriate dress
6. If needed, laid out clothing for the resident
7. Assisted with dressing, if necessary; provided privacy
8. When assisting to undress, removed clothing from strong or "good" side first and then from weak side
9. When assisting to dress, put clothing on weaker side first and then strong side
10. Put clothing on in order that resident directed
11. Identified clothing needs with resident; planned how to procure new clothes, if needed.
12. Washed hands after completion of the task

Pass:__________ More Practice:__________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Assist Limited Function Resident with Dressing

Demonstration:

1. Washed hands
2. Allowed resident to choose clothing to be worn or aide selected appropriate clothing
3. Provided privacy
4. Removed clothing from strong or “good” side first and then from weak side
5. Put clean clothing on weakest side (contracted or immobilized limb, etc.) and then strong side
6. Put clothing on in the order that resident directed, assuring the resident was neat, clean and comfortably dressed for the resident’s daily activities
7. Assured that resident was appropriately dressed for the weather, if going outside

Pass: __________ More Practice: __________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Emergency Care - Choking
(Heimlich Maneuver/Conscious Resident)

Demonstration:

___ 1. Has been properly trained to do the Heimlich maneuver before attempting the procedure
___ 2. Observed the resident is not able to talk, cough or breathe and skin color is turning blue
___ 3. Stands behind the person and puts arms around the waist allowing resident's arms to hang free
___ 4. Makes a fist with one hand and places the thumb side of hand on abdomen between the umbilicus (belly button) and the sternum (does not touch the chest)
___ 5. Grasps this hand already in place with the other hand and presses it into the abdomen with a quick upward movement
___ 6. Is sure each thrust is a separate movement
___ 7. Checks resident after five thrusts
___ 8. Repeats and continues until the object is successfully removed

Pass:__________ More Practice:__________

Comments:____________________________________________________________________________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Emergency Care - Choking
(Heimlich Maneuver/Unconscious Resident)

Demonstration:

___ 1. Called for help; sends someone to activate EMS
___ 2. Did not attempt to give care using Heimlich maneuver unless properly trained
___ 3. Positioned resident’s head to open the airway
___ 4. Sought the mouth with finger to try to remove object
___ 5. Attempted to ventilate (1-2 breaths)
___ 6. Straddled the victims’ legs with knees
___ 7. Positioned one hand on top of the other and gives 3-5 firm upward thrust in upper abdomen above the umbilicus but below the sternum
___ 8. Repeated and continued until object is dislodged
___ 9. Once object was removed; ventilates or did CPR, if necessary

Pass:__________  More Practice:__________

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Emergency Care - Bleeding
(cuts, nosebleeds, hemorrhage)

Demonstration:

____ 1. Used standard precautions; put on gloves. Used clean cloth, towel or appropriate dressings and disposed of contaminated materials/solid linen according to facility policy
____ 2. Applied direct pressure over the bleeding area
____ 3. Elevated the bleeding limb
____ 4. If treating nosebleed, had resident lean forward, using clean, dry towel. Placed pressure to the upper lip just below the nose; used ice pack to the bridge of the nose if bleeding did not stop in 5 minutes
____ 5. Called for medical help without delay
____ 6. Remained with the resident until medical help arrived
____ 7. Kept the resident warm
____ 8. Talked with the resident in a calming way
____ 9. Recorded the incident in the resident's record

Pass:__________  More Practice:__________

Comments: ___________________________________________________________________
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Signature of Instructor Date

Signature of Personal Care Staff Date
Emergency Care
(seizures)

Demonstration:

1. Called out for medical help
2. Turned resident's head to the side to promote drainage of saliva or vomitus (May be hard to maintain head in side position during seizure; did not force!)
3. Loosened clothing around the neck
4. Did not try to pry or force the teeth apart
5. Maintained resident’s airway
6. Did not attempt to restrain or prevent movement
7. Protected the resident from injury (e.g., striking limbs against objects during the seizure; moves objects or pads corners of furniture)
8. Protected the resident from emotional pain/embarrassment by requesting that others leave the immediate area
9. Noted the duration of the seizure
10. Assisted the resident to return to bed/chair if seizure is of short duration and resident regains ability to function
11. Immediately reported incident and observations to the supervisor

Pass:__________  More Practice:__________

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Signature of Instructor  Date

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SECTION XI – Competency Evaluation Instruments, Basic Nursing Skills

Emergency Care
(Burns)

Demonstration:

____ 1. Cooled the burned area with large amounts of cool water, never used ice or ice water and never used butter or other oils. If running water is not available, used a towel soaked in cool water

____ 2. Continued to soak the area in cool water until the residents stated the burn does not hurt or until medical help is available

____ 3. Knew not to remove clothing stuck to a burned area

____ 4. Covered the areas with clean sterile dressing until evaluated by a nurse or the physician

____ 5. Stayed with the resident until medical help arrives

Pass:__________ More Practice:__________

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Signature of Personal Care Staff Date