NC Department of Health and Human Services
NC Nurse Aide I Curriculum
Module AA
Measurement
July 2019

Objectives (1)
• Identify the structure and function of the cardiovascular and respiratory systems.
• Define body temperature and associated terminology.
• List equipment needed to measure pulse, respirations, blood pressure, temperature, intake of fluids, output, height, and weight.

Objectives (2)
• Compare and contrast the various thermometers used to measure temperature.
• Label components of select equipment used to measure blood pressure, height, and weight.
Objectives (3)

- Compare and contrast normal and abnormal findings of the following measurements: pulse, respirations, blood pressure, and temperature
- Locate sites used to measure pulse, respirations, blood pressure and temperature

Objectives (4)

- Describe the nurse aide's role in the care of residents who have not achieved fluid balance – edema and dehydration
- Explain how to use equipment that measures blood pressure, temperature, intake of fluids, output, height, and weight

Objectives (5)

- Differentiate units of measurement nurse aides use during the care of residents – millimeters of mercury (mm Hg), degrees Fahrenheit, ounces, milliliters (mL), cubic centimeters (cc), inches, and feet
- Convert ounces to milliliters and inches to feet/inches
Vital Signs

- Show how well vital organs are functioning
- Include temperature, pulse, respiration, and blood pressure
- Also called TPR & BP

Vital Signs – Importance

- Changes can indicate resident’s condition worsening
- Can reflect response to medication and/or treatment
- Value of a vital sign may be basis for a medication
- Accuracy when taking vital signs is crucial
- Report abnormal vital signs immediately to nurse and per facility policy
The 5th Vital Sign – Pain

- Facilities may consider pain the 5th vital sign; considered as important as other vital signs
- Pain is subjective and reported to health care provider by resident
- Pain is whatever the resident says it is

Respiratory System

The breathing in of oxygen into the lungs and breathing out of carbon dioxide from the body

Structure and Function – Lungs

- Location in the respiratory system where exchange of oxygen and carbon dioxide occur
- Left lung, 2 lobes; right lung 3 lobes
Respiration

- Process that supplies oxygen to cells and removes carbon dioxide from cells
- Involves
  - Inspiration (inhalation) – breathing in oxygen; chest rises
  -Expiration (exhalation) – breathing out carbon dioxide; chest falls
- Each respiration = 1 inspiration and 1 expiration
- Respiratory rate (or respirations) – the number of inspirations (inhalations) the person takes in a minute

Respiratory Site

Watch the chest rise and fall; count the chest rises (inspirations) only

Respiration Values – Normal

- Called eupnea
- Between 12 and 20 breaths/minute
- Regular
- Quiet
- Both sides of chest equal

Document
Respiration Values – Abnormal

- Bradypnea – less than 12 breaths/minute
- Tachypnea – more than 20 breaths/minute
- Apnea – 0
- Hypoventilation
- Hyperventilation
- Dyspnea
- Cheynes-Stokes

Document and notify nurse

Counting Respirations – Equipment

- Analog watch with second hand
- Note pad and pen

Analog Watch

- A watch that has moving hands and typically marked with numbers 1 – 12
- Has an hour hand, minute hand, and second hand

Nurse aide uses the second hand to count respirations and pulse rate
Analog Watch – 60 Seconds (1)
When counting respirations for 60 seconds:

while watching the second hand, start counting and stop counting on the same number

Using an Analog Watch – Practice (1)
Counting respirations for 60 seconds:

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<th>&quot;Start&quot;</th>
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Observation and Documentation
• Nurse aide counts respirations for 60 seconds
• 1 respiration = 1 inspiration (chest rising)
• While watching second hand of watch, nurse aide starts and stops counting on same number
• Document on record if respirations are normal
• Document on record and notify nurse if respirations are abnormal
Stealth Respirations
Check respirations right after checking pulse (without moving hand from wrist)

Why?

