STATE OF ARKANSAS

LONG TERM CARE FACILITY NURSING ASSISTANT TRAINING CURRICULUM

Written by
The Curriculum Committee for the
Nursing Assistant Training Program

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Division of Medical Services

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TO THE NURSING ASSISTANT
AND THE RESIDENTS OF LONG TERM CARE FACILITIES

May we never speak to deceive old people or
listen to betray them;

May we have the wit and wisdom to seek the
truth and the fortitude to stand
up for their basic human rights;

May we give recognition for past experiences
and memories;

May we show dignity and self respect
for the future;

May we minister the highest quality of
health care to each individual person;

May we seek to understand the last
period of life for which the first
was made.

~~The Curriculum Committee~~

~~PART I~~

~~CLASSROOM TRAINING – 16 HOURS~~
~~(Theory and Classroom Lab)~~

~~NOTE: The trainee cannot provide any direct nursing services to residents until completion of Part I.~~

~~Unit I Communication and Interpersonal Skills~~
~~(2 hours theory/ classroom lab)~~

~~OBJECTIVE~~	~~CONTENT~~

CONTENT

Discuss the role of the nursing assistant as a member of the health care team.	1. The Health Care Team 1.1 The nursing assistant is a member of The Health Care Team. 1.2 See diagram on cover.
List desirable attitudes and actions which will provide successful job performance for the nursing assistant.	2. Attitudes/Actions Which Lead to Successful Performance of a Nursing Assistant 2.1 Dependability: a. Reporting to work on time. b. Minimum absences. c. Keeping promises. d. Completing assigned tasks promptly and quietly. e. Performing tasks you know should be done without being told. 2.2 Accuracy in following instructions. 2.3 Sensitive to feelings and needs of others. 2.4 Personal appearance: a. Appropriate, neat, clean clothing. b. Comfortable, neat, clean shoes of an appropriate style.
List desirable personal grooming habits for the nursing assistant.	c. Personal hygiene. d. Name tag. e. Watch. f. Ink pen. 2.5 Personal health: a. Good nutrition. b. Adequate sleep and rest. c. Good emotional health. d. How to handle stress.
Define the goals of a long term care facility.	3. Goals 3.1 Goals of a long term care facility: a. Provide a safe environment. b. Maintain and promote health. c. Provide a satisfying social environment. 3.2 Goals of the nursing assistant: a. Learn to set daily goals consistent with the short and long term goals of

Unit I (contd.)

OBJECTIVE

CONTENT

	the Plan of Care. b. Learn to set short and long term personal, job and career goals.
Define Communication. Identify types of communication. List attitudes which promote communication.	4. Communication 4.1 Definition – The sending and receiving of messages. 4.2 Types of communication: a. – Nonverbal – Sending a message without words by – 1) – Body position & gestures. 2) – Facial expression. 3) – Touch. 4) – Tone of voice. b. – Verbal – Sending a message through talking or writing. 4.3 Attitudes which promote communication: a. – Courtesy. b. – Keeping emotions under control. c. – Empathy. 4.4 Behavior which enhances communication between the nursing assistant and the residents: a. – Provide opportunity for resident to express thoughts and feelings – 1) Listen to resident's comments. 2) – Allow enough time for communication. 3) – Allow enough time for silent communication. b. – Observe nonverbal behavior during interaction – 1) – Body position. 2) – Facial Expression. 3) Gestures. c. – Listen carefully to expressed thoughts and feelings and to tone of voice. d. – Encourage focus on resident- concerns – 1) – Don't criticize other staff. 2) – Be responsive to resident's needs.

	~~3) Self understanding on part of nursing assistant.~~

OBJECTIVE

CONTENT

~~Unit I (contd.)~~

OBJECTIVE	CONTENT
~~Identify basic factors which may block communication between resident, family and staff.~~	~~4.5 Communicating with resident's friends and family:~~ ~~a. Factors which promote good interpersonal relationships with resident's family and friends – 1) Kindness.~~ ~~2) Patience.~~ ~~3) Empathy.~~ ~~4) Listening to family members.~~ ~~5) Not interfering in private family business.~~ ~~b. Restrictions in information given to families –~~ ~~1) One designated individual (usually the charge nurse) communicates such information as diagnosis, doctor's orders, medical status.~~ ~~2) Maintain confidentiality in communicating with family.~~ ~~c. Inappropriate behavior or communication between resident, family, and staff may be due to –~~ ~~1) Family's feelings of guilt or grief at institutionalizing the resident.~~ ~~2) Resident's feelings of anger, guilt at being institutionalized.~~ ~~3) Concerns about money, pain, the future, separation from loved ones, etc.~~ ~~4.6 Information the nursing assistant shall report to charge nurse:~~ ~~a. Information about a resident that could result in harm.~~ ~~b. Any change in resident's behavior or physical condition.~~

OBJECTIVE	CONTENT
~~Identify steps for answering resident's call signal.~~	~~4.7 Using mechanical devices to promote communication:~~ ~~a. Answering call signals –~~ ~~1) Answer as soon as call light goes on.~~ ~~2) Turn off call signal upon entering the resident's room.~~

OBJECTIVE	CONTENT
	~~Unit I (contd.)~~

OBJECTIVE	CONTENT
List steps to communicate with the vision impaired resident. List steps communicating with the hearing impaired resident.	3) When finished helping the resident, replace call signal where it can be reached (OLTC Regulation). b. Techniques for using phone or intercom – 1) Identify your area. 2) Identify yourself and your position. 3) Speak slowly and clearly. 4) When taking a message, write it down and who it is from. 4.8 Communicating and assisting the vision impaired resident: a. Identify yourself when approaching the resident and when you are leaving. b. Recognize the use of light touch on the arm or shoulder to get attention. c. Objects (furniture, personal items, etc.) are not to be moved or changed. d. Use descriptions when you talk about – 1) Color. 2) Size. 3) Texture. 4) Location. e. Serve as a sighted guide – 1) Offer resident your elbow. 2) Allow resident to hold your arm. 3) Tell resident when approaching steps/stairs. f. If assisting resident in seating is requested, place resident's hand on seat of chair. 4.9 Communicating with the hearing impaired: a. Place yourself where the resident can see you and establish eye contact and move closer to the resident if necessary. b. Speak slowly.

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
	~~Unit I (contd.)~~

OBJECTIVE	CONTENT
~~Describe techniques for communicating with the resident who cannot speak.~~	~~c. Speak clearly using a moderately loud voice, avoid shouting.~~ ~~d. Sit or stand with the light above or toward you.~~ ~~e. Use body language as needed to emphasize your message.~~ ~~f. Be patient, friendly, kind, and do not patronize.~~ ~~4.10 Communicating with the resident who cannot speak or has difficulty speaking:~~ ~~a. Agree upon meaning of signals to be used (i.e. one for yes, two for no) – 1) Eye blinking.~~ ~~2) Hand squeezes. 3) Head nodding.~~ ~~b. Use communication flash cards/board.~~ ~~c. Verify resident's communication.~~ ~~d. Share with other team members the methods used to communicate with the resident.~~ ~~4.11 Communicating with a demanding/angry resident:~~ ~~a. Be courteous.~~ ~~b. Be in control of your emotions.~~ ~~c. Be tactful.~~ ~~d. Be a good listener.~~ ~~e. Be a careful, non-judgmental observer.~~ ~~4.12 NEVER act or appear condescending to a resident:~~ ~~a. DO NOT "talk down".~~ ~~b. DO NOT use "baby talk".~~ ~~c. Address the resident by name.~~ ~~d. Treat the resident as an adult.~~ ~~4.13 Respecting confidentiality in communication:~~

OBJECTIVE	CONTENT
~~Define Confidentiality.~~	~~a. Confidentiality means keeping residents personal information private.~~

OBJECTIVE		CONTENT
	~~Unit I (contd.)~~	

OBJECTIVE	CONTENT
~~List examples of appropriate and inappropriate use of resident information.~~	~~b. DO NOT discuss personal information with 1) Another resident.~~ ~~2) Relatives of friends of the relative.~~ ~~3) Representatives of the news media.~~ ~~4) Fellow workers, except when in conference.~~ ~~5) One's own family or friends.~~

OBJECTIVE	CONTENT

OBJECTIVE

CONTENT

~~Unit II Infection Prevention and Control~~
~~(2 hours theory/classroom lab)~~

~~OBJECTIVE~~	~~CONTENT~~

Unit II (contd.)

OBJECTIVE	CONTENT
~~Identify reasons why infection prevention and control is important.~~ ~~Identify practices which hinder the spread of infection.~~ ~~Name conditions needed for microorganisms growth.~~ ~~List ways microorganisms spread.~~	~~1. Infection Control~~ ~~1.1 Practices which help reduce the number and hinder the transfer of disease producing microorganisms from one person to another, or from one place to another may be called infection control.~~ ~~1.2 Infection control practices are important because:~~ ~~a. Microorganisms are always present in the environment.~~ ~~b. Some of these microorganisms can cause disease (pathogens).~~ ~~c. Elderly people and individuals with chronic disease are often more susceptible to pathogens.~~ ~~d. Reducing the number of microorganisms and hindering their transfer increases the safety of the environment.~~ ~~1.3 Conditions needed for growth of microorganisms:~~ ~~a. Nourishment.~~ ~~b. Moisture.~~ ~~c. Usually warm temperature.~~ ~~d. Usually air.~~ ~~e. Usually darkness.~~ ~~1.4 Ways microorganisms spread:~~ ~~a. Direct contact with a person who carries it or has the infection.~~ ~~b. Indirect contact – Touching objects contaminated by a person with infection, taking in food or other~~

OBJECTIVE

~~Name the single most important infection control practice.~~ ~~List infection control practices which hinder the spread of infection.~~	~~substances which have been contaminated.~~ ~~1.5 Practices which hinder the spread of infections:~~ ~~a. Infection control practices Washing your hand~~ ~~WASHING YOUR HANDS!!!~~ ~~Washing your hands is the single most important control practice.~~ ~~b. Cleaning the resident's unit.~~

Unit II (contd.)

OBJECTIVE	CONTENT
~~Identify and demonstrate measures of handwashing.~~	~~c. Handling bed linen correctly.~~ ~~d. Disposing of contaminated articles correctly.~~ ~~e. Cleanliness of self and resident.~~ ~~2. Handwashing~~ ~~2.1 Reasons for good handwashing:~~ ~~a. Everything you touch has germs on it.~~ ~~b. In your work you use your hands constantly.~~ ~~c. Our hands carry germs from resident to resident and from resident to you. Washing your hands will help prevent this transfer of germs.~~ ~~d. Handwashing is the first line of defense against spreading microorganisms. 2.2 Handwashing routine:~~ ~~(refer to procedure #9 in the Appendix)~~ ~~a. Wash your hands before and after contact with each resident (OLTC Regulation).~~ ~~b. Use soap dispenser rather than bar soap if available.~~ ~~c. Use enough soap to produce adequate lather.~~ ~~d. Vigorous rubbing over surface of hands helps remove microorganisms.~~ ~~e. Hold your hands lower than you elbows while washing.~~ ~~f. Rinse from the clean to dirty. Elbows (clean) to fingertips (dirty).~~ ~~g. Rinse your hands well after washing and dry thoroughly with paper towel.~~

OBJECTIVE

~~List three objectives of universal precautions for blood and body fluids.~~	~~h. The water faucet is always considered contaminated. Use paper towels to turn faucet off.~~ ~~3. Universal Precautions for Blood and Body Fluids~~ ~~3.1 Objectives:~~ ~~a. To minimize contact with blood and body fluids of ALL residents treated by the facility.~~ ~~b. To minimize the likelihood of~~

Unit II (contd.)

OBJECTIVE	CONTENT
	~~CONTENT~~

Unit II (contd.)

OBJECTIVE

~~List and describe universal precautions to be used when caring for a resident with potentially infectious conditions.~~	~~transmission of specific blood borne organisms such as Hepatitis B and Human Immunodeficiency Virus (HIV).~~ ~~c. To help achieve a consistent application of infection control principle.~~ ~~3.2 Universal Precautions:~~ ~~a. The blood and body fluids of all residents regardless of their diagnosis or isolation precaution status shall be considered POTENTIALLY INFECTIOUS.~~ ~~b. These universal precautions shall include but are not limited to the following procedures –~~ ~~1) Hands should always be washed before and after contact with residents. Hands should be washed even when gloves have been used. If hands come in contact with blood, body fluids or human tissue, they should be immediately washed with soap and water.~~ ~~2) Gloves should be worn when contact with blood, body fluid, tissues or contaminated surfaces are anticipated. Gloves shall be changed after each resident contact. Gloves should be readily available.~~ ~~3) Mask eye protection and other protective clothing should be worn~~

OBJECTIVE	CONTENT
	~~during procedures which are likely to generate splattering of body fluids.~~ ~~4) To minimize the need for emergency mouth-to-mouth resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.~~

Unit II (contd.)

OBJECTIVE

Unit II (contd.)

OBJECTIVE	CONTENT
State reasons for using isolation practices.	5) Blood spills, urine, feces and sputum shall be cleaned up promptly with a disinfectant solution. 6) All specimens should be put in a well constructed container with a secure lid to prevent leaking during transport. Contamination of the outside of the container shall be avoided during collection. 7) There are disease specific isolation precautions. The charge nurse will instruct the nursing assistant on them at the time of need. 4. Isolation 4.1 Residents with certain types of infections may be separated from other residents to: a. Keep the germs that cause disease isolated in the resident's unit where they can be destroyed or specially handled. b. Protect persons outside the resident's room from contact with germs. 4.2 Terms associated with isolation: a. Contaminated – any article that is in contact with the resident in the isolation unit is considered contaminated (dirty with germs). b. Clean – means uncontaminated; refers to all articles and places that have not

Unit II (contd.)

OBJECTIVE

	been contaminated by contact with pathogens. 4.3 Methods of isolation: a. There are diseases specific isolation methods and the charge nurse will give instructions to implement them.

Unit II (contd.)

OBJECTIVE	CONTENT

OBJECTIVE

Unit II (contd.)

	CONTENT
Identify and demonstrate measures of isolation: 1) Preparing the unit. 2) Isolation handwashing. 3) Gowning/gloving/masking.	4.4 (echniques: a. rocedure #45 in the Appendix) following precautions may be used 1) Preparing the unit – caution signs will be placed on the door of the isolation room as an alert (OLTC Regulation). Disposable dishes and utensils will be provided at meals. 2) Double bagging linen and trash before carrying out of room. 3) Gowns, gloves and/or masks will be worn: – Gowns are indicated if soiling of clothes is likely or to prevent cross contamination of clothing.

	5) Special handwashing techniques.

Unit III Safety and Emergency Procedures (4 hours theory/classroom lab)

OBJECTIVE	CONTENT

Define body mechanics as it applies to the nursing assistant. Identify the purpose of good body mechanics. Identify and demonstrate rules of body mechanics.	1. Employee Safety 1.1 Body Mechanics: a. Definition – Special way of standing and moving one's body. The term body mechanics is commonly used to describe the body movements by the staff when they move residents and/or objects. b. Purpose – 1) To make the best use of strength and avoid fatigue. By using good body mechanics you can prevent injuries, e.g., back strain and/or torn ligaments/muscles. 2) Good body mechanics on the part of the nursing assistant decreases the chance of injury. c. General Rules – 1) Use as many large muscles or groups of large muscles as possible: - Use both hands rather than one hand to pick up a heavy object. - Use the large muscles in your legs when picking up a heavy object instead of smaller back muscles. - Squat down, bending your knees. Keep your back straight and raise up, using your leg muscles, NEVER bend over at the waist to lift heavy objects. 2) Always stand erect. Good posture is essential to good body mechanics. 3) When lifting, your feet should be approximately with the width of your shoulders, distance apart (at least 12 inches). This gives a broad base of support.

~~Unit III (contd.)~~

~~OBJECTIVE~~	~~CONTENT~~

Identify reasons for safety precautions for the residents.	4) Be as close as possible to what you are lifting or moving. Don't reach and try to lift or move an object. 5) Use your arms to support the object. The muscles of the legs actually do the job of lifting NOT the muscles of your back. 6) When doing work, always work with the direction of your efforts not against them. Avoid twisting your body as much as possible. 7) If you think the object is too heavy to lift, then get help. Don't try to lift it alone. 8) Always move residents who cannot assist you by two people. It is easier on the resident physically and prevents you from being injured. 9) Lift smoothly to avoid strain. Always count "one, two, three" with the person you are working with. Work in unison. Do this with the resident. 10) When changing the direction of your movements: -pivot. -turn with short steps. -turn your whole body. 2. Resident Safety 2.1 Reasons for safety precautions for the elderly; increased chance of accidents due to: a. Mental confusion. b. Impaired mobility. c. Diminished senses (sight, hearing, touch, taste, smell). 2.2 Safety precautions the nursing assistant should take to help residents:

~~Identify the basic safety steps the nursing assistant must take to prevent falls.~~	~~a. Prevent falls~~ ~~1) Have bed rails up as needed and bed in lowest position.~~

Unit III (contd.)

OBJECTIVE	CONTENT

CONTENT

Identify the basic steps the nursing assistant must take to prevent burns.	2) Resident should wear shoes or slippers with non-skid soles. 3) Have shoelaces tied. 4) Avoid long gowns or robes which may trip resident. 5) Throw rugs should not be used. 6) All liquid spills should be wiped dry immediately. 7) Encourage use of handrails. 8) Canes and walkers should have good non-slip tips. b. 9) Use caution when skin and bath oils are used because it makes people and tubs slippery. 10) Assistance items such as shower chair and raised toilet seat may prevent falls for residents with limited mobility. 11) Resident should be instructed to ring the call bell for assistance rather than climbing over bed rails. Prevent burns – 1) Assist a confused person when he is given hot liquids to drink. 2) Bath water must be checked to insure it is a safe temperature before the resident gets in the tub. 3) Confused residents must be watched while in tub or shower so they don't turn on hot water, resulting in burns.

CONTENT

	4) A confused person must be supervised when he smokes. 5) Any equipment which produces heat must be carefully watched when in use. Elderly people sometimes have decreased sensation and may not feel that the skin is being burned.

Unit III (contd.)

CONTENT

~~OBJECTIVE~~

Unit III (contd.)

