Appendix A

PROCEDURE #1: INITIAL STEPS	
STEP	**RATIONALE**
1. Ask nurse about resident's needs, abilities and limitations, if necessary and gather necessary supplies.	1. Prepares you to provide best possible care to resident.
2. **Knock and identify yourself before entering the resident's room. Wait for permission to enter the resident's room**.	2. Maintains resident's right to privacy.
3. Greet resident by name per resident preference.	3. Shows respect for resident.
4. Identify yourself by name and title.	4. Resident has right to know identity and qualifications of their caregiver.
5. Explain what you will be doing; encourage resident to help as able.	5. Promotes understanding and independence.
6. Gather supplies and check equipment.	6. Organizes work and provides for safety.
7. Close curtains, drapes and doors. Keep resident covered, expose only area of resident's body necessary to complete procedure.	7. Maintains resident's right to privacy and dignity.
8. Wash your hands.	8. Provides for Infection Control.
9. Wear gloves as indicated by Standard Precautions.	9. Protects you from contamination by bodily fluids.
10. Use proper body mechanics. Raise bed to appropriate height and lower side rails (if raised).	10. Protects yourself and the resident from injury.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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Student Signature Date

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PROCEDURE #2: FINAL STEPS	
STEP	**RATIONALE**
1. Remove gloves, if applicable, and wash your hands.	1. Provides for Infection Control.
2. Be certain resident is comfortable and in good body alignment. Use proper body mechanics	2. Reduces stress and improves resident's comfort and sense of well-being.
3. Lower bed height and position side rails (if used) as appropriate.	3. Provides for safety.
4. Place call light and water within resident's reach.	4. Allows resident to communicate with staff as necessary and encourages hydration.
5. Ask resident if anything else is needed.	5. Encourages resident to express needs.
6. Thank resident.	6. Shows your respect toward resident.
7. Remove supplies and clean equipment according to facility procedure.	7. Facilities have different methods of disposal and sanitation. You will carry out the policies of your facility.
8. Open curtains, drapes and door according to resident's wishes.	8. Provides resident with right to choose.
9. Perform a visual safety check of resident and environment.	9. Prevents injury to you and resident.
10. Report unexpected findings to nurse.	10. Provides nurse with necessary information to properly assess resident's condition and needs.
11. Document procedures according to facility procedure.	11. What you document is a legal record of what you did. If you don't document it, legally, it didn't happen.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #3: HANDWASHING/HANDRUB	
STEP	**RATIONALE**
How to Hand wash (*Wash hands when visibly soiled or prior to giving care)*	
1. Turn on faucet with a clean paper towel.	1. Faucet may be used by resident/visitors and should be kept as clean as possible.
2. Adjust water to acceptable temperature.	2. Hot water opens pores which may cause irritation.
3. Angle arms down holding hands lower than elbows. Wet hands and wrists.	3. Water should run from most clean to most soiled.
4. Apply enough soap to cover all hand and wrist surfaces. Work up a lather	
NOTE: Direct caregivers must rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers.	
5. Rub hands palm to palm.	5. Lather and friction will loosen pathogens to be rinsed away.
6. Right palm over top of left hand with interlaced fingers and vice versa.	
7. Palm to palm with fingers interlaced.	
8. Backs of fingers to opposing palms with fingers interlocked.	
9. Rotational rubbing, of left thumb clasped in right palm and vice versa.	
10. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa. Clean finger nails	
11. Rinse hands with water down from wrists to fingertips	11. Soap left on the skin may cause irritation and rashes.
12. Dry thoroughly with single use towels.	
13. Use towel to turn off faucet and discard towel.	13. Prevents contamination of clean hands.
How to Use Hand rub (*otherwise, use hand rub*)	
14. Apply a quarter sized amount of the	14. May refer to label for estimated amount