Checking Respirations – Example #1
• Nurse aide begins counting respirations when the second hand is on 4 and stops counting respirations when the second hand lands on ______
• Nurse aide counts 16 chest rises in 60 seconds
• 16 is the number the nurse aide would document

Checking Respirations – Example #2
• Nurse aide begins counting respirations when the second hand is on 10 and stops counting respirations when the second hand lands on ______
• Nurse aide counts 24 chest rises in 60 seconds
• 24 is the number the nurse aide would document
• Nurse aide would notify the nurse; why?
Cardiovascular System

Also called the circulatory system and is the continuous movement of blood through the body.

Structure and Function – Blood Vessels (1)

The transportation system of the cardiovascular (circulatory) system

- Veins – carry blood with waste products away from cells and to heat
- Arteries – carry blood with oxygen and nutrients away from heart and to cells

Structure and Function – Blood Vessels (2)

Pulse – the beat of the heart felt at an artery, as a wave of blood passes through the artery

- Pulse rate
- Pulse rhythm
- Pulse force
**Pulse Sites**

- Temporal
- Carotid
- Apical
- Brachial
- Radial
- Pedal

**Radial Pulse Site**

- Typically used to take pulse during routine vital signs checks
- Does not expose resident
- Located on thumb side of wrist
- First 2 or 3 fingers used; never use thumb

**Pulse Values**

- Normal = between 60 and 100 beats per minute; regular and strong (document)
- Abnormal pulse (document and notify nurse)
  - Bradycardia – less than 60 beats/minute
  - Tachycardia – more than 100 beats/minutes
  - Irregular pulse rhythm
  - Weak in strength
Counting Pulse – Equipment

- Analog watch with second hand
- Note pad and pen

Analog Watch – 60 Seconds (2)
When counting pulse for 60 seconds:

while watching the second hand, start counting and stop counting on the same number

Using an Analog Watch – Practice (2)
Counting pulse for 60 seconds:

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Checking Pulse and Documentation

- Nurse aide counts pulse rate for 60 seconds
- While watching second hand of watch, nurse aide starts and stops counting on same number
- Document on record if pulse is normal
- Document on record and notify nurse if pulse is abnormal

Checking Pulse – Example #1

- Nurse aide begins counting pulse rate when second hand is on 4 and stops counting pulse rate when the second hand lands on _____
- Nurse aide counts a pulse rate of 82 in 60 seconds
- 82 is the number the nurse aide would document

Checking Pulse – Example #2

- Nurse aide begins counting pulse rate when second hand is on 10 and stops counting pulse rate when the second hand lands on _____
- Nurse aide counts a pulse rate of 109 in 60 seconds
- 109 is the number the nurse aide would document
- Nurse aide would notify the nurse; why?
Structure and Function – Heart (1)
The pump of the cardiovascular (circulatory) system

Consists of 4 chambers:
• Right and left atria, and
• Right and left ventricles

Structure and Function – Heart (2)
2 phases
(1) Working phase (systole) heart is pumping blood to body; top number of blood pressure reading and
(2) Resting phase (diastole) heart fills with blood; bottom number of a blood pressure reading

Structure and Function – Heart (3)
Blood pressure – the amount of force exerted by the blood against the walls of the artery
• Top number is the systolic pressure; the pressure when the heart contracts and pumps blood out
• Bottom number is the diastolic pressure; when the heart rests as the heart fills with blood
Blood Pressure (1)
Important indicator of health status; shows how well heart is working; can change from minute to minute depending on:

- The activity of the resident
- Lifestyle choices
- Reaction to stress
- Acute injury or emergency
- Medications

Blood Pressure (2)
Genetic factors affect blood pressure

- Age
- Gender
- Race

Blood Pressure Site
Brachial artery and upper arm – most often used by the nurse aide when checking blood pressure
The Blood Pressure Value
Measured in millimeters of mercury (mm Hg)
Recorded as a fraction

120 (systolic)
80 (diastolic)

Pronounced as 120 over 80

Normal Blood Pressure Ranges

- Systolic – 90 mm Hg to 119 mm Hg
- Diastolic – 60 mm Hg to 79 mg Hg

Document on record

Abnormal Blood Pressure Ranges

- Elevated blood pressure
  - Systolic – 120 mm Hg to 129 mm Hg AND
  - Diastolic – below 80 mm Hg
- Hypertension
  - Systolic – 130 mm Hg or higher OR
  - Diastolic – 80 mm Hg or higher
- Hypotension
  - Systolic – less than 90 mm Hg
  - Diastolic – less than 60 mm Hg