CONTENT

~~Identify the basic safety steps the nursing assistant must take to prevent falls.~~	~~c. Prevent falls from bed, chairs, wheelchairs –~~ ~~1) Restrain resident who is likely to fall from bed or chair (per physicians order or instruction from the charge nurse).~~ ~~2) Keep bedrails up.~~ ~~3) Lock wheels on bed or wheelchair.~~ ~~4) When transporting resident in bed, geriatric chair or wheelchair "drive safely", slowly, approaching corners with caution with resident facing front.~~ ~~5) Use transfer belt or hold resident securely when transferring between bed and chair.~~
~~Identify basic steps the nursing assistant must take to prevent choking.~~	~~d. Prevent choking –~~ ~~1) Make sure that food is cut or chopped in small enough pieces for resident to swallow.~~ ~~2) Monitor the portions of food put into the resident's mouth at one time.~~ ~~e. Prevent ingestions of harmful substances – Do not leave potentially poisonous or harmful substances at the bedside or places accessible to the residents (liquid soaps, skin medications).~~ ~~2.3 Safety precautions for oxygen use:~~

CONTENT

~~Identify basic safety precautions for oxygen use.~~	~~a. Precautions for oxygen safety should be posted outside the room where it is being used.~~ ~~b. Limit any situations which might start a fire because oxygen supports combustion.~~ ~~c. No smoking or open flame.~~ ~~d. Electrical equipment should be grounded.~~ ~~e. If an oxygen tank is used, it should be stabilized so it does not fall over.~~

Unit III (contd.)

CONTENT

~~OBJECTIVE~~

CONTENT

Name causes of airway obstruction. List symptoms of possible airway obstruction. List symptoms of complete obstruction. Demonstrate the Heimlich Maneuver.	3. Airway Obstruction 3.1 Most frequent causes of airway obstruction: a. Elevated blood alcohol level. b. Upper and lower denture slippage. c. Large, unchewed pieces of food. d. Decreased swallowing ability due to weakness in throat muscles. e. Laughing and talking. 3.2 Partial obstruction: a. Resident is able to take in and exhale some air. b. Results in weak cough. c. Causes high pitched sound while inhaling. d. Increases respiratory difficulty and possible cyanosis. e. If the victim can speak, cough, or breathe, DO NOT INTERFERE. 3.3 Complete Obstruction: a. Resident is suddenly unable to speak, cough, or make any sounds. b. Action to aid choking resident (complete obstruction). Emergency care must be given quickly since brain damage may begin within four minutes. The emergency action described here is called the abdominal thrust (Red Cross) or Heimlich Maneuver – (refer to procedure #26 in the Appendix) 1) Victim standing or sitting: If feasible, ask the resident if he/she is choking.

CONTENT

	~~- Be aware that the victim may walk or run away due to fear.~~ ~~- Remain calm, give continuous reassurance. Tell the resident you are there to help him/her.~~ ~~- Perform per procedure in Appendix.~~ ~~- When the resident is sitting, the rescuer stands behind the resident's chair and performs the maneuver in the same manner.~~

Unit III (contd.)

CONTENT

OBJECTIVE	CONTENT
	~~Unit III (contd.)~~

OBJECTIVE	CONTENT
	2) Victim lying down: - Place resident flat on back. - Facing resident, kneel astride hips. - With one of your hands on top of the other, place the heal of your bottom hand on the abdomen slightly above the navel and below the rib cage. - Press into the resident's abdomen with a quick upward thrust. - Repeat several times if necessary.

~~Unit IV~~

~~Promoting Independence/Respecting Resident's Rights~~

~~(3 hours theory/classroom lab)~~

~~OBJECTIVE~~ ~~CONTENT~~

Unit IV (contd.)

OBJECTIVE	CONTENT
~~Identify services that promote residents' independence.~~	~~1. Promoting Independence 1.1~~ ~~Introduction:~~ ~~a. Everyone needs to feel control over their lives and environment. As people age, many find that their roles as workers and contributing family members diminish as physical capabilities and income declines.~~ ~~b. The best policy is to keep the elderly as an integral part of the community and help them maintain as much independence as possible in the face of increasing difficulty in performing daily activities.~~ ~~1.2 Resident services:~~ ~~a. The highest level of resident participation should be encouraged.~~ ~~b. Encourage the resident to make their own choice and do things for themselves.~~ ~~c. Share the resident's care plan with the resident and family. Involving the resident in their own care stimulates a sense of responsibility.~~ ~~d. Be open to residents' suggestions, complaints and grievances. Comments from residents and their families should never be ignored.~~ ~~e. Resident councils provide an effective way for residents to meet for discussions and make recommendations regarding facility policies, programs, services and other issues.~~

	~~f. It is important to encourage a resident to attend activities. Activities expand horizons, challenge the mind, body and intellect; provide a way to fight loneliness and depression; encourage independence and individuality.~~

Unit IV (contd.)

OBJECTIVE	CONTENT

	g. Report personal dietary preferences of the resident to the charge nurse or dietary manager. With deteriorating sense of smell due to aging effects, presentation of food becomes especially important. h. Promote the resident's level of independence in managing Activities of Daily Living – 1) Ability to move about the environment independently. 2) Ability to eat independently. 3) Ability to maintain personal hygiene. 4) Ability to dress independently and appropriately. 5) Ability to care for toileting needs. 1.3 Fundamental philosophies of promoting independence: a. Recognize and help the resident and family to accept the frail years as a natural and positive part of the life cycle. b. Within the facility, encourage residents to continue with as familiar a lifestyle as possible. c. Provide residents with opportunities for growth by encouraging and taking them to activities. d. Emphasize the involvement of family members that there is still an important roles and place for them in a resident's life. Encourage volunteerism. e. Focus on the resident's physical and mental capabilities to maintain the optimum level of functioning. 2. Resident Rights 2.1 Arkansas nursing facility residents have all the rights of U.S. citizens as guaranteed by

Unit IV (contd.)

OBJECTIVE	CONTENT
	~~the Constitution of the United States of America.~~

Unit IV (contd.)

OBJECTIVE

~~CONTENT~~

OBJECTIVE

	a. Every resident admitted to an Arkansas nursing facility is informed of specific RESIDENT'S RIGHTS. The staff of the nursing facility is to be informed and protect the rights of residents. This will contribute to more effective resident care by enumerating the responsibilities of physician, staff and facility. b. Resident's Rights may vary from facility to facility but as a minimum the list of rights shall include the following: 1) The resident has a right to a dignified existence, selfdetermination, and communication with and access to persons and services inside and outside the facility. The facility must assert, protect, and facilitate the exercise of these rights. 2) The resident has the right to be fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services. The facility makes available to residents, a list of the kinds of services and articles provided by the facility. Charges for all services and supplies not included in the facility's basic per diem rate are identified. Residents are informed in writing in advance of any changes in the costs or availability of services. The resident has the right to be informed of the rules of the

OBJECTIVE	CONTENT
	~~facility upon admission in the language that he/she understands.~~ ~~3) The resident has the right to exercise rights as a resident, to exercise rights as a citizen or~~

OBJECTIVE

	~~resident of the United States, including the right to file complaints. The resident has the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. The resident has the right to recommend changes in policies and services to facility staff and/or outside representatives of his/her choice, free from coercion, discrimination, or reprisal.~~ ~~4) The resident has the right to information on Federal, state and local agencies concerned with enforcement of long term care facility rules and agencies acting as resident advocates and is afforded the opportunity to contact these agencies. The resident has the right to participate in a representative resident council in the facility. The resident has the right to make choices about significant aspects of his/her life in the facility.~~

Unit IV (contd.)

OBJECTIVE	CONTENT
	5) The resident has the right to be informed of his/her medical condition and an opportunity to participate in planning his/her medical treatment unless contradicted (as documented by a physician in the medical record). The resident has the right to choose a personal attending physician. The resident has the

CONTENT

	right to be informed in advance of any changes in care or treatment that may affect his/her wellbeing, unless medically contra- dicted. The resident has the right to refuse treatment and to refuse to participate in experimental research. The resident has the right to be advised of alternative courses of care and treatments and their consequences when such alternatives are available.

OBJECTIVE	
	6) ~~The resident has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. The resident has the right to be free from unnecessary drugs and physical restraints and is provided treatment to reduce dependency on drugs and physical restraint. Restraints may only be imposed: - To ensure the physical safety of the resident or other residents. - Only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances until such an order could reasonably be obtained). The resident has the right to be free from physical, psychological or sexual abuse or punishment.~~ 7) ~~The resident has the right to manage his or her financial affairs. If the facility manages~~

OBJECTIVE	CONTENT
	~~The financial affairs of the resident, the facility must comply with federal and state rules and regulations.~~ ~~8)~~ ~~The resident has the right to confidentiality, of personal and clinical records. The resident has the right to approve or refuse the release of information of personal and clinical records to any individual or agency outside the facility, except, in case of his transfer to another health care institution or as required by law or third party payment contract. The resident has the right to approve or refuse to allow photographs to be taken or interviews to be conducted.~~ ~~9)~~ ~~The resident has the right to personal privacy. The resident has the right to privacy with regard to accommodations, medical treatment, written and telephone communications, visits, and meetings of friends, family and of resident groups, unless medically contradicted.~~ ~~10)~~ ~~The resident has the right to send and receive mail that is not opened.~~

OBJECTIVE	
	~~11) The resident has the right to receive visitors at any reasonable hour and by arrangements at other times.~~ ~~12) The resident has the right to have access to the private use of a telephone.~~ ~~13) The resident has the right to reside and receive services with reasonable accommodations of individual needs and preferences,~~

OBJECTIVE	CONTENT
	Except where the health or safety of the individual or other residents would be endangered and to receive notice before the room or roommate of the resident in the facility is changed. 14) The resident has the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility. 15) The resident has the right to participate and/or refuse to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

OBJECTIVE

		16) The resident has the right not to perform services for the facility and to be compensated for services voluntarily performed, unless informed prior to performing services that services are of a voluntary nature and will not be compensated (unless the services are for therapeutic purposes in the residents plan of care as ordered by the attending physician). 17) The resident has the right to retain and use personal possessions and appropriate clothing, within space allocated by the facility, unless to do so would infringe upon the rights or security of other residents. 18) The resident has the right to privacy of visits with spouse. If both are residents, they have the right to share a room unless medically contraindicated and
		documented by the physician in the medical record. 19) The resident has the right to be provided a safe, clean,

Unit IV (contd.)

OBJECTIVE	CONTENT
	~~comfortable and homelike environment.~~
	~~20) The resident has the right to be provided food that is attractive, proper temperature, meets individual needs.~~ ~~21) The resident has the right to be provided an on going program of activities appropriate to residents needs and interests, designed to promote opportunities for engaging in normal pursuits, including religious activities of choice.~~ ~~22) The resident has the right to receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status as defined by a comprehensive assessment and plan of care.~~

OBJECTIVE

	23) The resident has the right to remain in the facility and not to be transferred or discharged unless: - the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility. - the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. - the safety of the individuals in the facility is endangered.

CONTENT

OBJECTIVE	CONTENT
	- the resident has failed, after reasonable and appropriate notice, to pay an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with Title XIX. - the facility ceases to operate. In each case, the basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician. Appropriate notice must be made in advance of the resident's transfer or discharge except in urgent medical needs. 24) The resident has the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the governing agency (in Arkansas, the Office of Long Term Care) with respect to the facility and any plan of correction in effect with the facility. 25) A resident's next of kin or legal guardian may exercise a resident's rights when a resident has been ruled incompetent by a Judge in a court of law. c. These rights are not all encompassing, but are specific to long term care facilities.

OBJECTIVE

	~~Each facility is responsible for developing its own Resident's Rights policy and procedures for implementing these rights and may make additions to this list of Resident's Rights.~~ ~~2.2 The nursing assistant is~~ ethically ~~responsible~~ and ~~legally~~ ~~accountable~~ ~~for upholding and protecting Resident's Rights in providing the resident's care:~~

Unit IV (contd.)

OBJECTIVE	CONTENT
~~Identify the treatment a nursing assistant shall have toward the resident.~~	~~a. Refer to Resident's Rights #1 – This is the responsibility of any staff member who has contact with the resident –~~ ~~1) The nursing assistant shall treat the resident as a fellow human with consideration, respect and full recognition of the resident's dignity and individuality.~~ ~~2) The nursing assistant shall always treat the resident as she/he would want to be treated.~~ ~~b. Refer to Resident's Rights #2 – 1) – This is the responsibility of administration.~~ ~~c. Refer to Resident's Rights #3 –~~ ~~1) It is the role of administration to develop and follow a procedure for the registration and disposition of grievances by the resident/family/legal representative.~~ ~~2) It is the responsibility of the nursing assistant to report grievances as told per a resident by facility policy and procedures to the appropriate authority.~~ ~~3) The nursing assistant shall encourage the resident to exercise the Resident's Rights.~~ ~~4) A nursing assistant is to NEVER coerce, discriminate or give~~
~~Identify the nursing assistant's responsibilities concerning resident's grievances.~~	

OBJECTIVE

~~Identify the person responsible to keep the resident informed of medical condition.~~	~~reprisal to a resident who voices grievances.~~ ~~d. Refer to Resident's Rights #4 – 1) – This is the responsibility of administration.~~ ~~e. Refer to Resident's Rights #5 – 1) – It is the responsibility of the physician to inform and keep the resident updated to medical condition.~~

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
~~Identify the nursing assistant's responsibility if asked about a resident's medical condition.~~ ~~Identify where the nursing assistant receives instructions to restrain a resident.~~ ~~Identify result of not reporting knowledge of abuse, neglect, exploitation of a resident.~~	~~2) Any questions or opinions asked of the nursing assistant about the condition of the resident are to be politely but firmly referred to the charge nurse as upholding the Resident's Rights.~~ ~~3) The nursing assistant shall refrain from giving or expressing opinions about the resident's condition or treatment.~~ ~~f. Refer to Resident's Rights #6~~ ~~1) The nursing assistant receives instructions for restraining the resident from the charge nurse.~~ ~~2) The nursing assistant shall be held responsible for knowing Office of Long Term Care rules and regulations and the facility's policy and procedures regarding restraints. (Refer to section of Restraints.)~~ ~~3) Persons are required by law to report suspected adult abuse, neglect, or exploitation. Persons who have knowledge of suspected adult abuse, neglect, or exploitation and do not report it become an accomplice to the act. (See unit on "Ethics and Legal Aspects").~~ ~~4) Avoiding the need for restraints in accordance with current professional standards:~~ ~~- Staff education.~~ ~~- Structured activities.~~ ~~- Attention to individual needs.~~ ~~- Drug dose reductions.~~ ~~- Diversion.~~ ~~g. Refer to Resident's Rights #7 – 1) This is the responsibility of administration.~~

OBJECTIVE	CONTENT
~~Identify areas of confidentiality.~~ ~~Give appropriate response to questions regarding resident's condition.~~ ~~Identify areas of breaking confidentiality.~~	~~h. Refer to Resident's Rights #8~~ ~~1) Confidentiality extends beyond the medical records to include all aspects about the residents; personal information, behavior, mental condition, physical condition, etc.~~ ~~2) When questions are asked of the nursing assistant about the condition of the resident, refer them to the charge nurse. Be polite, let it be known that interest is appreciated, but THAT ALL INFORMATION REGARDING THE RESIDENT IS CONFIDENTIAL AND CANNOT BE DICUSSED.~~ ~~3) Examples of breaking confidentiality:~~ ~~- Discussing one resident with another resident.~~ ~~- Discussing a resident's condition with relatives or friends of the resident.~~ ~~- Discussing a resident's condition with another staff member in front of another resident, visitor, etc.~~ ~~- Discussing a resident's condition with the news media.~~ ~~- Discussing a resident's condition with fellow workers, except when in conference or in planning resident care.~~ ~~- Anyone requesting to review the medical records of a resident is to be referred to the charge nurse.~~ ~~i. Refer to Resident's Rights #9~~ ~~1) The nursing assistant shall knock on a closed door and~~

OBJECTIVE	CONTENT
~~Identify ways the nursing assistant provides resident privacy.~~	~~announce entry into the room before opening the door.~~

Unit IV (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
	2) The nursing assistant shall provide for privacy of the resident during all aspects of care by closing the window curtain to screen from public and by closing the door to the room where care is being given and by the use of privacy screens and curtains. 3) The nursing assistant shall request that persons not involved with the care of the resident are not present during care/examination/ treatment without consent of the resident. j. Refer to Resident's Rights #10 – 1) This is the responsibility of the administration. k. Refer to Resident's Rights #11 – 1) This is the responsibility of the administration. l. Refer to Resident's Rights #12 – 1) This is the responsibility of the administration. m. Refer to Resident's Rights #13 – 1) This is the responsibility of the administration. n. Refer to Resident's Rights #14 – 1) This is the responsibility of the administration. o. Refer to Resident's Rights #15 – 1) This is the responsibility of the administration. p. Refer to Resident's Rights #16 – 1) It is the responsibility of the nursing assistant to attempt to get the resident to perform as many personal care tasks as possible, but NEVER to force a resident to care for self. 2) It is the responsibility of the nursing assistant to encourage the resident to attend activities provided by the facility and to

Unit IV (contd.)

