CNA Skills Day Outline

Temperature

- Types of Temperature
    - Oral, Axillary, Tympanic (Ear), Temporal (Forehead), Rectal
    - Temperature Comparison (based on oral temperature)
        - Rectal—0.5°F (0.3°C) to 1°F (0.6°C) higher than oral temperature
        - Tympanic—0.5°F (0.3°C) to 1°F (0.6°C) higher than oral temperature
        - Axillary—0.5°F (0.3°C) to 1°F (0.6°C) lower than oral temperature
        - Temporal—0.5°F (0.3°C) to 1°F (0.6°C) lower than oral temperature
- Temperature Ranges
    - Normal Range
        - Normal—98.6°F or 37°C
        - Range—97°F - 99°F or 36.1°C – 37.2°C
- Temperature Technique
    - Oral—wait at least 5 minutes after the resident ate or drank, ensure that the thermometer is under the resident's tongue, ensure mouth is kept closed.
    - Axillary—place tip of thermometer in center of armpit, make sure arm is closed tightly
    - Rectal—use lubrication, communicate with resident, insert ½ inch, never force (stop inserting if it becomes difficult)

CNA Skills Day Outline

Pulse/Respiration/O2 Sats

- Pulse
  - Normal Range—60 to 100 BPM
  - Pulse Locations
    - Radial, brachial, pedal, popliteal, carotid arteries
  - Technique
    - Count for 30 seconds and multiply by two—unless feels irregular (count for a full minute)
- Respirations
  - Normal Range—12 to 20 BPM
  - Technique
    - Count for 30 seconds and multiply by two—unless feels irregular (count for a full minute)
- Oxygen Saturation
  - Normal Range—95 to 100%
  - Technique
    - Probe on finger with even wavelength
    - Inaccurate if: nail polish, bright light on the probe, movement, poor perfusion

CNA Skills Day Outline

Intake/Output

- Cup exercise—have individuals match up number of cc's with each type of container
- Dehydration
    - Discuss CNA role in dehydration (refer to handout)
        - Encourage Fluids
        - Offer Water-Dense Food
        - Help with residents that require swallowing precautions
        - Assist with eating/drinking as needed
        - Notify nurse if food/fluid intake decreases

CNA Skills Day Outline

Blood Pressure

- Steps to taking a blood pressure
  1. Choose an appropriate size cuff
  2. Wrap cuff around the upper arm about 1 inch above elbow
     a. Make sure the arm is at the level of the heart
     b. Ensure that the arm is appropriate to use (check if they have a Do Not Use Limb order)
  3. Place stethoscope on brachial artery
  4. Inflate cuff to 180mmHg and release air at a slow to moderate rate (3mm/sec)
     a. The first "knocking" sound you hear is the systolic blood pressure
     b. When the sound stops, that is the diastolic reading
  5. Make sure that all air is released from the cuff and remove from resident's arm
- Issues with taking blood pressure
  - You hear the "knocking" sound immediately
    - The resident's systolic blood pressure may be above 180mmHg and the cuff needs to be inflated more
  - You are having trouble hearing the "knocking" sound
    - Ensure that the blood pressure cuff is the appropriate size
    - Check that the cuff is placed in the correct location (many cuff's show where the sleeve should be placed on the artery)
    - Try using the bell of the stethoscope