



Nurse Aid

Notes

Key tasks you should know



For :

Certified Nursing Assistants (CNA)

Home care Assistants

Private home care Caregiver

Elderly Care specialist

Home support Worker

Nurse aiders



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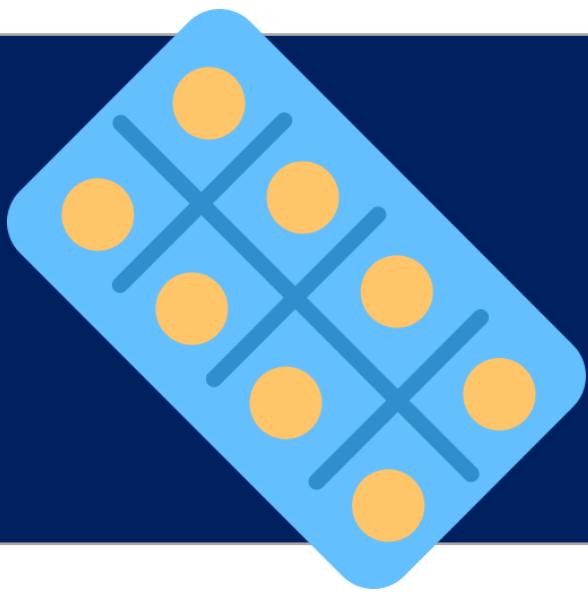
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Types of Drugs and their uses



"The right drug, at the right time, in the right dose, can make all the difference."

— Nursing Proverb

As a nurse aider, you are often the first point of contact for patients who rely on medications to heal, manage pain, or improve their quality of life. Understanding the types of drugs and their uses is one of the most important skills you'll develop in your role.

This chapter is here to guide you through the basics: what each medication does, why it's used, and how it helps your patients. You don't need to be a pharmacist, but you do need to know enough to administer medications safely and confidently.

Remember, every pill you give, every dose you measure, and every instruction you follow matters.

You're not just handing out medication—you're helping someone feel better, recover faster, or live more comfortably.

Common Drugs and Their Uses

- **Nefidipine:** Treatment of Hypertension & Chest Pains.
- **HCT (Hydrochlorothiazide):** Treatment of Hypertension & swelling due to fluid build-up.
- **Enalapril:** Treatment of Hypertension.
- **Tetracycline Hydrochloride:** Antibiotic used to treat wide infections, including Acne.
- **Amlodipine:** Treatment of Hypertension.
- **Ciprofloxacin:** Quinolone Antibiotic used to treat bacterial infections, anthrax, and plague.
- **CBZ (Carbamazepine):** Anticonvulsant for epilepsy/seizures & neuropathic/nerve pains.
- **Lenvatinib (Lenvima):** Tyrosine Kinase Inhibitor for certain types of cancers.
- **Vitamin C (Ascorbic Acid) :** Antioxidant for controlling infections, healing wounds, and protecting cells.
- **Cenvitan:** Multivitamins for boosting overall male health.
- **Metformin:** Treatment of Diabetes.
- **Loperamide:** Treatment of Diarrhoea.
- **Urazide:** Treatment of Hypertension.
- **Indocid:** Treatment of General Body Pains.
- **Prednisolone:** Treatment of Allergies, Inflammation, cancers, asthma, and multiple sclerosis.

Chapter 2

Drug Administration

What is a Drug?

A substance that has a physiological effect on the body when introduced to the bloodstream. It is used to relieve symptoms or treat conditions.



1. "The right drug, at the right time, in the right dose, can make all the difference."

- Nursing Proverb

Key Principles of Drug Administration

- Right Time
- Right Patient
- Right Medication
- Right Dosage
- Right Route
- Right Documentation

Steps for Administering Oral Medication (e.g., Paracetamol)

1. Greet the patient and introduce yourself.
2. Check the pill pack for:
 - Patient's name
 - Drug name
 - Quantity
 - Strength
 - Expiry date
 - Instructions (before/after meals)
3. Use a plastic spoon to avoid cross-infection.
4. Administer the medication and ensure the patient swallows it.
5. Record the administration and thank the patient.