OBJECTIVE	CONTENT
~~Identify the responsibility of the nursing assistant in encouraging self-care.~~	

Unit IV (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
~~Identify when a nursing assistant is to report concerning resident's personal possessions.~~ ~~Identify the nursing assistant's role in resident's participation in activities.~~ ~~Identify the nursing assistant's role in nursing service.~~	~~attend meals in the dining room, but NEVER to force attendance.~~ ~~3) It is the responsibility of the nursing assistant to inform the charge nurse of resident refusal to participate in self-care/activities.~~ ~~4) The nursing assistant shall ask the charge nurse for the appropriate manner for handling a resident's refusal of self-care/activities.~~ ~~q. Refer to Resident's Rights #17 –~~ ~~1) It is the responsibility to report to the charge nurse if it appears that a resident's personal possessions or clothing infringes upon the rights or security of others.~~ ~~2) The nursing assistant shall report to the charge nurse if a resident does not appear to have appropriate clothing.~~ ~~r. Refer to Resident's Rights #18 1) This is the responsibility of the administration.~~ ~~s. Refer to Resident's Rights #19 –~~ ~~1) Refer to sections on providing a resident a safe environment and care of resident's unit.~~ ~~t. Refer to Resident's Rights #20 –~~ ~~1) Refer to sections on nutrition.~~ ~~u. Refer to Resident's Rights #21 –~~ ~~1) The nursing assistant shall not impose religious beliefs on the residents.~~ ~~2) The nursing assistant shall encourage but not force the resident to be a participant at activities.~~ ~~v. Refer to Resident's Rights #22 –~~ ~~1) The nursing assistant shall provide nursing care per the instructions of the charge nurse~~

OBJECTIVE	CONTENT
	~~and the resident's individual plan of care.~~

OBJECTIVE	CONTENT
	~~w. Refer to Resident's Rights #23~~ ~~1) Transfer/discharge arrangements are made per physician and administration.~~ ~~2) The nursing assistant shall make every effort to make this change easy and pleasant.~~ ~~3) The nursing assistant shall be sure that all personal belongings are sent with the resident and inventory forms are completed and signed appropriately per facility policy.~~ ~~x. Refer to Resident's Rights #24 1) This is the responsibility of the administration.~~ ~~y. Refer to Resident's Rights #25 1) This is the responsibility of the administration. 2.3 Civil Rights of the resident:~~ ~~a. Facilities are to admit and treat all residents without regard to race, color, national origin, religious preference, or marital status.~~ ~~b. The same requirements for admission are applied to all and residents are assigned within the facility without regard to race, color, national origin, or religious preference.~~ ~~c. There is no distinction in eligibility for, or in the manner of providing, any resident service provided by or through the nursing home.~~ ~~d. All facilities of the nursing home are available without distinction to all residents and visitors regardless of race, color, national origin, religious preference or marital status.~~ ~~e. All persons and organizations having occasion either to refer residents for admission or to recommend the facility~~

OBJECTIVE	CONTENT
	~~are advised to do so without regard to the resident's race, color, national~~

Unit IV (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
~~Identify areas the nursing assistant is held responsible for by law.~~	~~origin, religious preference, or marital status.~~ ~~2.4 In Arkansas, adults are subject to the protection of the Department of Human Services, if endangered, abused, maltreated, exploited, or neglected:~~ ~~a. Endangered Adult – an adult eighteen years or older who is found to be in a situation or condition which poses an imminent risk of death or serious harm to such person who demonstrates the lack of capacity to comprehend the nature and consequence of remaining in that situation or condition.~~ ~~b. Abuse/Maltreatment – any willful or negligent act which results in negligence, malnutrition, physical assault or battery, physical or psychological injury inflicted by other than accidental means, and failure to provide necessary treatment, rehabilitation, care, sustenance, clothing, shelter, supervision, or medical services.~~ ~~c. Exploitation – any unjust or improper use of another person for one's own profit or advantage.~~ ~~d. Whoever, willfully or by culpable negligence, deprives an adult of, or allows an adult to be deprived of necessary food, clothing, shelter, or medical treatment, or who knowingly or by culpable negligence permits the physical or mental health of the adult to materially endangered, and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the adult, shall be guilty of a Class D felony and shall be punished by law.~~ ~~3. Ethics and Legal Aspects~~ ~~3.1 Ethical responsibilities –~~ ~~A set of standards or moral principles governing the conduct of a nursing assistant.~~

Unit IV (contd.)

OBJECTIVE	CONTENT
~~Identify ethical responsibilities of the nursing assistant.~~	

Unit IV (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
List ethical responsibilities of the nursing assstant. Recognize factors which identify the nursing assistant's loyalty to the resident and to the employer. Identify ethical responsibilities of the nursing assistant in caring for the resident.	It deals with the relationship of a nursing assistant/ to a resident, to families, to the teammates and associates, to the community: a. Integrity – 1) Honesty. 2) Sincerity. 3) Reliability. 4) Carrying out responsibilities of assignments. b. Loyalty – 1) to resident. 2) to employer. c. Performs only those duties which he/she is prepared and which are authorized. d. Respect religious rights and preferences - 1) of residents. 2) of teammates. e. Nursing assistant ethical responsibility in caring for the resident – 1) Expected to know content of job description. 2) Expected to know and anticipate the various types of behavior which residents may develop. 3) Expected to be responsible for own acts in providing competent basic care to residents. 4) Expected to perform only those activities for which prepared and which are authorized. 5) Expected to be responsible for helping maintain a safe environment. 6) Expected to be responsible for safeguarding the resident's possessions. f. The nursing assistant does not talk about the resident's behavior in a negative and/or condescending manner. g. The nursing assistant is expected to use a positive approach to meet the resident's needs.

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT
~~Identify examples of confidentiality.~~	~~h. The nursing assistant is expected to listen to the resident with a nonjudgmental attitude and reflects the resident's feelings rather than his words.~~ ~~i. The nursing assistant is expected to meet the residents on their own level, is truthful, always keep promises, and is consistent in activities and attitudes.~~ ~~j. The nursing assistant acts to meet the resident's needs rather than own needs.~~ ~~k. The nursing assistant is expected to respect the resident's feelings and protects the resident's right to privacy.~~ ~~l. The nursing assistants assigned residents are the nursing assistant's kingdom. The nursing assistant must always be on guard against becoming authoritative as the residents may interpret the nursing assistants commands as law.~~ ~~m. The nursing assistant must probe and focus on fact rather than feelings. The question "Why?" puts the resident on the defense. It may cause confusion and disorientation as to time, place or person.~~ ~~3.2 Confidentiality:~~ ~~a. Confidentiality means keeping resident's personal information private.~~ ~~b. Examples of confidentiality- Do not discuss personal resident information with –~~ ~~1) One resident about another resident.~~ ~~2) Relatives or friends of the resident.~~ ~~3) Representatives of the news media.~~ ~~4) Fellow workers, except when in conference or in planning resident care.~~ ~~5) One's own family and friends.~~ ~~3.3 Respect and uphold the residents' rights: These rights are of such vital importance that "Rights" are addressed in a separate unit.~~

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT
	3.4 Respect and dignity are integral aspects of all care and relationships with residents, families, teammates, and community.
Identify the nursing assistants' legal responsibilities in caring for resident.	3.5 Legal Aspects: a. Nursing assistant's legal responsibility in caring for residents 1) Is to know the content of the job description. 2) Is to know and anticipate the various types of hazards which may develop for residents.
Identify what conditions the nursing assistant may be held liable for negligence.	b. The nursing assistant may be held liable, if in the opinion of the court, the nursing assistant was negligent in providing protection and care constituting PREVENTION against the development of any situation INJURIOUS to the resident.
	c. The nursing assistant is legally responsible for carrying out procedures and carrying them out correctly.
Define battery.	d. Battery – physical abuse to resident – 1) Pushing. 2) Shoving. 3) Pinching. 4) Holding the resident too tight. 5) Tripping. 6) Pulling. 7) Hitting.
Define harassment.	e. Harassment – mental and emotional abuse. It can be verbal and/or non-verbal – 1) Argumental with the resident. 2) Making fun of resident behavior. 3) Harsh and/or derogatory (cursing) words. 4) Condescending tone of voice; hateful, derogatory. 5) Laughing at resident. 6) Making fun of resident. 7) Being judgmental. 8) Shaming residents for the way they eat, talk, walk, etc.

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT
Define each area of legal concern. State Arkansas law as it relates to reporting of abuse, neglect or exploitation of a resident. Identify nursing assistant's responsibility in reporting suspect abuse or neglect of the resident.	f. The nursing assistant is responsible for own acts in providing competent basic care to residents. g. The nursing assistant performs only those activities or duties for which prepared and which are authorized. h. The nursing assistant is responsible for helping to maintain a safe environment for the resident. i. The nursing assistant is responsible for helping safeguard the resident's possessions. (Don't steal from the resident or from the facility). j. All staff have a legal responsibility to respect and uphold the rights of the residents. k. Areas of legal concern 1) Libel. 2) Negligence. 3) Abuse. 4) Battery. 5) Assault. 6) Invasion of resident privacy. 7) Defamation: -slander. -libel. 8) Exploitation. 9) Self abuse. 3.6 Reporting and Investigation: a. Persons are required by law to report suspected adult abuse, neglect, or exploitations. Persons, who are acting in good faith, have immunity from civil or criminal liability that might result from this action. b. Persons failing to report suspected abuse, neglect, or exploitation if they know about it become accomplices to the act. c. Truthful statements and facts (not your feelings or interpretations of events) are to be given during an investigation.

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT

Unit IV (contd.)

OBJECTIVE	CONTENT
~~Identify the agencies responsible to investigate suspected abuse, neglect or exploitation of residents.~~	~~d. Violations of all reported incidents of failure to maintain legal aspects will be investigated by the Office of Long Term Care and/or the Attorney Generals Office and/or the state or local police.~~

Unit IV (contd.)

OBJECTIVE	CONTENT

~~Unit V Introduction to Resident Care~~
~~(5 hours theory/classroom lab)~~

~~OBJECTIVE~~	~~CONTENT~~

OBJECTIVE	CONTENT
~~Identify measures which make the bed safe and comfortable.~~	~~1. Bedmaking – 2 hours~~ ~~1.1 Making a comfortable bed:~~ ~~a. Older people have less tissue padding over their bones and wrinkles can actually cause them pain.~~ ~~b. The resident's skin is very easily damaged. Wrinkles can restrict circulation resulting in pressure areas (bedsores/decubiti).~~ ~~c. If a resident is unable to get out of bed, all activities of daily living will be carried out in bed.~~ ~~d. Residents who remain in bed all of the time need their linens straightened and checked frequently throughout the day and night.~~ ~~e. Many times residents are incontinent of urine and/or feces. Check these residents frequently. Change linens when soiled.~~ ~~1.2 Types of bedmaking:~~ ~~a. Unoccupied – The resident is able to leave the bed while it is made.~~ ~~Closed bed –~~ ~~1) Is made with the top sheets and spread pulled all the way up.~~ ~~2) Is usually used if the resident is to remain up for most of the day.~~ ~~3) The pillow can be enclosed or left out depending upon the facility.~~ ~~Open bed –~~ ~~1) Has the top sheet and spread fanfolded to the bottom of the bed.~~ ~~2) Allows easy access by the resident and when in, bed sheets and spread can be pulled up easily by the resident.~~ ~~b. Occupied bed (see Unit VI).~~ ~~1.3 Measures of bedmaking:~~ ~~(refer to procedure #27 in the Appendix)~~

OBJECTIVE	CONTENT
~~Identify and demonstrate measures of bedmaking (unoccupied – open and closed).~~	

~~Unit V (contd.)~~

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
~~List steps to promote a positive environment at mealtime.~~	~~a. Measures for resident comfort – 1) Preventing wrinkles. 2) Allowing toe room.~~ ~~b. Measures for resident safety – 1) Using bedrails.~~ ~~2) Having bed in lowest position to floor.~~ ~~c. Measures for infection control –~~ ~~1) Don't shake linens.~~ ~~2) Linens are not to be on floor.~~ ~~3) Carry clean and dirty linens away from uniform.~~ ~~4) Place linens in dirty linen hamper, not in with resident's dirty clothes.~~ ~~5) Wash your hands.~~ ~~d. Use good body mechanics.~~ ~~2. Meal Service – 2 hours~~ ~~2.1 Assisting the resident at mealtime.~~ ~~a. Promoting a positive atmosphere for mealtime –~~ ~~1) The resident should be physically comfortable.~~ ~~2) The surrounding should be pleasant and comfortable.~~ ~~3) The social aspect of mealtime should be considered.~~ ~~4) Residents who are physically able should eat in the dining room rather than in the isolation of their rooms.~~ ~~5) The resident should be encouraged to remain independent; food is provided in a manageable form (e.g. bread is buttered, meat cut). Assist visually impaired persons in locating food and utensils.~~ ~~6) Use special eating devices such as a plate guard or adapted spoon to aid handicapped residents in self-feeding.~~

OBJECTIVE	CONTENT
~~Identify steps to help residents remain independent while eating.~~ ~~Demonstrate assisting devices.~~	

OBJECTIVE	CONTENT
Unit V (contd.)	
Identify and demonstrate measures of serving a tray correctly.	b. A resident may require a therapeutic diet, which is prescribed by the doctor, and planned by the dietitian. Therefore, do not interchange food from one resident's tray to another. Never eat food served to a resident, even if the resident does not want it. c. Serving a tray correctly (refer to procedure #8 in the Appendix) 1) Wash your hands. 2) Diet card must accompany tray to resident's room (OLTC Regulation). 3) Check diet card for: - Name of resident. - Special instructions. - Diet order. - Allergies. 4) Observe the food content of tray, if there is a question about content versus diet card, return the tray to the kitchen/serving personnel. 5) Check tray for necessary items: - Self-help devices. - Napkin on tray or table. - Condiments. 6) Prepare tray and food. 7) Place tray according to need such as visual impairment, weakness, paralysis, etc. 8) Serve tray immediately.

OBJECTIVE	CONTENT
	d. Encourage and assist the resident as needed – 1) Open pre-packaged food and condiments. 2) Cut up food. 3) Place butter and jelly on bread. e. For vision impaired – 1) Place silverware, cup, etc. in same place each time.

Unit V (contd.)

OBJECTIVE	CONTENT
Describe how to report changes in eating habits of residents and other pertinent information. Identify ways of keeping the resident's environment comfortable.	2) Ask resident if assistance is needed: - If no, respect resident's wishes. - If rendering assistance, tell what foods are on tray in clockface order. f. Feeding a resident – Refer to Unit IV, #5. 2.2 Reporting/record: a. Amounts consumed of food and fluids. b. Difficulty of resident 1) Drinking. 2) Chewing. 3) Swallowing. c. If resident is refusing to eat. d. If resident is eating less than usual. e. The need for special eating utensils 1) Spoons, forks. 2) Cup and/or plate. f. Report complaints/recommendations for seating changes at dining table to charge nurse. 3. Caring for the Resident's Environment 1 hour 3.1 The Resident's Unit Proper furniture and equipment 3.2 Ways of providing environmental comfort in the resident's unit: a. Provide ventilation according to the resident's preference and condition. b. Adjust temperature for personal differences, keeping in mind that the elderly cannot adjust as well to extremes of temperatures. c. Provide extra humidity for residents with respiratory disorders, as directed by the nurse in charge. d. Adjust lighting for day and night safety. Place lights to avoid glaring. 3.3 Daily maintenance of the resident's unit: a. Be sure call bell is within reach (OLTC Regulation). Do this EACH TIME YOU LEAVE THE RESIDENT'S UNIT. This is VERY IMPORTANT to

OBJECTIVE	CONTENT
~~Identify steps to be taken to assure the resident's unit is safe and completely furnished.~~	

OBJECTIVE	CONTENT
	Unit V (contd.)
	remember. Accidents happen when residents try to help themselves. b. Chairs should be placed out of the mainstream of traffic areas, when not in use by the residents. c. Urinal should be within easy reach of male residents. Urinal needs to be emptied to prevent spilling (OLTC Regulation). d. The bedside stand should be within easy reach and contain items used frequently by the resident. Discourage hoarding while being sensitive to resident's desires. e. Fluids should be offered at frequent intervals. Water pitchers shall be refilled at least once each shift and should be kept in reach of patients. Clean drinking glasses shall be kept with each water pitcher (OLTC Regulation). f. The bed should always be in the lowest position. In case of falls, the resident is closer to the floor which might prevent serious injuries. g. Bed rails should be used consistently as the patient's condition requires. h. Each time you enter a resident's unit, look around for possible dangers such as spills on the floor, items that could trip someone, frayed electrical cords.

OBJECTIVE	CONTENT
	~~i. The unit should be cleaned daily. The nursing assistant or resident should straighten the resident's personal belongings. Housekeeping personnel will clean the remainder of the room.~~

~~PART II~~

~~CLASSROOM & CLINICAL TRAINING – 59 HOURS~~
~~(Theory, Classroom Lab, and Clinical)~~

~~NOTE: Each unit in Part II has the required number of hours specified, accounting for class room activity (theory and lab) and clinical on the floor. Each sub-unit has the number of hours specified for the classroom activity (theory/lab) but not clinical. Clinical training shall take place at the end of each Unit, with the students performing tasks/skills under the supervision of the instructor.~~

~~NOTE: The trainee may work in the staffing of a facility while completing Part II of the training course. However, the trainee can only perform the task/skills they have been trained and determined as competent to perform.~~

Unit VI Personal Care Skills
(23 hours theory/lab and 7 hours clinical)

OBJECTIVE	CONTENT

Unit VI (contd.)

OBJECTIVE	CONTENT
List factors which affect a resident's hygiene needs and practices. Identify purposes for bathing Identify types of baths.	1. Bathing – 4 hours 1.1 Factors affecting hygiene needs and practices: a. Proper hygiene promotes health and helps to prevent infections. b. The condition of the resident may change frequency of care. c. Individuals have preferences based on past habits. Allow flexibility in hygiene routines while maintaining standards of cleanliness. 1.2 Reasons for bathing: a. Clean the skin. b. Eliminate odors. c. Cool and refresh. d. Stimulate circulation. 1.3 Types of baths: a. Complete bed bath – For the resident who is too weak or sick to assist with their bathing. b. Partial bed bath – For the resident who is able to take care of most of their own bathing needs. The nursing assistant will bathe only the areas that are hard to reach. c. Whirlpool bath – For the resident whose doctor may order for therapeutic reasons. d. Tub/shower bath – For residents who are strong enough to get out of bed and walk around. 1.4 Guidelines for bathing: a. Protect the resident's modesty and prevent chilling by closing the door, drawing the curtains and exposing the resident as little as possible. b. Soap can dry out the skin, especially on the elderly. Be sure to rinse the soap off well. Special cleaning and/or moisturizing liquids may be used.

~~Identify guidelines to follow when bathing the resident.~~	

OBJECTIVE	CONTENT
Demonstrate bathing techniques: 1) Bed bath. 2) Tub bath. 3) Shower. 4) Whirlpool. List purposes for a backrub.	c. Bathe per accepted procedures (refer to procedures #40, 42, & 43 in the Appendix) 1) Keeping water temperature comfortably warm and clean. Water should be approximately 100 degrees or comfortable when felt on back of hand or elbow. 2) Making a mitt from the washcloth or showing other methods of keeping tails of washcloth under control. 3) Washing and drying one part of the body at a time. 4) Giving a backrub and massaging other bony prominences with warmed lotion. d. Never leave the resident unattended. e. Examine the resident's skin during bath. Carefully clean under all skin folds and in contracted areas. Report any changes in skin; redness, rashes, broken skin or tender places. f. Give range of motion exercises (ROM) during bath time (see Unit IX). g. Follow procedures for cleaning bathing area. 1.5 Backrub: a. Purpose 1) Refresh and relax resident. 2) Stimulate circulation. b. Backrub per accepted procedure (refer to procedure #24 in the Appendix). 2. Grooming 4 hours 2.1 Oral hygiene cleaning the resident's mouth, lips, and teeth: a. Purpose 1) Helps prevent inflammation to mouth and gums and damage to the teeth by removing food particles which promote bacterial growth.