product in a cupped hand and cover all surfaces.	of product to be placed in palm.
15. Rub hands palm to palm.	15. Thorough application will reach all surfaces of concern.
16. Right palm over left dorsum with interlaced fingers and vice versa.	
17. Palm to palm with fingers interlaced.	
18. Backs of fingers to opposing palms with fingers interlocked.	
19. Rotational rubbing of left thumb clasped in right palm and vice versa.	
20. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.	
21. Allows hands to dry. Waterless hand rubs must be rubbed for at least 10 seconds or until dry to be effective.	21. The product must be dry to be effective.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #4: GLOVES	
STEP	**RATIONALE**
1. Wash hands.	
2. If right-handed, slide one glove on left hand (reverse, if left-handed).	
3. With gloved hand, slide opposite hand in the second glove.	
4. Interlace fingers to secure gloves for a comfortable fit.	
5. Check for tears/holes and replace glove, if necessary.	5. Damaged gloves do not protect you or the resident.
6. If wearing a gown, pull the cuff of the gloves over the sleeves of the gown.	6. Covers exposed skin of wrists.
7. Perform procedure.	
8. Remove first glove by grasping outer surface of other glove, just below cuff and pulling down.	8. Both gloves are contaminated and should not touch unprotected skin.
9. Pull glove off so that it is inside out.	9. The soiled part of the glove is then concealed.
10. Hold the removed glove in a ball of the palm of your gloved hand. Do not dangle the glove downward.	10. To ensure the first glove goes into the second glove
11. Place two fingers of ungloved hand under cuff of other glove and pull down so first glove is inside second glove.	11. Touching the outside of the glove with an ungloved hand causes contamination.
12. Dispose of gloves without touching outside of gloves and contaminating hands.	12. Hands may be contaminated if gloves are rolled or moved from hand to hand.
13. Wash hands.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #5: GOWN (PPE)	
STEP	**RATIONALE**
1. Wash your hands.	
2. Open gown and hold out in front of you. Let the clean gown unfold without touching any surface.	2. Prevents contamination of the gown.
3. Slip your hands and arms through the sleeves and pull the gown on.	
4. Tie neck ties in a bow.	4. They can easily be un-tied later.
5. Overlap back of the gown and tie waist ties.	5. Ensures that your uniform is completely covered.
6. Put on gloves; extend to cover wrist of gown	
7. Perform procedure.	
8. **Remove gloves**	8. Outside of gloves are contaminated.
9. Untie the neck, then waist ties	
10. Pull away from neck and shoulders, touching inside of gown only.	10. By not touching the outside surface of the gown with your bare hands, it prevents contamination
11. Fold gown with clean side out and place in laundry or discard if disposable.	11. Gowns are for one use only. They must be either discarded or laundered after each use.
12. Wash your hands.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #6: MASK	
STEP	**RATIONALE**
1. Wash your hands.	
2. Place upper edge of the mask over the bridge of your nose and tie the upper ties. If mask has elastic bands, wrap the bands around the back of your head and ensure they are secure.	2. Your nose should be completely covered.
3. Place the lower edge of the mask under your chin and tie the lower ties at the nape of your neck.	4. Your mouth should be completely covered.
4. If the mask has a metal strip in the upper edge, form it to your nose.	5. This will prevent droplets from entering the area beneath the mask.
5. Perform procedure.	
6. If the mask becomes damp or if the procedure takes more than 30 minutes, you must change your mask.	7. Dampness of the mask will reduce its ability to protect you from pathogens. The effectiveness of the mask as a barrier is greatly diminished after 30 minutes.
7. If wearing gloves, remove them first.	8. This will prevent contamination of the areas you will touch when untying the mask.
8. Wash your hands.	
9. Untie each set of ties and discard the mask by touching only the ties. Masks are appropriate for one use only.	10. Hands may be contaminated if you touch an area other than the ties. Masks must be discarded after each use.
10. Wash your hands.	