Always document on the record and report abnormal blood pressures to nurse
Using What You Have Learned

Using factors effecting blood pressure and normal/abnormal values for blood pressure, evaluate the health of individuals on the next 3 slides

Example #1

• BP = 116/72
• A 64-year old female
• Weighs 130 pounds
• She has finished baking an apple pie
• She doesn’t smoke or drink

Example #2

• BP = 162/86
• A 72-year old male
• Weighs 260 pounds
• He just ate a couple of hot dogs and potato chips for lunch and is on his 4th beer
• He just sent his son to the store for more cigarettes
Example #3

- BP = 180/94
- A 22-year old male
- Weighs 170 pounds
- He just wrecked his brand new truck
- He has a broken leg
- He is on a stretcher in the back of an ambulance

Blood Pressure

The nurse aide uses 3 senses when checking a blood pressure

- Seeing – watches needle’s movement in relation to numbers on the manometer
- Hearing – using the stethoscope, listens for changes in blood flow in the brachial artery
- Touching – controls inflation and deflation of cuff using thumb and index finger

Checking Blood Pressure – Equipment

- Stethoscope
- Sphygmomanometer, also known as blood pressure cuff (BP cuff)
- Alcohol wipes
- Note pad and pen
The Stethoscope

- Instrument used to listen to heart and lung sounds
- For blood pressure checks, used to listen to sounds in brachial artery
- May be single-head (with diaphragm only) or dual-head (with diaphragm and bell)

Stethoscope – Parts

Stethoscope – Ear Pieces

- Always clean before and after use with alcohol wipes
- Insert ear pieces into ears so they point forward toward the nose
- Should fit snugly in ears
Before using dual-head stethoscope to take blood pressure, determine which side of chest-piece is active; to check blood pressure, diaphragm needs to be active.

Two Ways to Check for Active Diaphragm

#1 After inserting ear pieces into ears, tap diaphragm lightly to determine if tap is heard; if tap not heard, rotate chest-piece at tubing, and repeat the tap

#2 If chest-piece has an indicator dot, rotate chest-piece so indicator dot is closed

Diaphragm Concepts

- Always clean diaphragm with alcohol wipes
- Warm diaphragm before making contact with resident
- To use diaphragm, apply enough pressure to make seal against brachial artery
Blood Pressure Cuff – 2 Types

Manual (Aneroid)  Electronic (Digital)

Electronic (Digital)

- No stethoscope needed
- After BP cuff is placed on arm, button is pressed causing cuff to inflate/deflate automatically
- BP reading is displayed

Aneroid BP Cuff – Parts
**Manometer (1)**
Marked with long and short lines and has a needle

- Long lines mark 10 mm Hg
- Short lines mark 2 mm Hg

**Manometer (2)**

**Manometer (3)**
When checking blood pressure, the needle drops from a higher number to a lower number, so nurse aide will be counting backwards
Example of Blood Pressure Reading

- Systolic is 150 mm Hg
- Diastolic is 88 mm Hg
- BP is written down as 150/88
- BP is pronounced as “150 over 88”

Cuff (1)

After wrapping the cuff around the bare upper arm

- The cuff inflates and puts pressure on the brachial artery
- As cuff deflates, BP is determined

Cuff (2)

- Cuffs come in child-sized, small, regular, and extra-large
- Important to choose correct size
Cuff (3)

- Typically has 1 or 2 arrows (left arm/right arm) on cuff which align with brachial artery
- Cuff positioned/wrapped at least an inch above the elbow
- Cuff or stethoscope should not be placed over clothing

Tubing

- Made of rubber
- Two tubes connect the:
  - (#1) Cuff to the manometer and
  - (#2) Cuff to the handheld inflation bulb

Inflation Bulb with Air-release Valve (1)

To inflate cuff, turn air-release valve clockwise to close valve; then squeeze the bulb; remember thumb goes up, needle goes up
Inflation Bulb with Air-release Valve (2)
To deflate cuff and open valve, turn air-release valve counterclockwise with the thumb and index finger in a slow and controlled manner; remember thumb goes down, needle goes down