~~Demonstrate backrub.~~ ~~List purposes for oral hygiene.~~	

Unit VI (contd.)

OBJECTIVE	CONTENT

Identify and demonstrate measures of oral hygiene. Identify and demonstrate measures of denture care. Identify and demonstrate measures of oral hygiene for the unconscious resident.	b. 2) Refreshes the resident's mouth. General practices/measures – (refer to procedure #15 in the Appendix) 1) Brush teeth or dentures at a minimum in the morning and at bedtime. 2) Use soft, moist brush. 3) Encourage the resident to help as much as possible. 4) Gently cleanse tongue, teeth and gums. 5) Take special care to rinse out resident's mouth. 6) Check teeth, bums, color, shape, loose teeth, ulcers, odor, etc. c. Denture care (partial or full) – (refer to procedure #16 in the Appendix) 1) Dentures are slippery, handle with care. 2) Cleanse denture per accepted procedure. 3) Resident is to rinse out mouth, using water or mouthwash and brush gums and tongue with soft, moist toothbrush. 4) Return dentures to resident, replacing in mouth while moist. 5) Store dentures in fresh water or prepared solution when not in use. d. Mouth care for the unconscious resident – (refer to procedure #47 in the Appendix) 1) Mouth care for the unconscious resident must be done more frequently than regular mouth care, since the resident may not have enough saliva secretion to keep mouth moist. Lips and gums may become cracked and sore. 2) Position on side or have head turned to side to keep liquids

Unit VI (contd.)

OBJECTIVE	CONTENT

Identify and demonstrate measures of hair care.	from running down throat. 3) Use packaged mouth care swab or gauze wrapped tongue blades moistened in mouthwash. 4) Wipe all mouth surfaces. 5) Explain each step of the procedure to the unconscious resident. Even though a resident seems to be unconscious, they still may be able to hear you. 6) Keep mouth and lips moistened continuously. 2.2 Hair Care: a. Shampooing a resident's hair (refer to procedure #21 in the Appendix) 1) The cleanliness and grooming of both men's and women's hair is frequently associated with a resident's sense of well-being. 2) The frequency with which a resident needs to have hair shampooed is highly individualized. Hair is to be shampooed at least weekly (OLTC Regulation). 3) If a resident's hair tends to tangle after it has been washed, a conditioning rinse is to be used. 4) All of the shampoo is to be rinsed out of the hair to prevent drying and itching of the scalp. b. Combing a resident's hair (refer to procedure #22 in the Appendix) 1) Hair is to be combed at least daily and kept neat at all times. 2) Residents feel better about self if hair is combed and styled attractively. 3) Brushing and combing the hair stimulates the blood circulation in the scalp. It brings oils to the surface and spreads them evenly over the hair.

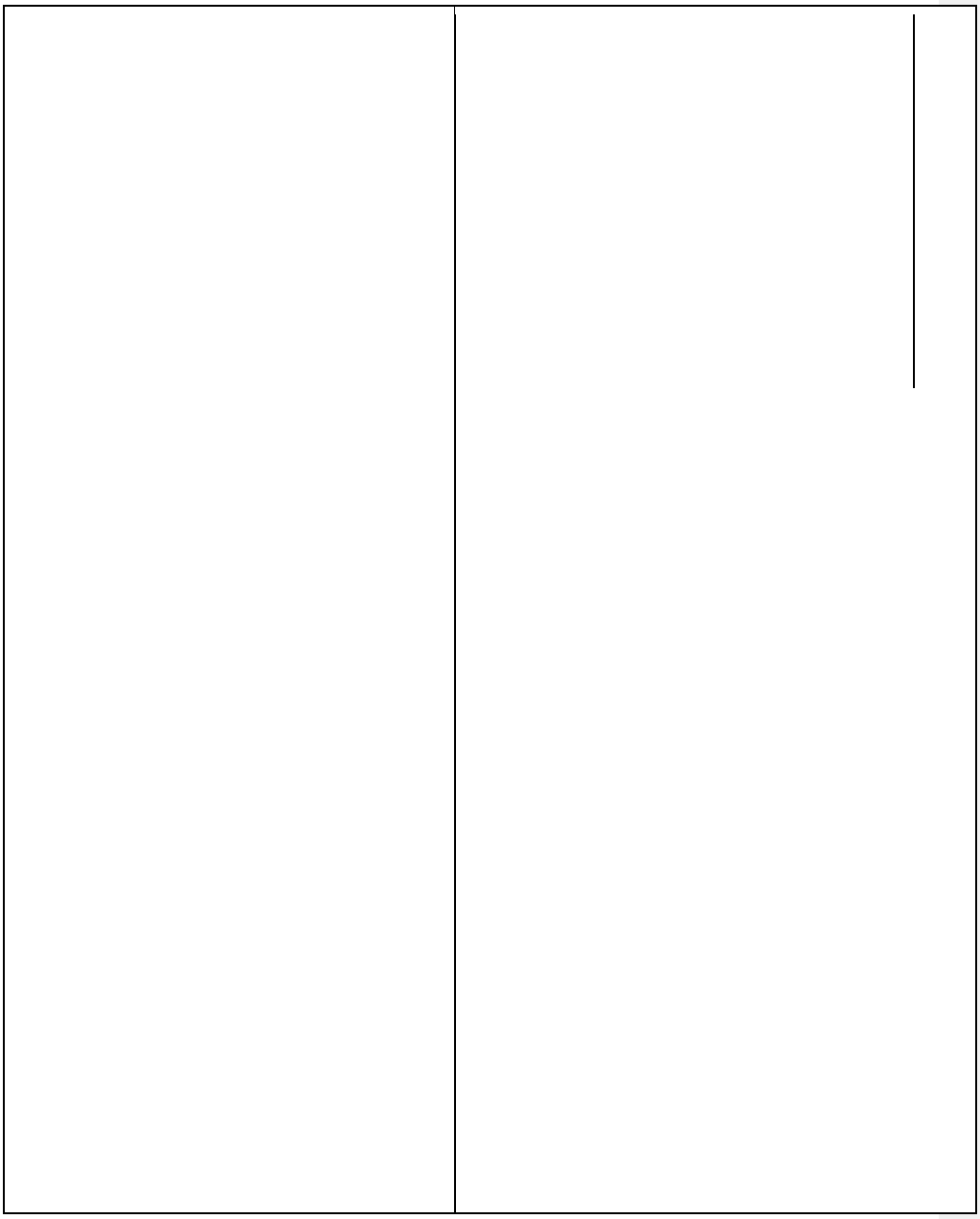
Unit VI (contd.)

OBJECTIVE	CONTENT
~~Identify and demonstrate measures of combing the resident's hair.~~	

Unit VI (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
Identify and demonstrate measures of proper nail care.	4) Brush up from the neck toward the top of the head. This stimulates the blood circulation in the scalp. It brings oils to the surface and spreads them evenly over the hair. 5) While combing, hold a small section of hair between the scalp and comb to prevent pulling. If the hair is long, start at the ends and work towards the scalp. 6) Try to style hair the way the resident likes it. 7) Residents are to always be encouraged to comb their own hair. c. Beard care 1) Wash beard either when hair is shampooed or with bath. 2) Wash beard more often if food or liquid is frequently spilled in beard. 3) Comb or brush beard when hair is groomed. 4) Trim as needed. 2.3 Nail Care: (refer to procedure #19 in the Appendix) a. Nails are to be cleaned at bathtime. b. Soaking the nails in warm, soapy water helps to loosen any material that might have collected. c. Be careful when cleaning the nails not to injure the skin surrounding the nail itself. d. Fingernails are to be trimmed to an oval shape. Toenails are to be cut straight across with a blunt-tipped scissors or heavy nail clippers. e. Nails of a diabetic resident or a resident with poor circulation are to be cut with extreme care. Check with charge nurse. f. Nails are to be given care every two weeks or more frequently as needed. (OLTC Regulation).



OBJECTIVE	CONTENT
	~~Unit VI (contd.)~~

OBJECTIVE

Demonstrate shaving of a male resident. Identify changes in feet to report to charge nurse. Identify and demonstrate measures of foot care.	2.4 Shaving: (refer to procedure #18 in the Appendix) a. All male residents shall be shaved every other day or as needed, unless they have a beard (OLTC Regulation). b. Encourage male residents to shave themselves and assist as needed. c. Shave and care for equipment per accepted procedure. 2.5 Foot Care: a. Feet need special care. b. Apply lotion to feet and toenails daily. c. Observe for changes in feet and report changes to charge nurse – 1) red spots. 2) corns or calluses. 3) cracks in feet or toenails. 4) loose toenails. 5) swelling/edema. 6) pain. d. Observe and report too tight socks, shoes, stockings, etc. e. Use footboards to prevent – 1) footdrop. 2) pressure from linens. f. Follow accepted procedure (refer to procedure #20 in the Appendix). 3. Dressing – 1.5 hours 3.1 Dressing and undressing a resident: (refer to procedure #25 in the Appendix) a. Residents in a long term care facility should be dressed in their own "street" clothes whenever possible and their choice when feasible. b. Residents should dress themselves whenever possible. c. If they need assistance – 1) Remove one arm of a shirt or blouse at a time. Older people do not bend as easily as a younger person.

OBJECTIVE	CONTENT
~~Identify and demonstrate measures of dressing and undressing a resident.~~	

OBJECTIVE

~~Unit VI (contd.)~~

~~CONTENT~~

OBJECTIVE		CONTENT
~~Describe normal and abnormal appearance of urine and abnormal sensation while urinating.~~		~~2) Sometimes raising both arms over the head and putting on or removing the sleeves on both arms at once prevents stretching of the shoulder muscles and pain, especially with people that have arthritis.~~ ~~3) If the resident is paralyzed on one side, dress that arm or leg first and remove that arm or leg last from the clothing.~~ ~~4) NEVER jerk or pull clothing off. Be gentle and remove clothing slowly.~~ ~~4. Toileting/Elimination – 3.5 hours 4.1~~ ~~Urinary Elimination:~~ ~~a. Urine –~~ ~~1) Normal appearance:~~ ~~- Straw colored.~~ ~~- Clear.~~ ~~2) Abnormal appearance:~~ ~~- Cloudy – sedimentation in urine.~~ ~~- Dark – concentrated from medication and/or dehydration.~~ ~~- Red – blood in urine or medication.~~ ~~3) Abnormal sensation:~~ ~~- Burning.~~ ~~- Painful urination.~~ ~~- Small amount. –~~ ~~Frequent voiding.~~ ~~b. Assisting the resident with urination (bedpan) –~~ ~~(refer to procedure #23 in the Appendix)~~ ~~1) WASH YOUR HANDS.~~ ~~2) Close door and curtain to provide for privacy.~~ ~~3) Position resident comfortably:~~ ~~- Pillow behind back.~~ ~~- Elevate head of bed.~~

OBJECTIVE

	~~- Warm bed pan before placing under resident.~~ ~~- Check frequently.~~

OBJECTIVE	CONTENT
	~~Unit VI (contd.)~~

OBJECTIVE

Identify and demonstrate measures of assisting a resident with bedpan, urinal or bedside commode. Identify and demonstrate steps in measuring and recording urinary output.	c. 4) Use warm running water on hands, over perineum or other techniques to promote urination, if necessary. 5) Infection control: Cleanse resident's perineum, hands and WASH HANDS of resident and self. Assisting a resident with urinal – (refer to procedure #1 in the Appendix) 1) WASH HANDS. d. 2) Provide privacy. 3) Place urinal if resident is unable to do so. 4) Urination for the male may be easier if he can stand up to use the urinal or sit on side of bed. 5) WASH HANDS of resident and self. e. Assisting resident to use bedside commode or toilet – 1) WASH HANDS. 2) Provide privacy. 3) Stay with resident if necessary for safety. f. 4) Restrain per accepted facility procedure/physician order. Measuring and recording of urinary output – (refer to procedure #3 in the Appendix) 1) Amount of urine. 2) Characteristics of urine; color, odor, appearance. Collecting urine specimen – (refer to procedure #12 in the Appendix) 1) General guidelines: - WASH YOUR HANDS before and after obtaining specimen. - Right resident – right time-right method. - Cleanse perineum/penis before collecting specimen.

OBJECTIVE	CONTENT
~~Identify and demonstrate measures for collecting urine specimens.~~	~~Label specimen correctly.~~

OBJECTIVE

OBJECTIVE

		CONTENT
		-Store specimen correctly. -Report anything abnormal to charge nurse. 2) Reason for urinalysis: it tells the physician if any abnormalities or infections are present. 3) Collecting a mid-stream urine specimen: -Used to determine if bacteria is present in the urine. -Strict asepsis must be obtained if urine is to be free of contamination. Urinary catheter care – 1) The urinary system is sterile, thus a nursing goal when a catheter is in place in the bladder is to avoid introducing microorganisms via the catheter drainage system. 2) A common reason for elderly residents to have a urinary catheter is to control incontinence, frequent UTI and poor skin condition.
Recognize how a urinary catheter works.	g.	

OBJECTIVE

	h. The closed drainage system consists of – 1) Catheter – a hollow tube having a small balloon at the end. The balloon is inflated after the catheter is inserted into the bladder to keep it from falling out. 2) Tubing – connects catheter to drainage bag. 3) Drainage bag – catches and stores the urine. Is to be emptied at the end of each shift. 4) The drainage bag may be a leg bag which straps to leg and allows more mobility. A leg bag should not be used by a resident when in bed.

CONTENT

OBJECTIVE

~~Identify and demonstrate measures of catheter and tubing care.~~ ~~Identify measures which help keep a urinary catheter draining correctly.~~		~~i. 5) Drainage bas or leg bags are to be changed only by a licensed nurse. Maintaining a closed system and prevention of urinary tract infection (refer to procedure #36 in the Appendix)~~ ~~1) To prevent microorganisms from entering the body at any point along the drainage system.~~ ~~2) Do not disconnect tubing at any point.~~ ~~3) Do not allow tubing or bag to drag on the floor.~~ ~~4) Never position catheter drainage bag above bladder.~~ ~~5) Catheter shall be cleaned at point it enters the body (meatus) according to procedure.~~ ~~6) Urine is emptied from clamp at the bottom of the bag. DON'T ALLOW TUBING END TO~~ ~~j. TOUCH CONTAINER into which urine is emptied. Maintaining continuous drainage of urinary catheter –~~ ~~1) If the catheter does not drain, the bladder becomes distended. This can be harmful.~~ ~~2) Observe to see that urine is flowing into catheter bag. DO THIS FREQUENTLY. If urine is not flowing, report this to the charge nurse.~~ ~~3) Keep catheter and tubing free of kinks.~~ ~~4) Keep resident from closing off tubing by keeping the resident from lying on tubing.~~ ~~k. Measures to avoid injury from pulling on the catheter –~~ ~~1) Tape catheter to leg for females.~~ ~~2) Tape catheter onto abdomen for males.~~

OBJECTIVE

~~Identify measures to avoid injury to the bladder opening from pressure on the catheter.~~	

Unit VI (contd.)

OBJECTIVE

CONTENT

OBJECTIVE

Identify observations made about the chatherized resident. Describe normal and abnormal appearance of feces.	3) Fasten drainage bag to part of bed which moves with the resident. (DO NOT FASTEN BAG TO BED RAIL.) 4) Take catheter, tubing and bag everywhere with the resident. 5) If confused resident is pulling on catheter, sometimes trousers over catheter can prevent this. l. Observations/reporting/recording — 1) Amount of urine. 2) That urine is continually draining. 3) Characteristics of urine/ color, odor, appearance. 4) Exudate at urinary opening. 5) Leaking anywhere in drainage system. 4.2 Colon Elimination: a. Appearance of feces (stool) – 1) Normal – bile-colored, formed, not necessarily one each day. 2) Abnormal – containing blood or mucous or undigested food: - Tarry. - Liquid. - Very dry and hard. Clay colored. b. Constipation – 1) Symptoms: - Hard stool. - No stool. - Liquid seepage from anus. - Distention. - Flatus. - Discomfort (restlessness, irritability). 2) Measures to relieve constipation: - Encourage the resident to take fluids. - Prompt response to the natural urge (usually after meals, especially after breakfast).

Unit VI (contd.)

OBJECTIVE

~~List measures to relieve constipation.~~	

Unit VI (contd.)

OBJECTIVE

~~CONTENT~~

OBJECTIVE

Demonstrate assisting the resident with a bedpan.	c.	- A diet which includes fruit, fiber, vegetables (allow enough time for meals to be eaten). - Exercise. - Proper positioning. - Provide privacy. Assisting the resident with elimination – 1) Bedpan (refer to procedure #23 in the Appendix) 2) Bedside commode/toilet (refer to 4.1,d. in this section).
Identify and demonstrate measures of a collecting fecal (stool) specimen.	d.	Collecting a fecal (stool) specimen – (refer to procedure #11 in the Appendix) 1) Usually performed when infection or bleeding in the colon are suspected. 2) Make sure to collect the specimen in a bedpan or commode. 3) Do not allow the specimen to touch the outside of the collection container. 4) Use throat sticks to handle the specimen. 5) Make sure that the specimen is properly labeled and promptly transported.
Identify observations made about elimination.	e.	Observation/reporting/recording – 1) Time. 2) Description: - Color. - Consistency (hard, soft, formed, liquid or loose). 3) Amount (smear, small, medium, large).
	f.	Colostomy – A surgical procedure which creates a new opening on the abdomen for release of solid waste (feces) from the body.
	g.	Ileostomy – A surgical procedure which creates a stoma on the abdomen for release of feces. The ileum (part of the

OBJECTIVE

	~~small intestine) is brought to the abdomen.~~
~~Define colostomy.~~	
~~Define ileostomy.~~	

Unit VI (contd.)

OBJECTIVE

~~CONTENT~~

OBJECTIVE

Define fecal impaction. List symptoms of fecal impaction. Identify causes of fecal impaction. Identify role of the nursing assistant in prevention of fecal impaction.	4.3 Fecal impaction: a. Definition – hard stool caught in the lower bowel which prevents normal passage of feces. b. Symptoms – 1) No normal stool. 2) Liquid fecal seepage from anus as small amount of fluid present in the colon is able to pass around the impacted mass. 3) Constant feeling of needing to have a bowel movement. 4) Rectal pain. c. Causes of fecal impactions – 1) Decreased muscle tone or stimulation in the lower bowel. 2) Inactivity. 3) Inadequate fluid intake. 4) Insufficient bulk in diet. 5) Uncorrected constipation, which may be caused by any of the above. d. Role of the nursing assistant in prevention of fecal impactions – 1) Observe resident's bowel movements: -Amount. -Consistency (firm, formed, liquid, hard). -Frequency. e. Checking for fecal impaction – (refer to procedure #31 in the Appendix) 1) This procedure is done by the nursing assistant when directed to do so by the charge nurse. Some facilities do not allow nursing assistants to do this procedure. 2) The removal of fecal impactions are to be done by a licensed nurse only.