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PROCEDURE #7: FALLING OR FAINTING	
STEP	**RATIONALE**
1. Call for nurse and stay with resident.	1. Allows you to get help, yet continuously provide for resident's safety and comfort.
2. Check if resident is breathing.	2. Provides you with information necessary to proceed with procedure.
3. Do not move resident. Leave in same position until the nurse examines the resident.	3. Prevents further damage if resident is injured.
4. Talk to resident in calm and supportive manner.	4. Reassures resident.
5. Apply direct pressure to any bleeding area with a clean piece of linen.	5. Slows or stops bleeding.
6. Take pulse and respiration.	6. Provides nurse with necessary information to properly assess resident's condition and needs.
7. Assist nurse as directed. Check resident frequently according to facility policy and procedures. Assist in documentation.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #8: CHOKING	
STEP	**RATIONALE**
1. Call for nurse and stay with resident.	1. Allows you to get help, yet continuously provide for resident's safety and comfort.
2. Ask if resident can speak or cough.	2. Identifies sign of blocked airway (not being able to speak or cough).
3. If not able to speak or cough, move behind resident and slide arms under resident's armpits.	3. Puts you in correct position to perform procedure.
4. Place your fist with thumb side against abdomen midway between waist and ribcage.	4. Positions fist for maximum pressure with least chance of injury to resident.
5. Grasp your fist with your other hand.	5. Allows you to stabilize resident and apply balanced pressure.
6. Press your fist into abdomen with quick inward and upward thrust.	6. Forces air from lungs to dislodge object.
7. Repeat until object is expelled.	
8. Assist with documentation.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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Instructor Signature Date

PROCEDURE #9: SEIZURES	
STEP	**RATIONALE**
1. Call for nurse and stay with resident.	1. Allows you to get help, yet continuously provide for resident's safety and comfort.
2. Place padding under head and move furniture away from resident.	2. Protects resident from injury.
3. Do not restrain resident or place anything in mouth, assist nurse with placing resident on his/her side	3. Any restriction may injure resident during seizure. Positioning resident on his/her side prevents choking if the resident should vomit.
4. Loosen resident's clothing especially around neck.	4. Prevents injury or choking.
5. Note duration of seizure and areas involved.	5. Provides nurse with necessary information to properly assess resident's condition and needs.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #10: FIRE	
STEP	**RATIONALE**
1. Remove residents from area of immediate danger.	1. Residents may be confused, frightened or unable to help themselves.
2. Activate fire alarm.	2. Alerts entire facility of danger.
3. Close doors and windows to contain fire.	3. Prevents drafts that could spread fire.
4. Extinguish fire with fire extinguisher, if possible.	4. Prevents fire from spreading.
5. Follow all facility policies.	5. Facilities have different methods of responding to emergencies. You need to follow the procedures for your facility.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #11: FIRE EXTINGUISHER	
STEP	**RATIONALE**
1. Pull the pin.	1. Allows the extinguisher to be functional.
2. Aim at the base of the fire.	2. Targets the source of the flames, which should be found at the base.
3. Squeeze the handle.	3. Releases the chemical(s) to extinguish the fire.
4. Sweep back and forth at the base of the fire.	4. Fully extinguishes the source of the fire.

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PROCEDURE #12: ORAL TEMPERATURE (ELECTRONIC)	
STEP	**RATIONALE**
Do not take oral temperature for a resident who is unconscious, uses oxygen, or who is confused/disoriented.	
1. Remove thermometer from storage/ battery charger.	
2. Do initial steps.	
3. Position resident comfortably in bed or chair.	
4. Put on disposable sheath and place thermometer under the tongue and to one side, press button to activate the thermometer.	4. The thermometer measures heat from blood vessels under the tongue.
5. The resident should be directed to breathe through their nose.	
6. Instruct resident to hold thermometer in mouth with lips closed. Assist as necessary.	6. The lips hold the thermometer in position.
7. Leave thermometer in place until signal is heard, indicating the temperature has been obtained.	
8. Read the temperature reading on the face of the electronic device, remove the thermometer, discard the sheath, and record the reading.	8. Record temperature immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you document is a legal record of what you did. If you don't document it, legally, it didn't happen.
9. Do final steps.	
10. Return thermometer to storage/battery charger.	
11. **Report unusual reading to nurse**.	11. Provides nurse with necessary information to properly assess resident's condition and needs.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #13: AXILLARY TEMPERATURE	
STEP	**RATIONALE**
Often taken when inappropriate to take an oral temperature; particularly if resident is confused or combative	
1. Remove thermometer from storage/ battery charger.	
2. Do initial steps.	
3. Position resident comfortably in bed or chair.	
4. Put on disposable sheath, remove resident's arm from sleeve of gown, wipe armpit and ensure it is dry. Hold thermometer in place with end in center of armpit and fold resident's arm over chest.	4. Places thermometer against blood vessels to get reading.
5. Press button to activate the thermometer.	
6. Hold thermometer in place until signal is heard, indicating the temperature has been obtained.	
7. Read the temperature reading on the face of the electronic device, remove the thermometer, discard the sheath, and record the reading.	7. Record temperature immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you document is a legal record of what you did. If you don't document it, legally, it didn't happen.
8. Assist the resident to return arm through sleeve of clothing/gown.	
9. Do final steps	
10. Return thermometer to storage/battery charger.	
11. Report unusual reading to nurse.	11. Provides nurse with necessary information to properly assess resident's condition and needs.