Keep drugs in a safe place away from kids and elderly. Never change drugs from original container

Important!

If all the information is correct use a plastic spoon to collect the medication from the pill pack so as to avoid cross infection by direct contact of your hand and the medication.

Avoid using a metal spoon whenever possible, you must avoid contamination at all costs.



Give the patient medication on their hand or mouth. If you are going to dispose of the spoon give them water and ask them to swallow the medication then check if they indeed swallowed it to make sure to record correct information.

What you should know about drugs

All drugs are poisonous at
a certain dosage, All Individuals
react differently to different drugs.

All drugs have side effects.
Follow the agreed times for
drug administration

so that your patients will get used to
'time for medication.'

Work with others nurses.



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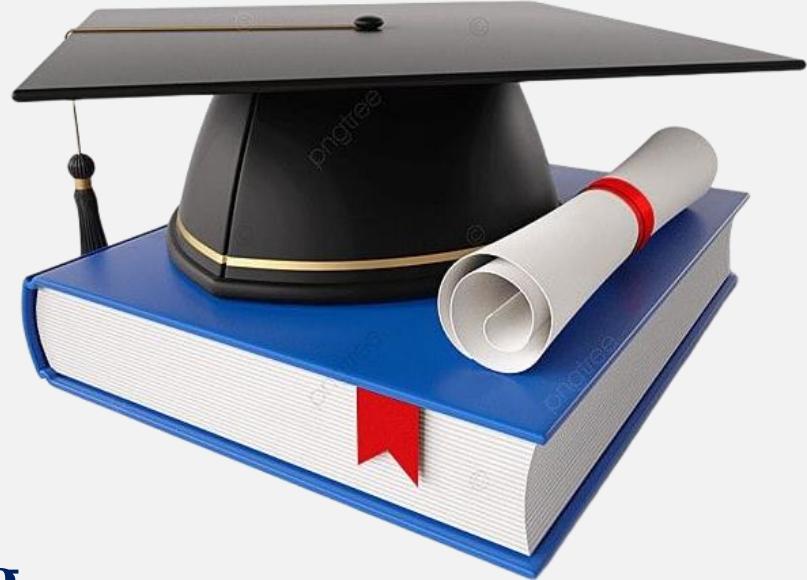
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Chapter 3