Unit VI (contd.)

OBJECTIVE

~~Identify and demonstrate measures of checking for a fecal impaction.~~		

Unit VI (contd.)

OBJECTIVE

~~CONTENT~~

OBJECTIVE

Identify the purpose of an enema. Identify and demonstrate measures of administering a prepackaged enema. List physical causes of incontinence.		4.4 Enema: a. Purpose – to cause the emptying of the lower bowel. b. Prepackaged ready to use saline solution enema – (refer to procedure #32 in the Appendix) 1) To be administered upon instruction of the charge nurse. This is the only type of enema a nursing assistant may administer. 2) A small amount of saline solution pre-packaged in a squeezable plastic container with prelubricated tip is instilled into the rectum. If resident can hold this solution about 20 minutes, it pulls body fluid into the bowel, stretching it and thus causing evacuation. 3) Observe, report, and record according to procedure. c. All other types of enemas are to be administered by a licensed nurse. 4.5 Incontinence: a. Incontinence is the loss of control of the bladder or bowel or both. b. Physical causes – 1) – Injuries. 2) – Spasms. 3) Disease. 4) Loss of sphincter control. c. Psychological causes – 1) Environment. 2) Lack of effort on part of resident and nursing staff. 3) Poor motivation. 4) Stress. 5) Fear. 6) Anxiety. 7) Anger.

Unit VI (contd.)

OBJECTIVE

~~List psychological causes of incontinence.~~	~~8) Frustration.~~

OBJECTIVE

Unit VI (contd.)

OBJECTIVE	CONTENT

OBJECTIVE

List signs/symptoms of a distended bladder to be reported to charge nurse. Identify and demonstrate measures for incontinent care. Describe feelings/behavior of incontinent resident.	d. Report any signs and/or symptoms of a distended bladder – 1) Dribbling. 2) Frequent small voidings. 3) Distention over pubic area. e. Measures for incontinent care – (refer to procedure #35 in the Appendix) 1) Maintain good skin condition. 2) Keep resident comfortable. 3) Check resident at least every two hours. 4) When resident is incontinent: -Wash and dry all affected skin. -Put on dry clean clothes. -Change bed linens as necessary. 5) Use protective pads on bed. 6) May use an adult undergarment. 7) DO NOT scold or treat resident like a child. f. Feelings/behavior of the incontinent resident – 1) Embarrassment. 2) Frustration. 3) Anger. 4) Depression. 5) Withdrawal. 6) "Giving Up". 7) Shame. 8) Loss of self esteem. g. 9) Social rejection. Feelings of family of the incontinent resident – 1) Impatience. 2) Criticism (scolding). 3) Fear. h. 4) Denial. 5) Overly sympathetic. Attitude/actions of the nursing assistant toward the incontinent resident –

OBJECTIVE	CONTENT
~~Describe feelings of family of the incontinent resident.~~ ~~Describe the proper attitudes/actions of the nursing assistant toward the incontinent resident.~~	~~1) The nursing assistant needs to explore feelings and attitudes about incontinence.~~

Unit VI (contd.)

OBJECTIVE

~~CONTENT~~

OBJECTIVE	CONTENT
Identify and demonstrate measures of proper feeding techniques: 1) for total feeding 2) for syringe feeding 3) for the vision impaired.	2) The nursing assistant negative feelings/ attitudes al 3) The nursing assistant shall adopt a positive approach toward the incontinent resident: -Calm. -Matter of fact. -Pleasant. 5. Feeding – 1.5 hours 5.1 Role of the nursing assistant in promoting good nutrition: a. The nursing assistant shall encourage the resident to eat a variety of foods presented at mealtime. The resident's food is prepared under the guidance of the food service supervisor and is planned as a balanced diet. b. A resident who is consistently unable to eat the prepared diet shall be identified to the charge nurse so that the diet can be modified to meet the resident's needs. 5.2 Feeding a resident: (refer to procedures #34 & 44 in the Appendix) a. To help prevent choking, assist the resident to a sitting position if possible. Raise the head of the bed if the resident is unable to get into a chair. b. Protect the resident's clothing by using a bib or napkin. Encourage the resident to help by holding finger foods. c. Feed hot foods and liquids cautiously to prevent injuring the resident. d. Allow adequate time for the resident to chew thoroughly. e. Offer only small amounts of food at a time and make sure the resident has swallowed all food before offering more. f. Alternate liquids and solids as the resident prefers.

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OBJECTIVE

Unit VI (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE

~~Identify alternate methods of feeding.~~	~~g. A feeding cup or feeding syringe should be used with care to prevent aspiration of liquid. The tip should be placed inside the resident's cheek instead of the top of the tongue providing opportunity to control the liquid and swallow it.~~ ~~h. Vision impaired resident -~~ ~~1) Describe food on the plate, as well as content of each bite.~~ ~~2) Determine if the resident prefers one food at a time or a variety.~~ ~~3) Allow resident to make as many choices as possible to help him/her feel less dependent.~~ ~~5.3 Alternate methods of feeding:~~ ~~a. Sometimes residents are too ill or weak to consume even a liquid diet.~~ ~~b. Alternate methods of providing nutrition -~~ ~~1) Nasogastric tube - introduced through the nose and into the stomach so that liquid or pureed food may be directly fed.~~ ~~2) Gastrostomy (an opening into the stomach through the abdominal wall) may be made and feedings are given through a gastrostomy tube.~~ ~~3) Intravenous feedings - special fluids and nutrients are administered directly into the blood stream.~~ ~~c. These alternate methods of feeding are performed by a licensed nurse. The nursing assistant should inform the charge nurse if any of the tubes become dislodged.~~ ~~d. In some cases, limited oral feeding is still continued for residents using these alternate feeding methods.~~

Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

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Unit VI (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
	6. Hydration 1.5 hours 6.1 Importance of adequate fluid intake: a. Helps prevent constipation. b. Helps dilute wastes and flush out urinary system. c. Promotes skin elasticity. 6.2 To encourage a resident to drink fluids, offer small amounts frequently and let the resident have his preference of fluids. 6.3 Fluid Balance: a. Fluid balance is maintained when the amount of fluid taken in is near the same amount eliminated. b. The nursing assistant aides the resident in maintaining this balance. c. Amount of water requirements vary -A resident shall be encouraged to drink at least 8 to 10 glasses of fluids each day unless restricted. d. The nursing assistant's role in maintaining fluid intake – 1) Changing water at bedside at least once a shift (OLTC Regulation). 2) Water pitcher shall be placed within reach of resident. 3) Clean water glass or cup kept next to water pitcher. 4) Offer water to resident frequently. 6.4 Measuring and recording of fluid intake: a. Imbalances in fluid intake and output can result in severe fluid imbalances such as – 1) edema (water retention). 2) dehydration (excessive water loss). b. The intake and output (I&O) is frequently measured and recorded – 1) Intake includes everything taken in that is liquid at room temperature:
Identify how fluid balance is maintained. Identify nursing assistant role in maintaining fluid intake.	

Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
	-Water, tea, etc. -Jello, ice cream, etc. -Fluids given directly into a vein (IV). 2) Output includes all fluids lost: -Amount of urine eliminated. -Perspiration. -Blood. -Diarrhea. -Vomiting. c. Measuring and recording of urinary output (refer to item 4.1,e. in this section). d. Measuring and recording of fluid intake – (refer to procedure #2 in the Appendix) 6.4 Dehydration: a. Is abnormal loss (depletion) of body fluids. b. Can become a life threatening problem. c. Signs and symptoms to observe for and report to charge nurse – 1) Tongue becomes coated and thickened. 2) Eyes and mouth very dry. 3) Eyes sunken. 4) Lips cracked. 5) Skin "stands alone" when pulled up between thumb and forefingers. 6) Skin warm to touch. 7) Drowsiness. 8) May become suddenly confused. 9) Below normal amount of urine output. 10) Concentrated urine. 11) Weight loss. 6.5 Edema: a. Swelling – tissues contains too much fluid.
Demonstrate measuring and recording of fluid intake. Define dehydration. Identify signs and symptoms of dehydration.	

Unit VI (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
Identify signs and symptoms of edema.	b. Signs and symptoms 1) Swelling/puffiness. 2) Sudden weight gain. 3) Shortness of breath, congested breathing. 4) Decrease in amount of urine output.
Identify ways to relieve edema.	c. Some ways to relieve edema 1) Observe and release tight fitting clothes and shoes. 2) Elevate (feet and legs) lower extremities. 3) Frequent position changes. 4) Ambulate at intervals (if condition permits). 5) Measure intake and out put accurately.
	7. Skin Care – 1.5 hours 7.1 Skin care factors: a. Skin is the first line of defense against infection. b. Skin assists in regulating body temperatures. c. Skin assists to remove body wastes (perspiration). d. Aging may cause changes in the skin 1) Becomes scaly and dry. 2) Becomes delicate, thin and fragile (bruises and tears easily). 3) Wrinkles. 4) Loses its sensitivity to temperature changes and pain. 5) Becomes susceptible to decubiti (bedsores or pressure sores). e. A resident may not realize that a skin irritation is present due to loss of sensitivity. Therefore, check 1) Bony prominences. 2) Scalp, head, neck, behind ears. 3) Skin folds. 4) Fingernails and toenails. 5) Change and color of skin.

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Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

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Unit VI (contd.)

OBJECTIVE	CONTENT
List changes in skin condition that shall be reported to the charge nurse.	f. Observe and report changes in skin – 1) Redness. 2) Rashes. 3) Broken skin. 4) Tender places. 5) Blue areas. 6) Any changes in color or appearance. 7.2 Decubitus ulcers (Bedsores/Pressure sores): a. Signs and symptoms – the resident's skin change will be –
Identify resident's skin changes which are signs and symptoms of a decubitus ulcer.	1) Discolored: red, blue and/or white. 2) Warm. 3) Tender. 4) Painful. 5) Have feeling of burning. 6) Open as a sore. Damage may occur in underlying tissue before the skin breaks. Places to check on the body for a decubitus are the bony prominences, such as: 7) Shoulder blades. 8) Elbows. 9) Knees. 10) Ankles. 11) Backbone.
Describe places to check on the body for a decutitus ulcer (pressure sore).	12) Behind ears. 13) Buttocks. 14) Hips. 15) Heels.
State reasons why the elderly are prone to skin problems.	b. Older people are more prone to development of decubitus – 1) Their skin is very easily damaged. 2) They may not have an adequate amount of tissue padding over their bones. 3) They need to be reminded to turn and encouraged to be up in the chair.

Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

OBJECTIVE	CONTENT

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Unit VI (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
List measures for preventing skin breakdown and decubitus. Identify measures which help prevent decubitus ulcers.	c. Obese residents tend to get decubitus formation on areas where their body parts rub together. Places to check for formation of bedsores are the folds of body where skin touches skin. 7.3 Prevention of decubitus: a. Prevention is the responsibility of everyone involved in the resident's care. b. Observe skin daily and every time you reposition the resident for signs and symptoms of decubitus. c. Prevention involves removing causes – 1) Pressure: - Turn the resident often. Change his position at least every two hours (OLTC Regulation). - Don't leave a resident on a bedpan for a long time. - Keep bed linens or residents clothing free from wrinkles under his body. - Keep resident well hydrated. 2) Shearing: - Lift, rather than slide, resident when positioning in bed or chair. 3) Irritation: - Keep resident's skin clean and dry. - Keep linen and clothing clean and dry. - Check incontinent residents frequently. - Clean up urine and feces immediately. 4) Poor circulation: - Lightly massage the bony prominences with lotion each time you turn a resident. d. Devices used in preventing pressure – 1) Sheep skin/foam pads for elbows and heels.

Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

OBJECTIVE	CONTENT
	2) Flotation pad. 3) Water bed. 4) Alternating air mattress. 5) Air cushions. 6) Sponge rubber bed cushions. 8. Transfers/Positioning/Turning 3 hours 8.1 Lifting and moving: a. Principles – 1) Before procedure, explain it to resident. 2) Protect all tubing when moving someone. 3) Give most support to heaviest parts of the body. 4) Hold resident close to the body for best support. 5) Use smooth, steady, not jerky motions. 6) Lock bed and chair wheels. 7) Raise bed when moving someone remaining in bed. 8) Use "draw" or turn sheet whenever possible. 9) Use transfer belt around resident's waist for safety. b. Demonstrate the ability to (refer to procedures #14, 38, & 41 in the Appendix)
Identify general principles for lifting and moving. Demonstrate ability to move resident: -Raise to sitting position. -Move toward head of bed. -Move to one side of bed. -Turn from side to side. -Transfer from bed to chair and chair to bed. -Transfer from bed to stretcher.	1) Raise resident to sitting position. 2) Move resident toward head of bed. 3) Slide helpless resident to one side of bed. 4) Turn resident from side to side. 5) Transfer non-ambulatory resident from bed to wheelchair or chair. 6) Transfer from bed to stretcher. 8.2 Body alignment: a. The correct positioning of the resident's body is referred to as body

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Unit VI (contd.)

OBJECTIVE	CONTENT
~~Describe correct body alignment.~~	

Unit VI (contd.)

OBJECTIVE	CONTENT

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Unit VI (contd.)

OBJECTIVE	CONTENT
List the steps and demonstrate proper use of geriatric chairs and wheelchairs.	alignment. When a person's body is in correct body alignment – 1) Head is erect, not flexed forward nor extended backwards. 2) Vertebral column is in normal alignment. 3) The extremities are positioned according to the position of the resident. 4) Feet are in the "walking" position, not slanted forward. 5) The wrists are neither flexed or extended. 6) Fingers are slightly flexed. 7) Hips are straight in line with the thighs. 8.3 Safety with wheelchairs and geriatric chairs: (refer to procedure #13 in the Appendix) a. Resident shall be covered to protect from chilling. Blankets shall be kept away from wheels. Tuck the blanket firmly around the resident. b. The wheelchair or geriatric chair shall be wiped off with a disinfectant solution after each use, if it is to be used by others. c. Push the wheelchair from behind except when going in and out of elevators, pull the wheelchair into and out of the elevator backwards. d. If moving a resident down a ramp, take the wheelchair or geriatric chair down backwards. Glance over your shoulders to be sure of your directions and prevent collision and possible falls. e. Sets the brakes when – 1) Assisting a resident into a wheelchair or geriatric chair. 2) Assisting a resident out of a wheelchair or geriatric chair.

Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

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OBJECTIVE	CONTENT
Identify and demonstrate measures of proper use of mechanical hydraulic lifts.	3) When the wheelchair or geriatric chair is to remain stationary. f. Put foot rests up when assisting resident in and out of wheelchairs or geriatric chairs. g. Have resident's feet on foot rests when moving. Never push the wheelchair if the foot rests are in an up postion. h. If safety straps are needed they shall be fastened correctly. This may be considered a restraint, so follow accepted policy. i. Observe the resident's feet when turning the wheelchair or geriatric chair or when going down corridors. Pay attention where you are going and push chair slowly. j. Slow down at corners and LOOK before moving the wheelchair to prevent collisions with other residents, staff, etc. k. Elderly residents depend on the nursing assistant for safety – 1) Never assume that corridors are empty. 2) Push the wheelchair or geriatric chair slowly to prevent accidents. 8.4 Hydraulic lifts: (refer to procedure #48 in the Appendix) a. Purpose – 1) Used for resident who cannot assist in transfer. 2) Used to move resident from bed to chair or into tub. b. General safety rules – 1) The wheelchair to which the resident is to be moved is placed nearby. 2) Allow enough room for the lift to be turned. 3) Wheelchair brakes are locked.

Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

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OBJECTIVE	CONTENT
Identify and demonstrate safe and proper use of walkers, canes and crutches.	4) Never operate a mechanical lift without the assistance of another staff person. Safety requires that at least two people are present. 5) LOCK ALL brakes after positioning lift. 6) Be sure that all locks and straps are fastened securely before operating lift. 7) When resident is secured in straps or slings, raise them slowly. 8) One person guides the resident's legs in the direction to go. Be careful that their legs do not bump into any objects. 9) The other person moves the lift. 10) Reassure the resident while transferring. 11) Elderly people are very frightened about falling. 8.5 Safe use of walkers, canes and crutches: a. All devices shall have skid-proof tips. b. Residents should wear skid-proof shoes. c. Walkers – 1) Stand still. 2) Place walker forward with all four legs solidly on floor. 3) Step forward toward walker, repeat. d. Crutches – 1) Should have some space between top of crutch and axilla. 2) Arms should be completely extended. 3) Weight supported on palms of hands. e. Cane – 1) Plain care (one foot). 2) Quad cane (having four feet to

Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
Identify and demonstrate steps to follow in assisting resident to walk. Identify and demonstrate measures of making an occupied bed.	put on the floor) is more stable than plain cane. 8.6 Assist resident with walking: a. Resident should wear skidproof shoes. b. When assisting a resident from bed to walking, move resident slowly to avoid dizziness. c. Assist on weak side. d. Allow resident to use strong side for holding onto hand rails. e. When assisting a visually impaired resident, walk slightly ahead, allow resident to hold nursing assistant's arm. Explain hazards in path as necessary. f. Transfer belt may be used for safety. 9. Occupied Bed – 1 hour 9.1 Used for a resident who is unable to be out of bed. 9.2 Important facts and considerations: a. To provide the resident with a clean, comfortable and dignified environment. b. To prevent skin irritation and breakdown by providing clean, dry and wrinkle-free linens. c. Is usually made after the resident's bed bath is completed. 9.3 Measures of making an occupied bed: (refer to procedure #46 in the Appendix) a. Respect the resident's privacy – 1) Knock before entering the room and wait for the resident's permission to enter. 2) Identify yourself to the resident and what you plan to do. 3) Use the resident's privacy curtain and do not expose the resident any more than is necessary.