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PROCEDURE #14: PULSE AND RESPIRATION	
STEP	**RATIONALE**
1. Do initial steps.	
2. Place resident's hand on comfortable surface.	
3. Feel for pulse above wrist on thumb side with tips of first three fingers.	3. Because of artery in your thumb, pulse would not be accurate if you use your thumb.
4. Count beats for 60 seconds, noting rate, rhythm and force.	4. Ensures accurate count. Rate is number of beats. Rhythm is regularity of beats. Force is strength of beats.
5. Continue position as if feeling for pulse. Count each rise and fall of chest as one respiration.	5. Resident could alter breathing pattern if aware that respirations are being taken.
6. Count respirations for 60 seconds noting rate, regularity and sound.	6. Ensure accurate count. Rate is number of breaths. Regularity is pattern of breathing. Sound is type of auditory breaths heard.
7. Record pulse and respiration rates.	7. Record pulse and respirations immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
8. Report unusual findings to nurse.	8. Provides nurse with information to assess resident's condition and needs.
9. Do final steps	

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PROCEDURE #15: BLOOD PRESSURE	
STEP	**RATIONALE**
1. Do initial steps.	
2. Clean earpieces and diaphragm of stethoscope with antiseptic wipe.	2. Reduces pathogens; prevents spread of infection.
3. Uncover resident's arm to shoulder.	
4. Rest resident's arm, level with heart, palm upward on comfortable surface.	4. A false low reading is possible, if arm is above heart level.
5. Wrap proper sized sphygmomanometer cuff around upper unaffected arm approximately 1-2 inches above elbow.	5. Cuff must be proper size and placed on arm correctly so amount of pressure on artery is correct. If not, reading will be falsely high or low.
6. Put earpieces of stethoscope in ears.	6. Earpieces should fit into ears snugly to make hearing easier.
7. Place diaphragm of stethoscope over brachial artery at elbow.	
8. Close valve on bulb. If blood pressure is known, inflate cuff to 20 mm/hg above the usual reading. If blood pressure is unknown, inflate cuff to 160 mm/hg.	8. Inflating cuff too high is painful and may damage small blood vessels.
9. Slowly open valve on bulb.	9. Releasing valve slowly allows you to hear beats accurately.
10. Watch gauge and listen for sound of pulse.	
11. Note gauge reading at first pulse sound.	11. First sound is systolic pressure.
12. Note gauge reading when pulse sound disappears.	12. Last sound is diastolic pressure.
13. Completely deflate and remove cuff.	13. An inflated cuff left on resident's arm can cause numbness and tingling. If you must take blood pressure again, completely deflate cuff and wait 30 seconds. Never partially deflate a cuff and then pump it up again. Blood vessels will be damaged and reading will be falsely high or low.

14. **Accurately record systolic and diastolic readings.**	14. Record readings immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
15. Do final steps.	
16. Report unusual readings to nurse.	16. Provides nurse with information to properly assess resident's condition.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #16: HEIGHT	
STEP	**RATIONALE**
1. Do initial steps.	
2. <u>Using standing balance scale</u>: Assist the resident onto the scale, facing away from the scale. Ask the resident to stand straight. Raise the rod to a level above the resident's head. Lower the height measurement device until it rests flat on the resident's head.	2. Measurements are written on the rod in inches.
3. <u>When a resident is unable to stand:</u> Flatten the bed and place resident in supine position. Place a mark on the sheet at the top of the head and another at the bottom of the feet. Measure the distance.	3. Places resident in proper position and alignment; allows you to measure resident accurately.
4. <u>If the resident is unable to lay flat due to contractures:</u> Utilize a tape measure and beginning at the top of the head, follow the curves of the spine and legs, measuring to the base of the heel.	4. Allows you to obtain an accurate measurement for the resident who cannot fully extend body.
5. Accurately record resident's height.	5. Record height immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
6. Do final steps.	