Administering a Bed Pan

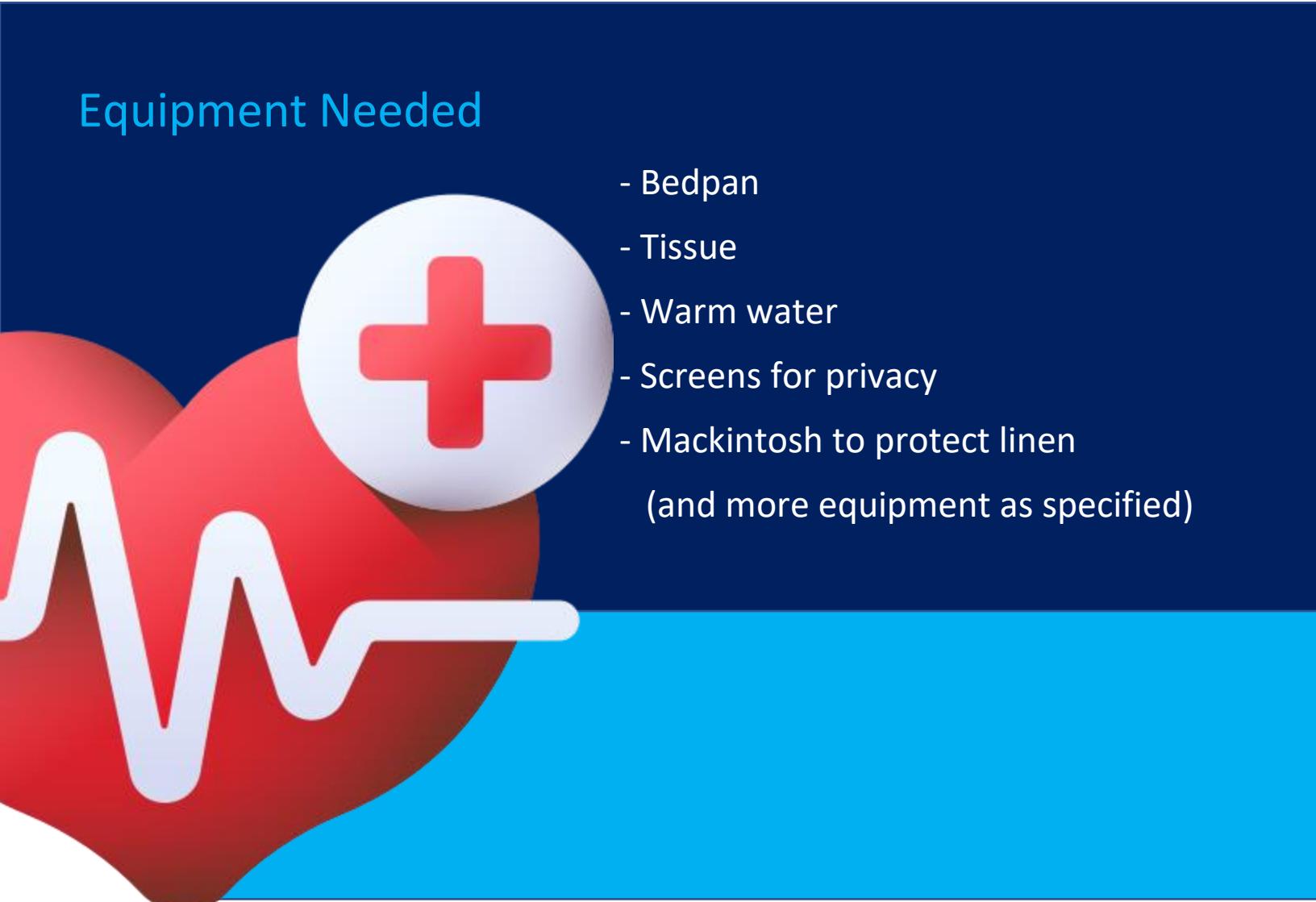
A bedridden patient **is a patient that, for some reason, has to stay in bed for a long period of time**. This patient might quickly develop serious complications that are not directly linked with the reason why they have to stay in bed. Some of those complications might be life threatening, most of them might be disabling (leading to a disability even if the first problem wouldn't have led to disability), and all of them will make the patient to require extra help in completing tasks they previously could do by themselves, including relieving themselves.

Usually, bedridden patients will need more time to recover - the complications will also have to be addressed during the treatment- and they might not recover as well and stay a little longer on the bed.



"Above all, It is your role as a nurse to maintain the patient's privacy and dignity at all times"

Equipment Needed



- Bedpan
- Tissue
- Warm water
- Screens for privacy
- Mackintosh to protect linen
- (and more equipment as specified)

Procedure

1. Prepare the bedpan by warming it with warm water.
2. Position the patient in a recovery position.
3. Insert the bedpan carefully, ensuring the patient is covered for privacy.
4. After use, clean the patient thoroughly and dispose of waste properly.
5. Inspect the stool for abnormalities (e.g., blood, worms) and report if necessary.

Starting with the arm farthest away, wash and dry the upper body, including the arms, hands, axilla and gradually moving to the inner and lastly private parts. Moving across the body in this way ensures the patient is clean and dry by the end of the procedure.