Unit VI (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
~~Demonstrate ability to make an occupied bed.~~	~~b. Much the same as the unoccupied bed (see Part I, Unit V).~~ ~~c. Bottom sheets are to be smooth, tight and wrinkle-free under the resident.~~ ~~d. Be constantly aware of infection control.~~ ~~e. Do not rush the procedure.~~ ~~f. Place signal cord or call bell within reach of the resident.~~
~~Give the purpose of restraints.~~	~~10. Restraints – 1.5 hours~~ ~~10.1 Purpose – for the protection of the resident to prevent injuries or interruption by the resident of needed treatments.~~
~~Identify the length of time restraints may be applied.~~	~~10.2 Applied after other measures have been tried and documented only on physician's order:~~ ~~a. Use is to be temporary. Not applied longer than 12 hours.~~ ~~b. To be applied properly.~~ ~~c. To be checked every 30 minutes.~~
~~Tell how frequently restraints are to be checked.~~ ~~Tell how frequently the restraints are to be released and for how long.~~	~~d. To be released every 2 hours and resident exercised for 10 minutes and resident's position changed.~~
~~Identify and describe the types of restraints.~~	~~10.3 Types of restraints:~~ ~~a. Hand and foot restraints –~~ ~~1) Used to keep a limb immobilized.~~ ~~2) Wrist/ankle is padded with special felt pads. The cloth restraints are then applied by using a clove hitch (which will not tighten when pulled). The ends are then tied to the bed frame. NEVER attach a restraint to the side rails.~~ ~~b. Cross over jacket restraints (posey vest) –~~ ~~1) Are put on like a jacket.~~ ~~2) Ends are crossed over in back or front (as directed by manufacturer).~~

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Unit VI (contd.)

OBJECTIVE	CONTENT

Unit VI (contd.)

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Unit VI (contd.)

CONTENT

~~OBJECTIVE~~

OBJECTIVE	CONTENT
Identify and demonstrate measures in the application of restraints. Identify symptoms of occlusion.	3) Ends are tied behind wheel chair or on bed frame. c. Safety belts – 1) Locked restraints are not allowed (OLTC Regulation). 2) Belt goes around resident's waist. 3) Attaches to a longer belt which is fastened behind wheelchair or on bed frame. d. Mitt restraints – 1) Are used for confused residents who could harm themselves with their hands or fingers. 2) A mitt is similar to a paddle that encloses the hands. 10.4 Guidelines to follow in the application of restraints: (refer to procedure #10 in the Appendix) a. Allow resident as much movement as possible but still serving the intended purpose. b. Resident's circulation shall not be occluded by the restraint. c. Pad bony points under a restraint in order to prevent trauma. d. The restraint shall be applied so that the resident's body is in a normal position. e. Use the least amount of restraint that will protect the resident. f. Never apply restraints without a direct order from charge nurse. g. Check the resident's extremity every 30 minutes for the following symptoms of occlusion: pallor, blueness, cold tingling, pain, pulses not present. If any of these symptoms are present, loosen restraints immediately and report to the charge nurse. h. Remove restraints every two hours. Exercise for at least 10 minutes

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	~~and provide skin care. Ambulate resident if possible (OTLC Regulation).~~ ~~i. Never apply a restraint without checking the resident's circulation before leaving the room. Pulses shall be felt. Loosen restraint if they are not felt.~~ ~~j. Resident's medical record shall include: physician's order for restraint, reason for use, when applied and released, type of restraint, nursing care provided (OLTC Regulation).~~ ~~10.5 PHYSICAL RESTRAINTS ARE NOT TO BE USED TO LIMIT RESIDENT MOBILITY FOR THE CONVENIENCE OF STAFF. If a resident's behavior is such that it will result in injury to self or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure designed to modify the behavioral problems for which the resident is restrained or as a last resort, after failure of attempted therapy.~~	

Unit VI (contd.)

OBJECTIVE	CONTENT

~~Unit VII Basic Nursing Skills~~
~~(10 hours theory/lab and 5 hours clinical)~~

~~OBJECTIVE~~

~~CONTENT~~

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Unit VI (contd.)

OBJECTIVE	CONTENT
	1. Vital Signs – 7 hours
Identify why measuring vital signs are important as it relates to the nursing assistant.	1.1 Vital signs are the signs of life. Vital signs are the measurements of the function of the vital organs. Included in vital signs are temperature, pulse, respiration and blood pressure (T.P.R. and B.P.).
Describe what causes body temperature.	1.2 Temperature: a. Description – 1) Is a measurement of the amount of heat in the body, a balance between heat created and lost. 2) Is lost from the body to the environment by contact, perspiration, breathing and other means. 3) Is created as the body changes food to energy.
Define normal temperatures.	b. "Normal" or average temperature – 1) Oral – 98.6 degrees F (Fahrenheit). 2) Rectal – 99.6 degrees F. 3) Axillary – 97.6 degrees F. 4) Older people have a greater variation in normal range. One individual may have a usual temperature of 97 degrees F, another 99 degrees F. To determine deviations from "normal", it is helpful to know what is usual for that resident.
List situations that cause variations from "normal" temperature.	c. Variations from "normal" – 1) Some situations causing higher than normal readings are: eating warm food, time of day, infection or other diseases, smoking, snuff or other tobacco use. 2) Situations causing lower readings: eating cold food, time of day, dry mouth, approaching death.

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Unit VII (contd.)

OBJECTIVE	CONTENT
Define fever. Describe the signs and symptoms of above normal body temperature. Describe the signs and symptoms of below normal body temperature. Describe the types of thermometers.	d. Fever – elevated body temperature – e. 1) Warm skin. f. 2) Flushed color. 3) Chills/teeth chattering. 4) Eyes burning. 5) Confusion. 6) Skin moist as fever breaks. Below normal body temperature – 1) Finger/toenails blush color. 2) Skin ashen color (gray/blue). 3) Cool/dry to touch. Types of thermometers – 1) Glass – made of hollow glass tube containing mercury, has markings on outside for reading level. Types of glass thermometers: -slender tip – mercury filled tip is longer and slender; used for oral or axillary checks. -stubby or safety tip – mercury filled tip is short and rounded; used for any temperature check. 2) Electronic (battery powered) – has a probe which is covered with a disposable plastic sheath before inserting. Temperature registers on a digital display. 3) Chemically treated paper – changes color to indicate reading.

OBJECTIVE	CONTENT
	g. 1) Easil care. 2) Avoid hot water in cleansing. 3) Disinfect after each use, as specified by facility or accepted nursing text procedure.

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Unit VII (contd.)

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Unit VII (contd.)

OBJECTIVE	CONTENT
Identify and demonstrate measures of taking an oral temperature. Identify and demonstrate measures of taking rectal temperature. Identify and demonstrate measures of taking an axillary temperature.	h. Method of checking temperature 1) Oral: Used in most all situations, when not contraindicated. Take per accepted procedure (refer to procedure #17 in the Appendix). Stay with resident. Wash your hands. 2) Rectal: Used when oral is contraindicate, is unsafe or inaccurate. Resident cannot hold mouth closed around thermometer. Resident's mouth is dry or inflamed. Resident is a mouth breather. Resident is comatose. Resident is using oxygen. Take per accepted procedure (refer to procedure #28 in the Appendix). Stay with resident. Wash your hands. 3) Axillary: Used when other methods are unsafe or inaccurate. This is a less accurate measurement than other methods of checking temperature. Place bulb of thermometer in center of armpit. Take per accepted procedure (refer to procedure #5 in the Appendix). Stay with resident, holding thermometer in place. Wash your hands.

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
~~Identify how the nursing assistant should record and report temperature measurement.~~ ~~Describe the cautions when taking a resident's temperature.~~	~~i. Record~~ ~~1) Mark chart w~~ ~~(axillary) for the method used in taking the temperature.~~ ~~2) Notify charge nurse when:~~ ~~Resident's temperature is above his normal range or has changed by more than 2 degrees from last measurement.~~ ~~There is difficulty obtaining temperature.~~ ~~3) Cautions:~~ ~~When removing the glass thermometer/electronic thermometer probe covering, the sheath shall be removed and destroyed.~~ ~~Stay with the resident, holding the thermometer in place.~~ ~~If thermometer breaks in the resident's mouth or rectum, report immediately to charge nurse.~~ ~~The glass thermometer shall register below 96 degrees F before taking a temperature.~~ ~~Ascertain that the electronic thermometer is fully charged and operable.~~ ~~1.3 Pulse:~~ ~~a. Description – a measurement of the number of times the heart beats, a simple method of observing how the circulatory system is functioning.~~ ~~b. "Normal" or average pulse –~~ ~~1) 60 to 90 beats per minute for an older resident.~~ ~~2) Should be regular in rate, rhythm and strength or force.~~

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OBJECTIVE	CONTENT

Unit VII (contd.)

OBJECTIVE	CONTENT
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OBJECTIVE	CONTENT
Identify and demonstrate measures of taking the radial pulse. Identify what is meant by respiration and an average respiratory rate.	c. Variations in the pulse 1) Abnormal force: Bounding pulse. Feeble, weak and thready. 2) Abnormal rate: A pulse beat of under 60 beats for one full minute. A pulse beat of over 90 beats for one full minute (exercise or activity normally cause a temporary increase in the pulse rate. Fever may increase the pulse rate). 3) Abnormal rhythm: Irregularity of beats. Feeling like beats are being "skipped" when pulse is counted for one full minute. d. Common sites for checking pulse 1) Radial. 2) Apical. 3) Femoral. 4) Temporal. 5) Carotid. e. Take per accepted procedure (refer to procedure #6 in the Appendix). f. Time take pulse for one full minute. g. Recording and reporting 1) Mark the chart with the symbol "Ap" when recording an apical pulse. 2) Notify the charge nurse when: Pulse begins to show variations from "normal". There is difficulty in obtaining pulse. 1.4 Respiration: a. Description respiration is the inspiration (taking in) and expiration (letting out) of air. b. Average respiratory rate 16-24 inspiration/expiration per one full minute for a resident.

Unit VII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
	c. Variations in respiration 1) Rate: -Increased by exercise, fever, lung disease, and heart disease. -Decreased by sleep, inactivity, and pain medication. -Report rate greater than 28. -Report rate less than 12.
Identify variations from normal respiration which should be reported. -Identify character of respirations.	2) Character: -Labored – difficulty breathing, extra muscles used for breathing. -Noisy – sounds of obstruction, wheezing gurgling. -Shallow – small amounts of air exchanged. -Cheyenes-stokes – pause between labored/shallow respirations. 3) Take per accepted procedure (refer to procedure #7 in the Appendix). 1.5 Blood pressure: a. Blood pressure is the force of blood against artery. b. A description of blood pressure – 1) The rate of strength of heart beat. 2) The ease with which the blood flows through the blood vessels. 3) The amount of blood within the system.
-Demonstrate taking respiration rate. -Define blood pressure. -Describe blood pressure.	c. Terms – 1) Systolic pressure – the force when the heart is contracted; the top number of BP; the first sound heard when measuring BP. 2) Diastolic Pressure – the force when the heart is relaxed; the lower number of BP; the level of which pulse sounds changed or cease.
-Define systolic. -Define diastolic pressure.	

Unit VII (contd.)

OBJECTIVE	CONTENT

Unit VII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
Identify "normal" blood pressure range for systolic and diastolic blood pressure for an elderly resident.	d. "Normal" or average blood pressure e. range for an elderly resident is – f. 1) Systolic – 100 to 160 mmhg g. (mercury). h. 2) Diastolic – 60 to 90 mmhg. i. Variations in blood pressure – 1) Blood pressure may increase with age.
Define hypertension.	2) Hypertension – blood pressure higher than normal.
Define hypotension.	3) Hypotension – blood pressure lower than normal.
Define postural hypotension.	4) Postural hypotension – the elderly resident's body is unable to rapidly adjust to maintain normal blood pressure in the head and upper body when the resident moves from lying to standing, or sitting to standing. The resident will complain of dizziness or feeling faint.
Identify common causes of hypotension.	Common causes of hypotension – 1) Hemorrhage (loss of blood). 2) Shock. 3) Blood diseases.
Identify common causes of hypertension.	Common causes of hypertension – 1) Narrowing and hardening of the arteries. 2) Rupture of blood vessels in the brain (stroke). 3) Aged resident. 4) Overweight (obesity). 5) Kidney disorders.
Identify instruments to check blood pressure.	Instruments for checking blood pressure – 1) Sphygomanometer (blood pressure cuff and gauge). 2) Stethoscope.
	Procedure for taking blood pressure –

Unit VII (contd.)

OBJECTIVE	CONTENT
~~Identify and demonstrate measures of taking blood pressure.~~	~~1) Choose a cuff appropriate size for the resident's arm.~~

Unit VII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
	2) Position cuff on upper arm and position gauge for accurate reading. j. Recording and reporting – 1) Record systolic over diastolic (e.g. 120/80). 2) Notify charge nurse when a resident's blood pressure is higher or lower than his normal range. 3) Difficulty in obtaining the blood pressure. 1.6 Height and Weight (refer to procedure #4 in the Appendix). a. Height – 1) Explain to the resident what you are going to do. 2) Wash your hands. 3) Have resident stand with arms to the side. 4) Make sure resident is standing as straight as possible. 5) Measure from top of head to bottom of feet. 6) If resident is unable to stand, have resident lie flat in bed and measure from head to feet. 7) Record height on paper and report to the nurse. b. Weight – 1) Importance: - Indicates nutritional status. - Weight loss/gain indicates change in medical condition. 2) Accurate measurements shall be taken: - If weight varies more than 5 pounds, verify accuracy of weight and report to charge nurse.
- Identify how to record and report blood pressure.	
- Identify and demonstrate height measurement: - for the bedfast resident. - for the ambulatory resident.	
- Identify importance of body weight.	
- Be able to explain accurate measurements and variance.	

Unit VII (contd.)

OBJECTIVE	CONTENT

Unit VII (contd.)

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OBJECTIVE	CONTENT
Identify and demonstrate measures for weighing. Identify when weights are taken. List some attitudes and actions which are prerequisites for making observations about residents.	3) Types of scales: -Wheelchair. -Bedscales. -Standing scales. -Scales attached to hydraulic lifts. -Bathroom. 4) Procedure for weighing (refer to procedure #4 in the Appendix). 5) Weight taken: -On admission (OLTC Regulation). -Once a month unless ordered more often by physician (OLTC Regulation). 2. Recognizing and Reporting Abnormal Changes (1 hour) 2.1 Attitudes and actions prerequisite to making observation about residents: a. Making observations is continuous during resident care. b. Be alert at all times. c. Use senses to observe - 1) See changes such as skin rash or edema. 2) Feel changes such as fever or change in pulse. 3) Hear changes such as changes in breathing sounds. Listen to resident complaints. 4) Smell odor of urine. 2.2 Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor. Some examples of abnormal changes are: a. Shortness of breath. b. Rapid respiration. c. Fever. d. Coughs. e. Chills. f. Pains in chest. g. Blue color to lips.

Unit VII (contd.)

OBJECTIVE	CONTENT

Unit VII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
~~Define Alzheimer's Disease.~~ ~~Recognize that there are changes in the brain caused by Alzheimer's.~~	~~h. Pain in abdomen.~~ ~~i. Nausea.~~ ~~j. Vomiting.~~ ~~k. Drowsiness.~~ ~~l. Excessive thirst.~~ ~~m. Sweating.~~ ~~n. Pus.~~ ~~o. Blood or sediment in urine.~~ ~~p. Difficulty urinating.~~ ~~q. Frequent urination in small amounts.~~ ~~r. Pain or burning during urination.~~ ~~s. Urine has dark color or strong odor.~~ ~~2.3 Reporting observations:~~ ~~a. Changes in resident's condition should be reported to charge nurse.~~ ~~b. The nursing assistant is encouraged to recall the observation of what was actually seen, heard, felt, rather than the interpretation of these observations.~~ ~~2.4 Some of the more common diseases:~~ ~~a. Alzheimer's Disease~~ ~~1) Progressive, age related brain disease that impairs thinking and behavior.~~ ~~2) Causes decline in intellectual functions and ability to perform routine activities.~~ ~~3) Disease has gradual onset and resident may experience confusion, personality change, impaired judgment and difficulty finding words, finishing thoughts or following directions.~~ ~~4) Eventually the resident becomes totally unable to care for themselves.~~ ~~5) Changes in the brain are:~~ ~~Senile plagues.~~ ~~Neurofibraillary tangles in~~

Unit VII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE

OBJECTIVE	CONTENT
Define Diabetes. Identify the purpose and use of insulin.	b. those areas of the brain responsible for memory and intellectual functions. Lack of brain chemical acetylcholine which is involved in the processing of memory by the brain. 6) There is no treatment available to stop or reverse the mental deterioration of Alzheimer's Disease. Diabetes Mellitus – 1) Diabetes is the result of the body's inability to break down and use carbohydrates (starches and sugars) to nourish the body cells in the production of insulin. 2) Insulin is the hormone that produces the amount of glucose to be secreted into the blood stream to nourish the body cells. 3) If the body does not produce insulin, glucose builds up in the blood stream (hyperglycemia) and the cells cannot be nourished. The glucose spills out through the kidney into the urine (glycosuria). 4) The cells begin to use fats for metabolism. When fat is used too much a by-product (acetone) is excreted. Acetone is a type of ketone and when there are too many ketones in the body, it is excreted through the kidney. When the acetone/ketone level is very high the body is unable to excrete poison toxic substances causing acidosis. Coma and

Unit VII (contd.)

OBJECTIVE

Unit VII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE

Discuss the respiratory conditions which prevent the intake of sufficient oxygen. Identify nursing assistant responsibility in caring for resident with a stroke.	c. death are a result of severe acidosis. d. 5) Symptoms to report to nurse in charge; hunger, nervousness, weakness, headache, sweating, drowsiness, blurred vision, tingling sensations, stupor, death, thirst, increase in urine, nausea, vomiting, abdominal pain, slow mental response, flushed face, dry skin, and sweet breath. Respiratory Diseases – 1) Conditions which interfere with breathing and prevent the intake of sufficient oxygen. 2) Causes of problem are; Emphysemia, cancer, colds and flu, pneumonia, muscle weakness, changes in lungs, tuberculosis. 3) Symptoms; shortness of breath, wheezing, tightening and raising of shoulders, respiration faster and more shallow breathing, coughing, bluish or grayish skin color. 4) Report any symptoms to the charge nurse. Cerebrovascular Accident (CVA) – 1) A "stroke" is caused by; bleeding in the brain, blood clot in the brain, partially blocked blood vessel in the brain that impair the circulation of blood. 2) Symptoms; changes in vital signs, impaired memory, speech difficulty, changes in behavior, paralysis of part of the body, incontinence, difficulty swallowing, mental confusion, loss of sensitivity, and balance impairment.

Unit VII (contd.)