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PROCEDURE #17: WEIGHT	
STEP	**RATIONALE**
1. Do initial steps.	
2. Balance scale.	2. Scale must be balanced on zero for weight to be accurate.
3. Depending on scale used, assist resident to stand on platform or sit in chair with feet on footrest or transport wheelchair onto scale and lock brakes.	3. When using chair scale, if resident has feet on floor, weight will not be accurate. Wheel locks prevent chair from moving when using a wheelchair scale.
4. When using a standard scale –lower weight to fifty pound mark that causes arm to drop. Move it back to previous mark. Move upper weight to pound mark that balances pointer in middle of square. Add lower and upper marks. When using a digital scale – press weigh button. Wait until numbers remain constant.	4. When arm drops, weight is too high. When pointer is suspended, weight is accurate. Total gives accurate weight.
5. Subtract weight of wheelchair from total weight, if applicable.	
6. Accurately record resident's weight.	6. Record weight immediately so you won't forget. Weight changes are an indicator of resident condition. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
7. Do final steps.	
8. **Report unusual reading to nurse**.	8. Provides nurse with information to assess resident's condition and needs.

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #18: ASSIST RESIDENT TO MOVE TO HEAD OF BED	
STEP	**RATIONALE**
1. Do initial steps. Ask another CNA to assist you if needed.	
2. Lower head of bed and lean pillow against head board. Adjust bed height as needed.	2. When bed is flat, resident can be moved without working against gravity. Pillow prevents injury should resident hit the head of bed. Adjusting the bed height decreases risk of injury.
3. Ask resident to bend knees, put feet flat on mattress.	3. Gives resident leverage to help with move.
4. **Place one arm under resident's shoulder blades and the other arm under resident's thighs. If a draw sheet or pad is under resident, 2 caregivers should grasp the sheet or pad firmly, with trunk centered between hands**.	4. Putting your arm under resident's neck could cause injury. Use of a draw sheet/pad causes less stress on caregiver and reduces risk of injury.
5. Ask resident to push with feet on count of three.	5. Enables resident to help as much as possible and reduces strain on you.
6. Place pillow under resident's head.	6. Provides for resident's comfort.
7. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #19: SUPINE POSITION	
STEP	**RATIONALE**
1. Do initial steps.	
2. Lower head of bed.	2. When bed is flat, resident can be moved without working against gravity.
3. Move resident to head of bed if necessary.	3. Places resident in proper position in bed.
4. Position resident flat on back with legs slightly apart.	4. Prevents friction in thigh area.
5. Align resident's shoulder and hips.	5. Reduces stress to spine.
6. Use supportive padding and/or float heels, if necessary.	6. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.
7. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #20: LATERAL POSITION	
STEP	**RATIONALE**
1. Do initial steps.	
2. Place resident in supine position.	2. Places resident in proper position and alignment.
3. Move resident to side of bed closest to you.	3. Allows resident to be positioned in center of bed when turned.
4. Cross resident's arms over chest.	4. Reduces stress on shoulders during move.
5. Slightly bend knee of nearest leg to you or cross nearest leg over farthest leg at ankle.	5. Reduces stress on hip joint during turn.
6. Place your hands under resident's shoulder blade and buttock. Turn resident away from you onto side.	6. Prevents stress on shoulder and hip joints.
7. Place supportive padding behind back, between knees and ankles and under top arm.	7. Maintains position, prevents friction and reduces pressure on bony prominences.
8. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #21: FOWLER'S POSITION	
STEP	**RATIONALE**
1. Do initial steps.	
2. Move resident to supine position.	2. Places resident in proper position and alignment.
3. Elevate head of bed 45 to 60 degrees.	3. Improves breathing, allows resident to see room and visitors.
4. Use supportive padding if necessary.	4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.
5. Do final steps.	