Inflation Bulb with Air-release Valve (3)
- Inflate cuff to between 160 mm Hg to 180 mm Hg
- If beat is heard immediately, deflate the cuff; wait 30 – 60 seconds; inflate cuff to no more than 200 mm Hg

Inflation Bulb with Air-release Valve (4)
Goal: learn how to inflate the cuff and how to deflate the cuff in a slow, controlled manner
Blood Pressure – Nevers

• Do not take blood pressure on an arm with an IV, dialysis shunt, or other medical device
• Avoid taking blood pressure on a side that has been injured or burned, is paralyzed, has a cast, or has had a mastectomy

Orthostatic Hypotension

Abnormal low blood pressure that occurs when resident suddenly stands up; complaint of feeling weak, dizzy, faint and seeing spots before the eyes

May be a complication from being on bed rest

Orthostatic Hypotension – Process

• BP checked while lying down, record on note pad
• Have resident sit up, wait 2 minutes, check BP, record on note pad
• Have resident stand up, wait 2 minutes, check BP, record on note pad
• Record/report to nurse

Throughout process, check to see if resident is feeling weak, dizzy, faint, or seeing spots
Orthostatic Hypotension – Prevention

• Per care plan, increase activity in stages
• Before standing, while sitting on side of bed (dangling), have resident cough/deep breathe and move legs back-and-forth in circles, 1 to 5 minutes
• Ask resident to report weakness, dizziness, faintness and seeing spots
• May need 2 people

Body Temperature

Amount of heat created by the body; balance between the amount of heat produced and the heat lost; typically stable

Produced – when cells use food for energy
Lost – through skin, breathing, urine, and stool

Body Temperature – Terminology

• Fever – elevated temperature
  • Febrile – with a fever
  • Afebrile – without a fever
• Thermometer – device to measure body temperature
  • Fahrenheit and Centigrade
Factors Affecting Temperature

- Age
- Illness
- Stress
- Environment
- Exercise
- Time of day

Sites

- Mouth (oral)
- Rectum (rectal)
- Armpit (axilla)
- Ear (tymppanic)
- Temporal (forehead)

Important to check with nurse or care plan to see what type of thermometer is used

When NOT to Take an Oral Temperature

- Unconscious
- Recent facial/mouth surgery
- Recent injury to face
- Sores/redness/mouth pain
- Confused/agitated
- History of seizure
- Using oxygen
- Mouth-breather
- Feeding tube
When NOT to Take a Rectal Temperature

• Has diarrhea
• Has rectal problem
• Has heart disease
• Recent rectal surgery
• Is confused or agitated

Temperature Values (1)

• Oral
  o Baseline – 98.6°F
  o Normal range – 97.6°F to 99.6°F
• Rectal
  o Baseline – 99.6°F
  o Normal range – 98.6°F to 100.6°F
• Axillary
  o Baseline – 97.6°F
  o Normal range – 96.6°F to 98.6°F

Temperature Values (2)

• Tympanic membrane
  o Baseline – 98.6°F
  o Normal range – 97.6°F to 99.6°F
• Temporal
  o Baseline – 98.6°F
  o Normal range – 97.6°F to 99.6°F
Types of Thermometers

- Digital – oral, rectal, axillary
- Electronic – oral, rectal, axillary
- Tympanic – ear
- Temporal – forehead
- Non-mercury, liquid-filled glass (oral – green tipped; rectal – red tipped)

Digital Thermometer

- Oral, rectal, or axillary
- Displays results digitally within 2 – 60 seconds; beeps or flashes when done
- Battery-operated
- Requires a disposable sheath

Electronic Thermometer

- Oral, rectal, or axillary
- Have oral/axillary and rectal probes; requires probe cover
- Displays results digitally 2 – 60 seconds; beeps or flashes when done
- Battery-operated; stored in recharging device
Tympanic Thermometer

- Ear
- Registers temperature in seconds
- May need practice to operate accurately

Temporal Thermometer

- Measures heat from skin over the forehead, specifically over temporal artery
- Done by a stroke or scan over the area
- Registers within 3 seconds
- Noninvasive