OBJECTIVE	CONTENT

OBJECTIVE

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OBJECTIVE	CONTENT
Define fracture. Define AIDS. Identify modes of transmission of AIDS.	e. 3) Care is to prevent f. complications, injury, provide safety and to restore maximum amount of independence: physically, mentally, and emotionally. Fractures – 1) Break in a bone. 2) Symptoms; loss of strength and movement, pain, tenderness over break area, bruising and swelling, deformity or misaligned body position. 3) Stay with resident. DO NOT MOVE RESIDENT. Call charge nurse when appropriate. Need to insure patient has adequate intake of fluids even though patient does not express "being thirsty." Acquired Immune Deficiency Syndrome (AIDS) – 1) AIDS is a body fluid and sexually transmitted disease in which a virus invades the body, damages the immune system, and allows other infectious agent to invade the body and cause death. 2) ARC (AIDES Related Complex) refers to a variety of conditions caused by secondary infections related to AIDS. 3) AIDS /ARC is caused by the Human Immune Deficiency Virus (HIV). 4) Transmission: - Spreads through body fluids, primarily blood and semen. - All body fluids and tissues should be regarded as potentially infectious.

Unit VII (contd.)

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Unit VII (contd.)

OBJECTIVE	CONTENT
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OBJECTIVE

~~Identify nursing assistants responsibilities in caring of the resident with heart disease.~~	~~AIDS is transmitted by sexual contact, by needle sharing, and through contaminated blood products.~~ ~~5) Symptoms; may have no symptoms, may have AIDS Related Complex, enlarged lymph nodes, fungal infection of mouth accompanied by fatigue, weight loss.~~ ~~g. Heart Disease~~ ~~1) Is the leading cause of death in the elderly.~~ ~~2) Muscles of the heart do not pump as well.~~ ~~3) The vessels leading to the heart become narrow.~~ ~~4) Symptoms; changes in blood pressure, perspiration and weakness, pale, clammy skin, kidney output decreases, ankles and feet may swell, and nail beds may turn blue.~~ ~~5) Nursing assistant responsibilities:~~ ~~Follow directions of charge nurse.~~ ~~Make resident as comfortable as possible.~~ ~~Rest periods should be encouraged.~~ ~~Help keep environment quiet.~~ ~~Position residents to help breath easier.~~
~~Identify society's attitude about death.~~	~~3. Death and Dying (1 hour)~~ ~~3.1 Stages of reaction to dying:~~ ~~a. DENIAL – denying that death will occur~~ ~~1) Behaviors:~~ ~~Unrealistically cheerful.~~ ~~Ask lots of questions.~~ ~~Disregard medical orders.~~

Unit VII (contd.)

OBJECTIVE	CONTENT
~~Describe stages of reaction to dying.~~	

OBJECTIVE

		2) Response to this behavior: - Listen and be accepting. - Do not probe. b. ANGER – anger that thi to me, and anger at other not happening to them – 1) Behaviors: - Complaining. - Unreasonable requests. - Anger at family, doctor, and nursing staff. 2) Response to this behavior: - Listen. - Remain open and calm. - Don't try to place blame. c. BARGAINING – tryi agreement for postpon Behaviors: - May be difficult to observe this stage. - Person vacillates between doubt and hope. 2) Response to this behavior: - Listen. - Do not contradict plans. - Promote a sense of hope.

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Unit VII (contd.)

OBJECTIVE	CONTENT
	~~d. DEPRESSION – rea unavoidable; is a reac sicker; and is grieving for the losses they will experience – 1) Behaviors: -Turn face away from people. -Not speak or speaks in expressionless voice. -Separating self from the world. 2) Response to behaviors: -Stay with the person as much as is possible. -Avoid cheery phrases and behavior. -Encourage the person to express feelings.~~

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Unit VII (contd.)

OBJECTIVE	CONTENT

Unit VII (contd.)

OBJECTIVE	CONTENT
~~Identify and demonstrate measures of post mortem care.~~	~~e. ACCEPTANCE – realizes that death is inevitable.~~ ~~3.2 Physical care of the dying resident:~~ ~~a. Physical care to meet the resident's needs continues to the person's death.~~ ~~b. Provide for keeping resident warm.~~ ~~c. Keep room well-lighted since vision diminishes.~~ ~~d. Provide for skin cleanliness due to perspiration and perhaps incontinence.~~ ~~e. Change position at least every 2 hours unless contraindicated.~~ ~~f. Give special attention to mouth care and take measures to moisten mouth to promote comfort.~~ ~~g. Speak to the resident in a normal voice. Assume that they can hear you even if they appear unconscious and speak accordingly.~~ ~~h. Provide for spiritual support, respecting the resident's personal wishes and not imposing one's own beliefs.~~ ~~i. Communicate through touch if the person appears unconscious.~~ ~~3.3 Post mortem care: (refer to procedure #37 in the Appendix).~~ ~~a. Meaning – caring for the body of the deceased.~~ ~~b. When a person dies, their physician is called to certify the death.~~ ~~c. The purpose for much of the post mortem care which is done is to prepare the body for reviewing at the funeral.~~ ~~d. How much is done by nursing home personnel depends on the local situation. If mortuary personnel pick up the body soon after death, care provided by the nursing home may consist of only~~

Unit VII (contd.)

OBJECTIVE	CONTENT

Unit VII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
Identify feelings of resident/family on admission of resident. Identify and demonstrate responsibilities of the nursing assistant during the admission of a resident.	1) Place body in supine position. 2) Remove tubes, replace soiled dressings. 3) Account for what is done with or to whom personal effects are given. 4) Follow facilities policy and procedures. 4. Admission/Transfer/Discharge (1 hour) 4.1 Admission: a. Before admission – 1) Check the unit to insure furniture is present and in good condition. 2) Make sure that necessary equipment is available. b. Feelings of resident/family – 1) May be acutely aware of losses experienced with aging and illness. 2) Resident may feel lonely, lost, confused or relieved. 3) Family may experience guilt. c. Responsibilities of the nursing assistant during admission – (refer to procedure #33 in the Appendix). 1) Greet the resident/family. Call the resident by proper name or the name the resident prefers. 2) Introduce yourself to the resident/family giving your name and position. Be courteous and friendly. REMEMBER, first impressions are often lasting impressions. 3) Show the resident the room, bathroom and how to use the call bell. 4) Assist in unpacking clothing and belongings.

Unit VII (contd.)

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Unit VII (contd.)

OBJECTIVE	CONTENT
~~Identify and demonstrate the responsibilities of the nursing assistant on transfer/discharge of a resident.~~	~~5) All items are to be properly labeled according to a policy of a facility.~~ ~~6) Follow an approved inventory list of valuables, possessions, and clothing.~~ ~~7) Give instructions as to time and place of meals.~~ ~~8) Orient the resident/family to the facility.~~ ~~9) Introduce resident/family to other residents and staff.~~ ~~10) Make sure that the resident is comfortable. Check on the resident frequently.~~ ~~4.2 Transfer/Discharge: (refer to procedure #30 in the Appendix).~~ ~~a. Transfer/discharge arrangements are made by the attending physician and administration.~~ ~~b. The nursing assistant shall allow the resident to talk about anxieties and shall make every effort to insure the change is easy and pleasant.~~ ~~c. The nursing assistant shall be sure that all personal clothes and belongings are sent with the resident.~~ ~~d. When appropriate, the nursing assistant shall complete and sign inventory forms and transfer/discharge forms.~~ ~~e. Following the resident's discharge the room shall receive a thorough cleaning.~~

Unit VII (contd.)

OBJECTIVE	CONTENT

Unit VII (contd.)

OBJECTIVE	CONTENT

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~~Unit VIII Social/Cognitive/Behavioral~~
~~(5 hours theory/classroom lab)~~

~~OBJECTIVE~~

~~CONTENT~~

Unit VIII (contd.)

OBJECTIVE	CONTENT
Define the term cognitive as it relates to the responsibility of the nursing assistant. Define cognitive functions as it refers to mental process of the resident. Identify the various mental abilities as it relates to level of consciousness, orientation, and intellectual capacity.	1. Cognitive (Mental Functions) 1.1 Cognitive (Mental) Achievements: a. Memory and orientation. b. Immediate recall. c. Memory for recent and remote events. d. Orientation in time, place, and person. e. Concentration and good judgment. f. Current social and physical performance. g. Insight and judgments excellent. 1.2 Cognitive (Mental) Impairments: a. Comprehension. b. Judgments. c. Memory. d. Reasoning. 1.3 The various mental abilities do not decline at the same rate of speed: a. Level of consciousness – 1) The resident alert and quick to respond. 2) The resident drowsy and slow to respond. 3) The resident semiconscious and difficult to arouse. 4) The resident comatose and unable to respond. b. Orientation – 1) The resident alert to time, to place, to person. 2) The resident does not pay attention or understand when someone else is talking. 3) The resident wanders about, not oriented to place. 4) The resident is not knowing of self and others. c. Intellectual Capacity – 1) The nursing assistant should recognize factors which may block resident's intellectual abilities.

Unit VIII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
~~Identify factors which affect the resident's ability to recall, understand, for self- awareness and judgment.~~	~~2) The nursing assistant must be patient. The resident will most likely respond to kindness.~~ ~~3) The nursing assistant must use a tone of voice that carries respect for the resident. Ability to recall –~~ ~~1) Events recent and past. 2) Attention span short.~~ ~~3) Attention span normal.~~ ~~d.~~ ~~e. Ability to understand~~ ~~2) Planned d~~ ~~3) Slow to follow planned daily activities.~~ ~~4) Unable to follow planned daily activities.~~ ~~f. Level of ability to~~ ~~1) Quick to unders~~ ~~friendly relationships with others.~~ ~~2) Slow to understand and to make friendly relationships with others.~~ ~~g.~~ ~~Se~~ ~~1) Has insight in~~ ~~problems.~~ ~~2) Little or no insight into own health problems.~~ ~~h.~~ ~~1) Resid~~ ~~concentrate and make reasonable and appropriate decisions.~~ ~~2) Selecting clothes to wear.~~ ~~3) Taking part in care plan.~~ ~~4) Expresses desires and needs as to individual resident's rights of long term care facility.~~

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Unit VIII (contd.)

OBJECTIVE	CONTENT
	~~i. Resident's ability to understand the rules and regulations of care facility.~~

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OBJECTIVE	CONTENT
	1.4 Memory:
List factors which affect memory and reasoning of the resident.	a. Mental registration, mental retention, mental recall of past experiences of –
	1) Knowledge.
	2) Ideas.
	3) Sensations. 4) Thoughts.
	b. Forgetfulness is a normal process of aging.
	1.5 Reasoning: the ability to think and/or respond and/or make choices.
	1.6 Cognitive Impairments:
	a. Factors which influence are 1)
Identify factors which affect cognitive impairments of the resident.	Reactions to stress.
	2) Progressive loss of brain cells.
	3) Poor nutrition.
	4) Interactions of medications.
	5) Alcoholism.
	6) Strokes.
	7) Other diseases and/or disorders.
	2. Behavior
	2.1 Behavior is defined as:
	a. Ability to adapt and adjust.
Define behavior as it relates to the residents.	b. To behave appropriately in situations.
	c. To behave in accordance with culturally approve standards.
	d. Satisfactions are achieved through love, work, and interpersonal relationships.
	2.2 Factors which influence behavior:
	a. Attitudes.
	b. Past and present experiences.
List factors which influence behavior of the resident.	c. Illness.
	d. Fever.
	e. Loss of self-confidence.
	2.3 Appearance and behavior:
	a. Dress, posture, facial expression.
	b. Motor activity such as 1) Agitation.
Identify ways in which the resident may express feelings through their behavior.	2) Impulse mannerism.
	3) Retardation.

Unit VIII (contd.)

OBJECTIVE	CONTENT

Unit VIII (contd.)

OBJECTIVE CONTENT

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OBJECTIVE	CONTENT
~~Identify factors which affect the residents thought process.~~	~~2.4 Thought process – When any of these thought processes are observed, they should be reported to the charge nurse:~~ ~~1) Stream of talk.~~ ~~2) Impairment of thought process.~~ ~~3) Pace and progression of speech.~~ ~~4) Whether the speech is logical and to the point.~~ ~~5) Whether the speech is confusing and irrelevant.~~ ~~6) Whether there is a presence of thought disorder such as flight of ideas or obsessive thoughts.~~
~~Identify observations to be made during care of the confused or withdrawn resident.~~	~~3. Cognitive/Behavior Improvements~~ ~~3.1 Caring for the confused or withdrawn resident:~~ ~~a. Symptoms of confusion –~~ ~~1) Not knowing self or others.~~ ~~2) Talking incoherently.~~ ~~3) Forgetful.~~ ~~4) Not paying attention or understanding when someone is speaking.~~ ~~5) Sleep disorders.~~ ~~6) Hallucinate, visual and auditory.~~ ~~7) Wanders about, not oriented to place.~~ ~~8) Combative, hostile.~~ ~~b. Symptoms of Psycho-social impairments –~~ ~~1) Frightened, unhappy, bewildered.~~ ~~2) Unaware of environment; thus, does not sense danger.~~ ~~3) Reduced intellectual and emotional contact with others.~~ ~~4) Loss of self-expression.~~ ~~5) Loss of independence.~~ ~~6) Insecurity.~~

Unit VIII (contd.)

OBJECTIVE	CONTENT

Unit VIII (contd.)

OBJECTIVE	CONTENT
List medical problems related to the residents care.	3.2 Possible causes a. Medical problem 1) Chronic disease, such as heart, liver, kidney, and lung problems. 2) Stresses such as surgery or injury. 3) Degenerative brain conditions such as Alzheimer's Disease. 4) Arteriosclerosis. b. Poor nutrition. c. Medication – 1) Older people may not tolerate drugs as well. 2) Combination of drugs may cause confusion. 3.3 Causes of withdrawal: a. Losses, including sight and hearing. b. Depression. c. Mental illness. d. Confusion. 3.4 Therapies for confusion and withdrawal: a. Reality orientation (R.O.). b. Purpose – to maintain reality contact and halt or reverse confusion or withdrawal. c. Technique – 1) Consistent, constant (all 3 shifts) 24 hour repetition of information about person, place, time expectations. 2) Aids such as calendars, clocks, information boards can be used. 3) Reality orientation: Introduce yourself upon entering a resident's room. Explain what you are doing in the room. Tell the resident the date, time and place. Frequently ask the resident the date, time and place. Ask the resident who he/she is and family members names, etc.
Identify the purpose of reality orientation of the resident.	
List the responsibilities of nursing assistant in the reality orientation for residents.	

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Unit VIII (contd.)

OBJECTIVE	CONTENT

Unit VIII (contd.)

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Unit VIII (contd.)

~~OBJECTIVE CONTENT~~

OBJECTIVE	CONTENT
Identify the nursing assistants role in response to the residents combativeness. Define the purpose of the re-motivation program for the resident.	3.5 Responses to combativeness: a. Use non-threatening approach. b. Give recognition to feelings behind behavior. c. Request directions from charge nurse for proper plan of care. d. When approaching combative resident, go with enough assistance to complete procedure. e. If resident suddenly becomes combative, call for help, IMMEDIATELY. f. Do not try to physically restrain a combative resident by yourself. g. Report to charge nurse. 3.6 Re-motivation: a. Purpose – 1) Prevent withdrawal. 2) Increase interest in reality. 3) Stimulate thinking. 4) Participate/perform activities of daily living (ADL's). 3.7 Reminiscing: a. The resident has the right to reminisce about his/her life and to share feelings about the past, to promote feelings of worth and to reduce feelings of loneliness. 4. Understanding and Managing Behavioral Symptoms of Alzheimer's Disease and Related Disorders 4.1 Social Facade: a. Description – 1) Ability of the resident to look "not sick". 2) Ability of the resident to make casual conversation or general comments based on well ingrained memories. 3) While not looking ill, apparent energy can fool a casual observer.

Unit VIII (contd.)

OBJECTIVE

Unit VIII (contd.)

OBJECTIVE	CONTENT
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OBJECTIVE

	~~b. Approaches –~~ ~~1) Build on any and all attempts to have adult conversation with the resident.~~ ~~2) Never remind the resident that self care is not possible.~~ ~~3) Keep your conversation with the resident brief and pleasant.~~ ~~4) Introduce the resident with a remark that calls upon the resident's past or present experience or interest.~~ ~~4.2 Depression/Apathy/Withdrawal:~~ ~~a. Description –~~ ~~1) Depression must last awhile, be fairly severe, and not be a grief reaction after the death of a loved one.~~ ~~2) Older people may withdraw, appear listless or restless, have difficulty concentrating, not feel life is worth living.~~ ~~3) Depression is sometimes different in older persons.~~ ~~4) Alzheimer's residents function even more poorly than others who are depressed.~~ ~~b. Approaches –~~ ~~1) If resident is sad and with drawn, are there certain things that cheer the resident up?~~ ~~2) Alert the doctor or nurse.~~ ~~3) Spend special time with just the resident.~~ ~~4) Reassure the resident of the resident's value as a person.~~ ~~5) Reassure the resident that he/she will be cared for.~~ ~~6) A special relationship with a staff person, favorite family visitor or a minister can relieve depression.~~

Unit VIII (contd.)

OBJECTIVE	CONTENT

OBJECTIVE

	7) Respect the resident's right t give reassurance that you're th resident to feel better. 8) It's wise to remove potentially dangerous objects and check the resident more frequently. 4.3 Rummaging, Pillaging, and Hoarding: a. Description 1) Many Alzheimer's residents seem to be driven to search for something which they believe is "missing". 2) The resident has lost the ability to tell the difference between things that belong and things that are out of place. 3) Alzheimer's residents often lose memory of good manners. May enter a room without knocking or take their clothes off in public. 4) The resident believes things are taken away from him/her. 5) It is hard for the resident to tell which bed is his/hers so will sometimes enter the wrong bed. b. Approaches 1) Best strategies are preventive. 2) Try to keep the resident occupied with a drawer of his/ her belongings. 3) Don't give moral judgment or rational explanations to the resident. 4) Distract the resident if he/she is in someone else's room by asking them if they want to go see TV, etc. 5) Learn the resident's favorite hiding place. 6) Persuade the resident that their chair is more comfortable if

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Unit VIII (contd.)

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Unit VIII (contd.)