Remove clothing from the lower body, then wash and dry the legs and feet, starting with the leg farthest away and working from the top of the leg to the foot. Check feet for any problems such as calluses and dry skin. Change the water and wash cloth and, if required, apply non-sterile gloves before washing the patient's genitals..

With help from a colleague (who has decontaminated their hands and put on an apron, roll the patient onto one side using appropriate equipment. Assess if gloves are required for washing the sacrum. Using a clean wash cloth and towel, wash and dry the back then the sacral area, moving from top to bottom

Roll the patient with a colleague
decontaminate your hands

Key points on bed bath procedures

General principles of bed bathing

- | Keep the patient warm at all times
- | Position a linen skip near the patient and dispose of used linen immediately to reduce dispersal of microorganisms and dead skin cells into the environment
- | Only expose the area of the body being washed
- | Change water if it becomes dirty or cold and always after washing the genitalia and sacrum.
- | Change wash cloths if they become soiled and after washing the genitalia and sacral area
- | Check skin for pressure damage
- | Avoid contaminating dressings and drains with water
- | Pat the skin dry to reduce the risk of friction damage
- | Separate skin folds, and wash and pat them dry
- | If the patient is awake, remember to talk them through what you are doing; nurses should not talk over the patient

Chapter 4

Oral Care

Equipment Needed

- Sterile dressing tray
- Toothpaste & toothbrush
- Mouthwash solution
- Gloves
- Cup of water
- Face towel
- Petroleum jelly



Procedure

- 1. Greet the patient and explain the procedure.**
- 2. Assess the oral cavity for sores, decay, or other issues.**
- 3. Brush the teeth in a circular motion, starting from above and moving downward.**
- 4. Rinse the mouth and apply petroleum jelly to prevent dryness.**

Chapter 5

Grooming

Hair Care

Perform hair care for neatness and so as to keep your patients with their good presentable look. Consider the patient's hair texture colour or thickness when choosing the type of hair care (trim, comb, tie etc) among other careful considerations.

Soak nails in warm soapy water to soften them. **Trim and file nails**, ensuring they are neat and smooth. **Apply lotion** and massage the hands and feet.

Nail Care



Chapter 6

Bed Making

Types of Beds

- Unoccupied Bed
- Occupied Bed
- Occupied Bed with a Patient

Procedure

1. Prepare the linen and ensure the patient is comfortable.
2. Remove old blankets carefully to avoid cross-infection.
3. Layer the blankets in the correct order:

- **Long mackintosh**
- **Bottom blanket**
- **Bottom sheet**
- **Short mackintosh**
- **Draw sheet**
- **Top sheet**
- **Top blanket**
- **Counterpane**

4. Tuck in the sheets using envelope corners for neatness

Principles of bed making

1. Envelop corners to keep the blankets intact and to kill crisis as to avoid bed sores and ensure comfort..

2. Avoid talking over the patient. Rather, talk to them.

3. Avoid putting another patient's blanket on another patient. This avoids cross infection..

4. Sluce all blankets that need sluicing before taking them to the laundry.

5. Record and report all abnormalities you find in your patients bed eg blood stains

6. Do not make the bed while the patient or other patients in the same ward are eating

7. Use the 3 step movement for efficiency

Types of Beds

1. bring your linen or blankets rolled

2. bed making trolley

Infectious linen is linen with the patient's infection

Remove all the linen and leave the top sheet on top of the patient for privacy n dignity.

Principles of bed making

- 1.3 step movement
2. Don't lie the creases wif yuh hand
3. Blankets mustn't touch the floor

Procedure

1. Untuck all the ends
2. Cross the legs them n slowly turn him/her
3. Roll the linen
4. Roll the clean linen in
5. Change position
6. Roll the other end

Three types of bed

Occupied

Unoccupied

Chapter 7

Damp Dusting



Equipment Needed

- Bucket of soapy water
- Bucket of clean water
- Towels for soapy water, clean water, and drying

Procedure

- 1. Wipe** surfaces with a soapy towel using one stroke.
- 2. Rinse** with a clean towel using one stroke.
- 3. Dry** with a dry towel using one stroke.