Non-mercury, Liquid-filled Glass Thermometer – Equipment

Oral

Rectal
Non-mercury, Liquid-filled Glass Thermometer

- Oral, rectal, or axillary
- Color-coded; blue or green for oral; red for rectal
- Takes a long time to register
- Nurse aide must read at eye level after it registers temperature; held at stem
- Most use Fahrenheit scale to measure temperature

Non-mercury, Liquid-filled Glass Thermometer – Reading

For Fahrenheit readings (the top numbers):

- The long line represents 1 degree
- The short line represents two tenths (2/10) of 1 degree

Example of an Oral Temperature Reading

Temperature = 102.8°

Long Line = 102

Short Lines = eight tenths (.8 or 8/10)
Fluid Balance (1)

- Living things need water to survive
- Adults need about 1500 mL of water intake daily to survive
- Adults need about 2000 to 2500 mL for normal fluid balance

Hydration – having the right amount of water in the body's tissues

Fluid Balance (2)

- Body takes in water by drinking fluids and eating foods
- Body loses water by way of urine, bowel movement, vomitus, sweat, and breathing out; plus drainage from wounds or liquids from stomach suctioning

Death can occur if the body has too much or too little water in the tissues
Intake and Output

- Intake (also called input) – the amount of fluid taken in by the body
- Output – the amount of fluid lost from the body
- Intake and output are typically seen together and commonly abbreviated (I&O)

For fluid balance to occur, fluid intake roughly equals fluid output.

Fluid Balance Not Achieved – Edema

- Fluid intake is greater than fluid output, edema occurs
- Body tissues swell with water
- May occur from heart or kidney disease

Edema – Nurse Aide’s Role

- Obtain accurate weights per order
- Increase pillows per resident’s request
- Restrict fluids per doctor’s order
- Measure and record I&O accurately, if ordered
- Observe for and report signs/symptoms
Fluid Balance Not Achieved - Dehydration

- Fluid intake is less than fluid output, dehydration occurs
- Body tissues are lacking in water
- May occur from vomiting, diarrhea, fever, or simply refusing to drink fluids

Dehydration – Nurse Aide’s Role

- Determine preferences of fluids and offer
- Assure water pitcher and cup within reach
- Measure and record I&O, if ordered
- Force fluids, if ordered
- Observe for/report signs and symptoms

I&O

- Ordered by the doctor; found on care plan and directive from nurse
- Typically calculated at end of each shift; totaled every 24-hours
- Documented on a facility-specific form
- Calculations and totals based on the milliliter (mL)
The Milliliter (mL)

- A unit of measure in the metric system
- Fluids measured using the milliliter (mL)
- Another unit of measure used in healthcare is called the cubic centimeter (cc); should use the mL instead of cc when documenting
- 1 milliliter is equal to 1 cubic centimeter
- Most people familiar with the teaspoon; there are 5 mL or 5 cc in a teaspoon

The Graduate

- Accurate measuring device for fluids when resident is on I&O
- Fluid for I&O is measured/documented in milliliters (mL)
- Measure fluid at eye-level on flat surface
- If both intake and output to be measured with the graduate, two separate graduates used and labeled

Units of Measure for the Graduate

- The C.C. (cubic centimeter) side of the measurement scale is used in healthcare
- Recall 1 C.C. on the graduate = 1 milliliter (mL)

Shortest line represents either 25 cc/mL or 75 cc/mL
Longest lines represent multiples of 50 cc/mL
Measuring I&O – Importance

• Evaluates fluid balance
• Evaluates kidney function
• Planning and evaluating medical treatment
• Carrying out special fluid orders
• Helps prevent or detect complications from fluid intake
• Fluid intake is factor that reflects nutritional status

Fluids Considered as Intake

• Liquids that the resident drinks
• Semi-liquid foods that the resident eats
• Other fluids including intravenous (IV) fluids and tube feedings that nurse is responsible for maintaining and measuring

Fluids – Liquids

• Water
• Milk
• Coffee
• Tea
• Juices
• Soups
• Soft drinks
Fluids – Semi-liquid Foods