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PROCEDURE #22: SEMI-FOWLER'S POSITION	
STEP	**RATIONALE**
1. Do initial steps.	
2. Move resident to supine position.	2. Places resident in proper position and alignment.
3. Elevate head of bed 30 to 45 degrees.	3. Improves breathing, allows resident to see room and visitors.
4. Use supportive padding if necessary.	4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.
5. Do final steps.	

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PROCEDURE #23: SIT ON EDGE OF BED	
STEP	**RATIONALE**
1. Do initial steps.	
2. Adjust bed height to lowest position.	2. Allows resident's feet to touch floor when sitting. Reduces chance of injury if resident falls.
3. Move resident to side of bed closest to you.	3. Resident will be close to edge of bed when sitting up.
4. Raise head of bed to sitting position, if necessary.	4. Resident can move without working against gravity.
5. Place one arm under resident's shoulder blades and the other arm under resident's thighs.	5. Placing your arm under the resident's neck may cause injury.
6. On count of three, slowly turn resident into sitting position with legs dangling over side of bed.	
7. Allow time for resident to become steady. Check for dizziness	7. Change of position may cause dizziness due to a drop in blood pressure.
8. Assist resident to put on shoes or slippers.	8. Prevents sliding on floor and protects resident's feet from contamination.
9. Move resident to edge of bed so feet are flat on floor.	9. Allows resident to be in stable position.
10. Do final steps.	

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PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION	
STEP	**RATIONALE**
1. Do initial steps.	
2. Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.	2. Allows resident to adjust to position change. A change in position may cause dizziness due to drop in blood pressure.
3. Place belt around resident's waist with the buckle in front (on top of resident's clothes) and adjust to a snug fit ensuring that you can get your hands under the belt. Position one hand on the belt at the resident's side and the other hand at the resident's back.	3. Buckle is difficult to release if in back and may cause injury to ribcage if on side. Placing the belt on top of resident's clothes maintains proper infection control procedures. The belt must be snug enough that it doesn't slip when you are assisting resident to move.
4. Assist the resident to stand on count of three.	4. Allows you and resident to work together.
5. Allow resident to gain balance. Ask the resident if dizzy.	5. Change in position may cause dizziness due to a drop in blood pressure.
6. Stand to side and slightly behind resident while continuing to hold onto belt.	6. Allows clear path for the resident and puts you in a position to assist resident if needed.
7. Walk at resident's pace.	7. Reduces risk of falling.
8. Return resident to chair or bed and remove belt.	
9. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

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PROCEDURE #25: TRANSFER TO CHAIR	
STEP	**RATIONALE**
1. Do initial steps.	
2. Place chair on resident's unaffected side. Brace firmly against side of bed.	2. Unaffected side supports weight. Helps stabilize chair and is shortest distance for resident to turn.
3. Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.	3. Allows resident to adjust to position change. A significant change in position may cause dizziness due to a drop in blood pressure.
4. Stand in front of resident and apply gait belt around resident's abdomen.	4. Gait belts reduce strain on your back and provides for security for the resident.
5. Grasp the gait belt securely on both sides of the resident	5. Provides security for the resident and enables them to turn.
6. Ask resident to place his hands on your upper arms.	6. You may be injured if resident grabs around your neck.
7. On the count of three, help resident into standing position by straightening your knees.	7. Allows you and resident to work together. Minimizes strain on your back.
8. Allow resident to gain balance, check for dizziness.	8. Change of position may cause dizziness due to drop in blood pressure.
9. Move your feet 18 inches apart and slowly turn resident.	9. Improves your base of support and allows space for resident to turn.
10. Lower resident into chair by bending your knees and leaning forward.	10. Minimizes strain on your back.
11. Align resident's body and position foot rests. Remove gait belt	11. Shoulders and hips should be in straight line to reduce stress on spine and joints.
12. Do final steps.	

I verify that this procedure was taught and successfully demonstrated according to ISDH Standards.

_____ _____

Student Signature Date

_____ _____

Instructor Signature Date