Chapter 9

Vital Signs

What are vital signs?

Vital signs are measurements of the body's basic functions. Normal vital signs change with age, sex, weight, exercise tolerance, and overall health. The four main vital signs that are usually monitored include:

- Body temperature
- Pulse rate (heart rate)
- Rate of breathing (respiration rate)
- Blood pressure

Body temperature?

The temperature of a person varies depending on recent activity, consumption of food or fluids, and time of day. Normal temperature can range from 97.8 to 99.1 degrees Fahrenheit

Blood Pressure & Pulse

The pulse rate measures the heart rate, or the number of times the heart beats per minute. As the heart pushes blood through the arteries, the arteries pulsate with each beat. Taking a pulse not only measures the heart rate but it can also be felt if the heart

The normal pulse for adults ranges from 60 to 100 beats per minute.

Normal BP: 90/60 to 120/80 mmHg.

Normal Pulse: 60-100 BP

Procedure

1. Use a digital sphygmomanometer.
2. Ensure the patient's arm is at heart level.
3. Record systolic and diastolic readings.



What do blood pressure numbers mean?

‘120/70’

Read as “one twenty over seventy millimeter mercury” (mm Hg)

Systolic

The top number, which is the higher of the two numbers, measures the pressure in the arteries when the heart beats (the heart muscle squeezes or contracts).

Diastolic

The bottom number, which is also the lower of the two numbers, measures the pressure in the arteries between heart beats (when the heart muscle relaxes)

Normal Range: 36.5°C (97.7°F) to 37.5°C (99.5°F).

Methods: Oral, axillary, rectal, tympanic, temporal artery.

NOTE

Blood pressure varies throughout the day and night. Physical activity and stress. Smoking and/or drinking caffeinated beverages also raise the blood pressure. Accurate measurement of blood pressures requires paying attention to the size and placement of the cuff, the position of the person, and the technique used.

Blood Sugar Levels

Normal Range: 3.9 to 7.9 mmol/L.

Procedure

1. Use a glucometer and lancet device.
2. Prick the side of the finger and place a drop of blood on the test strip.
3. Record the reading.

Chapter 11

Waste Disposal And Cleaning

Types of Waste

Infectious Waste: Contaminated items.

Sharps: Needles, broken vials.

Pathological Waste: Human or animal tissue.

Pharmaceutical Waste: Unused or expired drugs.

Genotoxic Waste: Cytotoxic drugs.

Radioactive Waste: Potentially radioactive materials.

Chemical Waste Liquid waste like disinfectants.

General Waste Non-hazardous waste.

Color Coding of Waste & Equipment

Waste Color Codes

Red Anatomical waste (blood, organs)

Orange Clinical/infectious waste.

Yellow Highly infectious waste.

Blue Unused drugs.

Purple Cytotoxic products.

White Dental waste.

Yellow Tin Sharps.

Black & Yellow Offensive products (e.g., nappies).

Black Non-clinical waste.

Mops & Buckets Colour Codes

Green Consultation rooms.

White Office/kitchen.

Black TB wards.

Red Toilets, dressing rooms.

Yellow Chemicals.

Chapter 11

Additional Notes & Procedures

Helping with Bed Bath

- Wash the eyelids, face, ears, neck, arms, chest, legs, and feet.
- Pay special attention to skin folds and bony areas.

Symptoms of a Heart Attack

- Chest pains, shortness of breath, blurry vision, weakness, back pain, severe anxiety, nosebleeds, severe headache, difficulty speaking.