- Milkshakes
- Ice cream
- Sherbet
- Custard
- Pudding
- Gelatin
- Popsicles

Providing Drinking Water

- Residents need fresh drinking water
- Before providing water, check with care plan or nurse
- Follow facility’s procedure regarding time schedule and process

Providing Drinking Water – Concepts

- Ensure resident’s name and room number are labeled on ice pitcher
- Check for cracks and chips in water pitcher and cup; make sure they are clean
- Never touch inside or rim
- Never take resident’s used water pitcher directly to ice machine
- Never scoop ice with water pitcher
- Always place ice into the water pitcher first
Special Fluid Orders

- In order to maintain fluid balance, the doctor may order amount of fluid a resident must drink a day
  - Encourage fluids – increased fluids
  - Restrict fluids – limited fluids
  - Nothing by mouth (NPO) – no fluids (or food)
  - Thickened liquids – all fluids are thickened
- Located on the care plan
- Nurse aide must measure and record intake very carefully

Determining Oral Fluids as Intake

- To determine intake, nurse aide must know serving sizes of containers that fluids are served in a facility; typically found on I&O sheet
- Two methods
  - Measures
    - Using fractions
  - Follow facility policy and/or procedure when determining intake of fluids during and between meals

Typical Serving Sizes of Liquids

- Water glass = 240 mL
- Tea glass = 180 mL
- Juice glass = 120 mL
- Milk carton = 240 mL
- Coffee cup = 240 mL
- Soft drink can = 360 mL
- Gelatin = 120 mL
- Soup bowl = 180 mL
Determined Intake – Measures

• The glass with the resident’s apple juice holds 240 mL of fluid.
• Using the graduate and measuring apple juice left in glass, the resident did not drink 120 mL of apple juice.
• Subtracting 120 mL of apple juice the resident didn’t drink from number of mL the glass holds.
• Resident drank 120 mL of apple juice.

Determined Intake – Fractions (1)

To determine fluid intake using fractions, the nurse aide needs a basic understanding of fractions in relation to a whole, which is 1.

The entire bar is 1 and includes:
- 4 equal parts or 4 fourths
- 2 equal parts or 2 halves
- 3 equal parts or 3 thirds

Determined Intake – Fractions (2)

\[ \frac{2}{3} \text{ of } 240 \text{ mL of coffee} \]

- **Numerator** tells the number of parts resident drank.
- **Denominator** tells the total number of parts originally in container.
- **Amount** of fluid served to resident.
Determining Intake – Fractions (3)
- 240 mL in the resident’s coffee cup
- Resident drank 2/3 cup of coffee
- Resident drank 160 mL of coffee

\[
\frac{2}{3} \times \frac{240}{3} = \frac{80}{1} = 160 \text{ mL}
\]

Determining Intake – Fractions (4)
- 240 mL in the resident’s coffee cup
- Resident drank 1/2 cup of coffee
- Resident drank 120 mL of coffee

\[
\frac{1}{2} \times \frac{240}{1} = \frac{120}{1} = 120 \text{ mL}
\]

Recall Determining Intake – Fractions
Numerator tells the number of parts resident drank
Amount of fluid served to resident
Denominator tells the total number of parts originally in container
Determining Intake – Fractions (Quick)

\[ \frac{2}{3} \text{ of } 240 \text{ mL of coffee} \]

- Determine what 1 part of total coffee equals by dividing the total mL amount of coffee (240) by 3 = 80
- Resident drank 2 of the 3 parts of the coffee, so multiply 80 (which is 1 part) by 2 because the resident drank 2 of the 3 parts = 160
- The resident drank 160 mL of the coffee

Milliliters and Ounces

- A common conversion in health care is changing (or converting) ounces to milliliters
  - 1 ounce = 30 mL
  - To convert ounces to milliliters, simply multiply number of ounces by 30

Conversion Problem – Apple Juice

- 8 fluid ounces of apple juice in the glass
  - 1 fluid ounce = 30 milliliters (mL)
  - 8 x 30 milliliters (mL) = 240 milliliters (mL)
  - 240 mL of apple juice in the glass
Milliliters and Cubic Centimeters

- Devices in health care are often marked in cubic centimeters (cc)
- A common conversion is changing (or converting) cc to milliliters (mL)
- 1 cubic centimeter (cc) = 1 milliliter (mL)
- To convert cc to mL, simply use the exact number measured

Conversion Problem – Grape Juice

- 120 cubic centimeters (cc) of grape juice in the glass
- 1 cc = 1 milliliter (mL)
- 120 mL of grape juice in the glass

Fluids Considered as Output

- Urine
- Vomitus
- Diarrhea
- Wound drainage
- Gastric suction material
Devices That Collect Output

- Catheter bag
- Urinal
- Commode hat
- Emesis basin

Foley Catheter Bag

- Connected to indwelling (Foley) catheter which drains bladder of urine
- Empty into a measuring device at end of shift (or sooner, if full)
- Measurement done using measuring device instead of catheter bag

Urinal

- A plastic, elongated device used by men to urinate into
- Meant for single-resident use
- As a measuring device, marked in ounces and cc (same as mL), with 100 cc (mL) increments marked lines and 50 cc (mL) unmarked lines between
Commode Hat (Specimen Pan)

- Plastic collection container placed under commode lid
- Used when resident on bathroom privileges and
  - Is on output
  - Urine or stool specimen is ordered
- Marked in ounces and cc (same as mL); grooved edge

Emesis Basin

- A plastic, shallow basin shaped like a kidney that fits against resident's neck and collects body fluids
- Used
  - During mouthcare
  - When a resident is nauseated
- Marked in ounces and cc (same as mL) with 100 cc (mL) increments

RECALL: Units of Measure for the Graduate

- The C.C. (cubic centimeter) side of the measurement scale is used in health care
- Recall 1 C.C. on the graduate = 1 milliliter (mL)
  - Shortest line represents either 25 cc/mL or 75 cc/mL
  - Longest lines represent multiples of 50 cc/mL
Measuring Urine #1

- Long line = 200 cc (mL)
- Short line = 25 cc (mL)
- Amount = 225 cc (mL)
- Document = 225 mL

Measuring Urine #2

- Long line = 500 cc (mL)
- Amount = 500 cc (mL)
- Document = 500 mL

Measuring Urine #3

- Long line = 300 cc (mL)
- Short line = 25 cc (mL)
- Amount = 325 cc (mL)
- Document = 325 mL
Determining/Documenting Food Intake

Determining Food Intake

- Nurse aide compares amount of food eaten with amount of food served
- To measure food intake, nurse aide needs a basic understanding of percentages in relation to a whole, which is 100%

Determining Intake of Meals Accurately

Importance
- Identifies residents at risk for or already experiencing impaired nutrition
- Food intake is one of the factors that reflects the resident's nutritional status
- Poor food intake at meals or changes in food intake that persists for multiple meals may indicate underlying problem or illness and should be reported to the nurse
- Much of a resident's daily fluid intake comes from meals; when resident has decreased appetite, can result in fluid/electrolyte imbalance
Understanding Percentages of a Whole

- The entire circle = 100% and includes 4 equal parts
- Each 25% is ¼ of the whole
- 25% + 25% = 50% (or ½ of the whole)
- 25% + 25% + 25% = 75% (or ¾ of the whole)

Determining Food Intake (1)

Follow facility procedure regarding determining and documenting food intake, for example:
- Listing exact food eaten (all of chicken, all of green beans, ½ of mashed potatoes, ¼ of biscuit, all of pie)
- Using specific words (all, good, fair, poor, refused)
- Using percentages of food eaten (100%, 75%, 50%, 25%, 0%)

The Resident is Served His Meals

**Breakfast** consists of 2 eggs, 2 slices of bacon, fried apples, grits, biscuit, coffee, and apple juice

**Lunch** consists of 4 grilled chicken tenders, mashed potatoes, broccoli, a corn muffin, coffee, and water
Resident Ate 0% of Meals (Refused)

Breakfast

Lunch

Resident Ate 25% of Meals (Poor)

Breakfast

Lunch

Resident Ate 50% of Meals (Fair)

Breakfast

Lunch
Resident Ate 75% of Meals (Good)