Cleaning the bed pan

- **Close the bedpan to avoid spreading the bacteria and to reduce any bad smell.**
- **Check if the blankets or macking tosh was not soiled if soiled. If it was soiled change it.**
- **Dress up your patient and ask them if they are indeed done just to be sure.**
- **Now let them rest.**
- **Take the counter pan to the sluce room. Always make sure it is closed and covered with a cloth.**

If you don't have a trolley put the bed pen on the palm of your hand, raise it up next to your ear using the hand that is closer to the wall.

When u get to the sluice room, check the stool for any foreign objects such as worms, blood or even the color and texture of the stool.

Record and report if you find anything abnormal

Dispose and thoroughly clean the bedpan and sluice room

While doing all of that your other partner will be collecting the other equipment

Vital Signs

The four main vital signs that are usually monitored include:

- Body temperature
- Pulse rate (heart rate)
- Rate of breathing (respiration rate)
- Blood pressure

What are normal blood pressures?

<i>Blood Pressure Category</i>	<i>Systolic</i> mm Hg		<i>Diastolic</i> mm Hg
Normal	less than 120	and	less than 80
Prehypertension	120 – 139	or	80 – 89
High Blood Pressure (Hypertension) Stage 1	140 – 159	or	90-99
High Blood Pressure (Hypertension) Stage 2	160 or higher	or	100 or higher
Hypertensive Crisis (Emergency Care Needed)	Higher than 180	or	Higher than 120

Symptoms of high blood pressure:

High blood pressure usually occurs with no symptoms. Many people believe that people with high blood pressure will have headaches, nervousness, sweating, or facial flushing. Those symptoms are actually seldom seen. Studies have actually shown that people with high blood pressure often have fewer headaches than those with normal blood pressure.

A hypertensive crisis, however, can cause many symptoms and emergency medical treatment is needed. Symptoms that occur with very high blood pressure readings include severe headaches, severe anxiety, and shortness of breath.

Symptoms of low blood pressure:

Low blood pressure (hypotension) is generally defined as a systolic pressure less than 90 mm Hg and a diastolic pressure less than 60 mm Hg. However blood pressure is not considered too low unless the person has symptoms. Many athletes have blood pressures that are quite low and this is a sign of their fitness.

Symptoms of low blood pressure include:

- Dizziness or lightheadedness
- Fainting
- Nausea
- Blurred vision
- Fatigue
- Depression

Low blood pressures can occur with:

- Prolonged bed rest
- Blood loss such as from a bleed in the gastrointestinal tract
- Medications such as those used for high blood pressure, drugs for Parkinson's disease, and pain medications.
- Heart problems
- Thyroid problems
- Severe infection (such as septic shock)
- Allergic reactions (anaphylaxis)
- Anemia

Kinds of Linens

A- Blanket: a large piece of clothe often soft, woolen and is used for warmth as a bed cover.

B- Top sheet: used to cover the patient to provide warmth, made of thick cotton, thermal material.

C- - Cotton draw sheet: a piece of cloth that the rubber sheet and is used to absorb and moisture.

D- -Bottom sheet: used to cover the bed after mattress cover.

E- - Rubber sheet: used to protect the bottom sheet from soothng due to patient secretions and prevent the patients from getting bedsores. It's usually placed over the center of the bottom sheet.

Guidelines in Bed Making	Rational
1- Wash hand thoroughly before and after handling clients bed linen	- helps to control nosocomial infection
2- Hold soiled linens a way from the body.	- To avoid contact with nurses clothes and to avoid spreading micro-organism.
3- Linen for one client is never placed on another client's bed.	- to avoid transporting micro-organism from patient to patient
4- Soiled linens is placed directly in a portable linen hamper or tucked in to a pillow case at the end of the	- To limit the patient secretion and avoid contamination with other furniture.

How to make a mitered corner:



Laying a triangular fold on the bed.



2. Tucking the end of the sheet under the mattress



3. Pulling the triangular fold over the side of the mattress.

There's plenty to note about.

We've made it **easier** for you!

Understand your various roles
as a Care Assistant and
related conditions like
Alzheimers', Stroke, dementia



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