Resident Ate 100% of Meals (All)

Module AA Measurement
Weight and Height
Weight and Height – Overview

- Weight and height measured on admission to the facility
- Units of measure per facility policy
  - Weight may be measured in pounds or kilograms
  - Height may be measured using feet and inches or just inches
- After admission
  - Height typically not measured again
  - Weight measured per facility policy and/or doctor’s orders as directed by nurse and care plan – daily, weekly, monthly

Weights of Residents in Long-term Care

- Current standards of practice recommend weighing resident on admission/readmission, weekly for first 4 weeks after admission, and at least monthly thereafter
- Crucial that weight is obtained accurately and consistently
  - Facility-wide scales are calibrated and functioning appropriately
  - A consistent process in place

Weights – Consistent Process

Weigh the resident:
- Wearing a similar type of clothing
- At approximately the same time of the day (preferably before breakfast)
- Using the same scale
- Either consistently wearing or not wearing orthotics or prostheses
Accurate Weights – Importance

- Weight is a parameter that reflects a resident’s nutritional status.
- Fluid loss or retention can cause short-term weight changes; abrupt weight changes along with change in food intake are signs of fluid and electrolyte imbalance.
- Weight loss may be an important indicator of a change in resident’s health status or sign of malnourishment.
- If significant weight loss is noted, the healthcare team reviews for possible causes.

Physician Mechanical Beam Scale (1)

- Used for measuring weight and height.
- Residents who cannot stand:
  - Weighed using chair, wheelchair, bed, or mechanical lift, as directed by nurse or care plan.
  - Height measured in bed using tape measure and ruler.

Physician Mechanical Beam Scale (2)
Balance Beam
- Has 2 poise bars – upper and lower
- May include pounds only or pounds on the top part of each bar and kilograms on the bottom part of each bar; may have interchangeable pound and kilogram bars

Upper Poise Bar
- Long lines represent pounds
- Short lines represent ¼ pounds each; increments include ¼, ½, ¾

Lower Poise Bar
- Single lines represent increments of 50 pounds
- Grooves located along the top of the lower bar align with weight increments
Weight Indicators

- Both upper and lower bars have movable weight indicators
- The weight indicator for the lower bar fits into the groove as weight is obtained

Balance Bar and Balance Window

- Ensure balance bar floats freely and in center of window when poise bars set on 0 and resident is not standing on scale platform
- If balance bar is off-center and/or touching window, do not weigh resident and notify nurse

Reading the Weight

To determine weight: add the value for the lower bar to the value for the upper bar

100 pounds + 38 pounds = 138 pounds
**Height Component – Head Piece**

- Becomes active when extended upward in preparation for measuring resident's height
- Lowered and placed on resident's head and height measured
- Becomes at rest when flat and low against height rod

**Height Component – Rod (1)**

2 Units of measure
- Inches
- Centimeters
2 sections
- Movable upper section
- Non-movable lower section

**Height Component – Rod (2)**

Movable upper section
- Raised or lowered to adjust to resident's height
  - “Read height here” area is the location of the weight value if resident’s height is located in this section
  - Numbers increase from top to bottom
Non-movable lower section
- Height read in lower section if resident's height is located in this area
  - Numbers increase from bottom to top
Measuring the Height (1)

- When measuring in feet and inches using height rod
  - Long lines represent inches
  - Shorter lines represent ¼ inch each; increments include ¼, ½, ¾
- Read height to the nearest ¼ inch

Measuring the Height (2)

How tall is the resident?

Converting Inches into Feet and Inches

- Resident’s height is 68 inches
- How does the nurse aide convert 68 inches to feet and inches?
Converting Inches into Feet/Inches

• To convert inches to inches and feet
  • Divide the number of inches by 12
  • The quotient is the feet and the remainder (if there is one) is the inches

Height in Feet and Inches

• Resident’s height is 68 inches
• How does the nurse aide convert 68 inches to feet and inches?
  • 1 foot = 12 inches
  • Divide 68 inches by 12 inches
  • Quotient = 5, remainder = 8
  • Answer = 5 feet, 8 inches

Resident’s height is 68 inches or 5 feet, 8 inches