OBJECTIVE	CONTENT

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	~~he/she keeps sitting in the wrong chair or bed.~~ ~~7) Wandering may be part of a search for the bathroom.~~ ~~4.4 Wandering:~~ ~~a. Description –~~ ~~1) There are more theories and proposed solution about wandering in dementia residents than any other symptoms of the disease.~~ ~~2) Wandering has major implications for the family, facility and the community.~~ ~~3) Some professionals see wandering as an expression of aimlessness, excessive restlessness, or the need for self stimulation that comes from brain damaging illness.~~ ~~b. Approaches –~~ ~~1) See if the resident is hungry, feels uncomfortable, needs to void, or is genuinely lost.~~ ~~2) Removing from view, shoes, coat and suitcase may remove the immediate idea of the desire to "leave".~~ ~~3) Try to keep the resident busy and in view of the staff.~~ ~~4) Placing a picture on resident's door may help the resident to locate his/her room.~~ ~~5) Avoid putting the resident in close, crowded situation where he/she may experience stress and confusion.~~ ~~6) Give the resident something to occupy his/her time.~~ ~~7) If the resident wanders away from the facility, approach the resident calmly and reassure him/ her. Do not interrogate the resident.~~

Unit VIII (contd.)

OBJECTIVE	CONTENT

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OBJECTIVE	CONTENT
	~~4.5 Suspiciousness:~~ ~~a. Description –~~ ~~1) Resident experiences more and more difficulty making sense of their experience and environment.~~ ~~2) Residents are suspicious because it is hard for them to accept the fact that they forget where they put things.~~ ~~3) The dementia resident feels victimized by something that robs him/her of his/her previous well being.~~ ~~4) Whispering between staff or family and staff is interpreted as a plot to steal their money, power, influence or possessions.~~ ~~b. Approaches –~~ ~~1) Don't argue or rationally explain disappearances. This only makes the resident feel stupid. Arguing only backs the resident into a corner, making him/her more insistent.~~ ~~4.6 Delusions:~~ ~~a. Description –~~ ~~1) Delusions are fixed or persistent beliefs of the resident that remain despite all rational evidence to the contrary.~~ ~~2) Delusions can be frustrating or frightening to the resident.~~ ~~3) Some delusions are harmless and can be ignored or glossed over.~~ ~~4) Some delusions are based on real possibilities.~~ ~~b. Approaches –~~ ~~1) Try to judge how much the delusion bothers the resident.~~

OBJECTIVE	CONTENT

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~~UNIT VIII (contd.)~~

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OBJECTIVE	CONTENT
	~~2) Don't use rational explanations to convince the resident that a delusion is incorrect.~~ ~~3) Reassure the resident and try to divert him/her to a less stressful subject.~~ ~~4.7 Hallucinations:~~ ~~a. Descriptions –~~ ~~1) Hallucinations are sensory experience (seeing, hearing, or feeling) which can't be verified by anyone else.~~ ~~2) Seeing or hearing things is common in adults with brain disorders.~~ ~~3) Symptoms may be worse if the resident has visual or hearing defects.~~ ~~b. Approaches –~~ ~~1) If the resident is not too upset or disturbed by the hallucination then the resident can usually be diverted or distracted.~~ ~~2) Frightening hallucinations especially if resulting from dream states usually subside in the well lighted company of others with plenty of attention and reassurance.~~ ~~3) Anti-psychotic medication may be ordered in instances where the resident believes bugs are crawling on him/her or is in his/her food.~~ ~~4) Residents with frightening hallucinations are best reassured by someone they trust.~~ ~~4.8 Catastrophic Reactions:~~ ~~a. Description –~~ ~~1) Catastrophic reactions is a term describing the behavior of a~~

Unit VIII (contd.)

OBJECTIVE	CONTENT

OBJECTIVE		CONTENT
		~~overwhelms his/her ability to think and react.~~ ~~2) Behavior may be any of the following: suddenly changing mood, crying inconsolably for a long time, anger, increasing suspicious, increasing restless- ness, pacing, wondering off, combativeness, stubbornness, and worry or tension.~~ ~~3) The resident appears stubborn, overly critical or overly emotional, all out of proportion to what has actually happened.~~ ~~4) Reactions can be set off by a number of things: several questions being asked at once, being asked "why" questions, feeling lost, small accidents, too many people in a new place, being scolded or contradicted, having an argument, staff members that are tense, rushed or impatient, and if a patient tries and fails to complete a task he/she once regarded as simple.~~ ~~5) Dementia residents experience a loss of impulse control.~~ ~~6) The resident loses adult judgment.~~ ~~7) The resident is unable to evaluate the seriousness of an incident therefore he/she "overreacts".~~

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Unit VIII (contd.)

OBJECTIVE	CONTENT

OBJECTIVE		CONTENT
		~~b.~~
		~~situations that lead to catastrophic reaction.~~ ~~2) Give directions one step at a time.~~ ~~3) Using a rocking motion, patting, holding hands or~~

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Unit VIII (contd.)

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	soothing music to calm the resident. 4) Distract the resident gradually with something new. 5) Allow the resident plenty of space during a catastrophic reactions. Move slowly and tell the resident exactly what you are doing. 6) Don't force a resident to spend time with someone that frightens or upsets him/her today because tomorrow may be a whole different story. 7) Don't take attacks personally. Attacks usually take place on whomever is closest. 4.9 Sundowning: a. Description – 1) Persons with acute or chronic confusion become more confused, restless and insecure late in the day and especially after dark. 2) Attention span and concentration become even more limiting. 3) No one knows what causes sundowning. 4) Patients with Alzheimer's tire more easily, even from minimal demands on their thinking ability, and become more restless and hard to manage when tired. 5) Sundowning may relate to a lack in sensory stimulation and the absence of routine daytime noises and dim lighting may trigger the Sundown behavior. 6) Alzheimer's residents may become more anxious late in the	

Unit VIII (contd.)

OBJECTIVE

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OBJECTIVE

	~~day because they think they sho~~ ~~home" (all those feelings indic~~ ~~security and protection).~~ ~~b. Approaches~~ ~~1) An early afternoon rest may help if sundowning is caused by fatigue.~~ ~~2) Keep the resident active in the morning.~~ ~~3) Don't physically restrain the resident.~~ ~~4) Let the resident pace back and forth where he/she can be watched.~~ ~~5) Give the resident something to fiddle within his/her hands to distract him/her.~~ ~~6) Don't ask the resident to make decisions.~~ ~~4.10 Inappropriate Behavior:~~ ~~a. Description~~ ~~1) Loss of impulse control seen in brain diseases means infantile behaviors reappear.~~ ~~2) Has nothing to do with success or failure of childhood discipline or training.~~ ~~3) Resident may lose awareness that his/her behavior is not considered proper in public.~~ ~~4) Time sense is severely affected and the resident becomes intolerable to even slight delays.~~ ~~b. Approaches~~ ~~1) Resident's tactless insults don't necessarily mean displeasure with one person but rather he/she is upset with his/her situation and the lack of control.~~ ~~2) Ignore insults or cursing of the resident.~~

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Unit VIII (contd.)

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Unit VIII (contd.)

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OBJECTIVE

~~List the basic human needs described.~~	~~3) Reassure the resident that yo~~ and that the doctor told you how ~~him/her.~~ ~~4) Childish patients who exhibit attention getting behavior may be craving more stimulation and will respond to a hug, pat or the chance to move around a little.~~ ~~5) Don't over react to incidents.~~ ~~5. Social Care~~ ~~5.1 There are five basic human needs which each individual needs are to be nurtured, accepted, loved and assisted to reach their highest potential (see Maslow's chart in Appendix):~~ ~~a. 1st level~~ ~~1) Food.~~ ~~2) Air.~~ ~~3) Water.~~ ~~4) Activities.~~ ~~5) Sleep.~~ ~~6) Physiological survival. 7) Need.~~ ~~b. 2nd level~~ ~~1) Protection from harm.~~ ~~2) Violence.~~ ~~3) Disease. 4) War.~~ ~~5) Poverty.~~ ~~6) Assurance of continuing income and employment security. 7) Safety needs.~~ ~~c. 3rd level 1) Love.~~ ~~2) Accepted by others.~~ ~~3) Approval.~~ ~~4) Membership in group.~~ ~~5) Belonging.~~ ~~6) Social need.~~

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Unit VIII (contd.)

OBJECTIVE

Unit VIII (contd.)

OBJECTIVE

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OBJECTIVE	CONTENT
List the emotional needs of the resident in a long term care facility.	d. 4th level 1) Worth. 2) Status. 3) Power. 4) Recognition. 5) Self-confidence-esteem. 6) Ego Needs. e. 5th level 1) Full potential. 2) Creativity. 3) Self-actualizing needs. 5.2 Meeting emotional needs of the resident in a long term care facility: a. Independence 1) Encourage decision-making in areas about which there can be a choice; foods when there is a selection, activities, when to do activities of daily living. 2) Encourage resident to be in control of his own body; selfcare as is possible, choice of clothing. b. Need for supportive environment 1) Supportive physical environment: Proper medical and dental care. Safe, comfortable clothing. Room and halls free of accident-causing situations. Protection from others. c. Need for social interaction 1) Encourage contact between residents and persons outside facility. 2) Encourage interaction among residents. 3) Keep charge nurse informed of expressed needs or wants of resident. 4) Encourage resident to do as much as he can as well as he can for as long as he can.

OBJECTIVE

Unit VIII (contd.)

OBJECTIVE	CONTENT
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OBJECTIVE

	5) Encourage resident to maintain sense of belonging and selfesteem. 6) Insure resident does not become isolated or withdrawn from others by establishing rapport and becoming acquainted. 7) Promote interaction among other residents. d. Need for recognition as an individual - 1) Be respectful of each resident and allow for as much privacy as is possible. 2) Encourage self-expression in crafts, listening to their stories, recognizing past accomplishments. e. Spiritual needs - 1) Encourage and help resident to participate in spiritual observances. 2) Encourage and facilitate visits by clergy, if desired. 3) Respect individual beliefs; don't impose your own beliefs on residents. f. Status needs - 1) Speak to the resident by proper name and title. 2) Listen to their memories and fears. 3) Recognize residents past experiences. 4) Remind resident to be proud and feel important.
Identify ways to help the residents meet their needs status.	5) Discuss current events and ask their opinion. 5.3 Social aspects of sexuality in the aging: a. Sexuality fulfills strong needs for elderly in close relationship to another. b. Sexuality is part of a person's individuality.
Identify the aspects of sexuality in the aging.	

Unit VIII (contd.)

OBJECTIVE	CONTENT

Unit VIII (contd.)

OBJECTIVE

	~~c. There is continued need among the elderly for respect and privacy in sexual matters.~~ ~~d. Individuals should be protected from unwanted advances of others and from embarrassing themselves if confused.~~

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OBJECTIVE	CONTENT
	~~e. Masturbation – allow privacy and don't interfere with this. However, if it occurs in public, it should be managed in a sensitive way to prevent offending others and degrading the individual. The nursing assistant should inform the charge nurse of this type of occurrence.~~

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~~Unit IX Basic Restorative Services~~
~~(5 hours theory/lab and 4 hours clinical)~~

~~OBJECTIVE~~

~~CONTENT~~

Unit IX (contd.)

OBJECTIVE	CONTENT
	1. Restorative Care – 1 hour
Define Restorative Care.	1.1 Restorative care involves the rehabilitation of the individual to the greatest personal, social, economical usefulness and independence of which the resident is capable:
Identify requirements of restorative care.	a. Restorative care requires the development of a fine degree of judgment to know when and when not to intervene. It is important to know how to intervene without the resident feeling he has failed.
	b. The maintenance of physical, mental and social functional abilities and capabilities require their constant use. The effects of inactivity becomes apparent within a few days and compounds the disabilities that result from injury or illness.
	1.2 Residents awareness of changes of functional ability associated with aging:
	a. Becomes aware of using stair railings.
	b. Becomes aware of pausing before stepping off a curb.
Identify changes in functional abilities associated with aging.	c. Becomes aware of stopping part of the way up a flight of steps.
	d. Becomes aware of the need for reading glasses or bifocals.
	e. Becomes aware that a whole day spent with children, friends, or relatives is tiring.
	f. Becomes aware that behavior that once was accepted is now irritating.
	g. Adoption to illness, emotional or social crisis become difficult.
	1.3 Approaches to restorative nursing care:
	a. Efforts directed to assist each resident to –
	1) Express how he feels about his illness, himself, his behavior and wants.
Identify approaches to restorative care.	

Unit IX (contd.)

OBJECTIVE	CONTENT

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Unit IX (contd.)

OBJECTIVE	CONTENT

OBJECTIVE	CONTENT
List approaches to restoring resident's independence.	2) Become as independent as possible in Activities of Daily Living (ADL). 3) Prevent complications of illness or injury. 4) Learn new skills. 5) Develop a sense of personal accomplishment, usefulness, and pride. 6) Learn to accept the accomplishment of small goals because total rehabilitation may not be possible. 7) Remember skills are acquired. b. Approaches to restore resident's independence – 1) Be patient and give the resident plenty of time to do for himself. 2) Express confidence in his ability to be independent. 3) Emphasize the progress the resident makes. 4) Offer verbal praise for the resident's efforts to do things for himself. 1.4 Measures of restorative care: a. Physical measure – 1) Proper body alignment. 2) Bed/Chair positioning. 3) Range of motion exercise. 4) Bowel and Bladder training. 5) Ambulation. 6) Elevation of extremities as indicated. b. Mechanical devices – 1) Foot board. 2) Self help devices. 3) Pillows. 4) Hand rolls. 5) Eye glasses. 6) Hearing aid. 7) Dentures.
List physical measures of restorative care.	
Name mechanical devices used in restorative care.	

Unit IX (contd.)

OBJECTIVE	CONTENT

Unit IX (contd.)

OBJECTIVE	CONTENT
State educational and counseling services in restorative care. Identify the types of ROM exercises.	8) Prosthetic and orthotic devices c. Educational and counseling services – 1) Prevention of Intellectual regression. 2) Reality Orientation. 3) Remotivation. 2. Range of Motion (ROM) – 2 hours 2.1 Range of motion exercises should permit each of the resident's joints to be exercised. There are three types: a. Active exercise is performed by the resident. b. Passive exercises are performed by someone else when a resident cannot carry out such movement. c. Resistive exercises are performed in response to resistance that is offered by a therapist. 2.2 Rules to follow – Range of motion exercises: a. Do each exercise three times. (Follow the head nurse's or team leader's instructions.) b. Follow a logical sequence so that each joint and muscle is exercised. For instance, start at the head and work your way down to the feet. c. If the patient is able to move parts of the body, encourage him to do as much as he can. d. Be gentle. Never bend or extend a body part further than it can go. e. If a patient complains of unusual pain or discomfort in a particular body part, be sure to report this to your head nurse or team leader. 2.3 Procedure – ROM exercises: (refer to procedure #39 in the Appendix) a. Assemble your equipment – 1) Blanket. 2) Extra lighting, if necessary.

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Unit IX (contd.)

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OBJECTIVE	CONTENT
List goals of bladder and bowel training.	b. Wash your hands. c. Identify the patient by checking the identification bracelet. d. Ask visitors to step out of the room, if this is your hospital's policy. e. Explain to the patient that you are going to help him exercise his muscles and joints while he is in bed. f. Pull the curtain around the bed for privacy. g. Raise the bed to a comfortable working position. h. Place the patient in a supine position (on his back) with his knees extended and his arms at his side. i. Loosen the top sheets, but don't expose the patient. j. Raise the side rail on the far side of the bed. k. Exercise the neck. 3. Rehabilitative Care – 2 hours 3.1 Bowel and bladder training: a. Goals of bowel and bladder training – 1) Establish a regular pattern of elimination. 2) Decrease the amount of times a resident is incontinent. 3) Increase a resident's self esteem by attaining control of elimination. 4) Decrease the chance of other problems; e.g. skin breakdown that can occur fro continued incontinence. 5) Preserve the integrity and function of the elimination system. b. Preparation for bowel and bladder training – 1) Explain the reason and the importance of possible positive

Unit IX (contd.)

OBJECTIVE	CONTENT

Unit IX (contd.)

OBJECTIVE CONTENT

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OBJECTIVE	CONTENT
~~Identify steps in bladder training.~~	~~benefits of bowel and bladder training.~~ ~~2) Encourage involvement of the family members.~~ ~~3) The resident's past elimination pattern is reviewed, as well as the total resident history.~~ ~~4) A routine for elimination is established by the nurse and written on the nursing care plan. It is resident's personal plan of elimination is carried out by the entire staff.~~ ~~5) Each long term care facility will have a specific program that is followed by the staff. These may be different from facility to facility but the basic goal is the same.~~ ~~Steps involved in bladder training 1) Provide privacy.~~ ~~2) Adequate fluid intake.~~ ~~3) Bedside commode or toilet other than bedpan.~~ ~~4) Use any technique to stimulate voiding.~~ ~~5) Adhere to the time schedule as outlined in the care plan of the resident.~~ ~~6) Regularity is the key to successful program.~~ ~~7) Requires cooperation of shifts.~~ ~~8) Increase the time interval as possible.~~ ~~9) Positive reinforcement.~~ ~~10) Record output and success or non-success each time for evaluation and planning.~~ ~~c.~~

Unit IX (contd.)

OBJECTIVE	CONTENT

Unit IX (contd.)

OBJECTIVE CONTENT

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OBJECTIVE	CONTENT
~~Identify steps in bowel training.~~	~~d. Steps involved in bowel training 1) Provide privacy.~~ ~~2) Encourage resident to eat prescribed diet.~~ ~~3) Assist resident to bathroom facilities immediately after morning meal.~~ ~~4) Encourage exercise.~~ ~~5) Positive encouragement.~~ ~~6) Encourage fluids.~~ ~~7) Record success or non-success for evaluation and planning.~~

Unit IX (contd.)

OBJECTIVE	CONTENT

Unit IX (contd.)

OBJECTIVE CONTENT

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~~PART III~~

~~CLASSROOM & CLINICAL TRAINING – 15 HOURS~~

~~(Theory, Classroom Lab and Clinical)~~

~~NOTE: Effective July 1, 2006, all nursing assistant training programs must include Part III in their program. This is required in addition to the 75 hour training program, making the total of 90 clock hours of training.~~

Do not ask me to remember.
Don't try to make me understand.
Let me rest and know you're with me.
Kiss my cheek and hold my hand.

I'm confused beyond your concept.
I am sad and sick and lost.
All I know is that I need you.
To be with me at all cost.

Do not lose your patience with me.
Do not scold or curse or cry.
I can't help the way I'm acting.
Can't be different though I try.

Just remember that I need you.
That the best of me is gone.

~~Please don't fail to stand beside me.~~
~~Love me 'til my life is done.~~

~~Author unknown~~

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~~The Office of Long Term Care wishes to extend sincere appreciation to University of Arkansas Athletic Director Frank Broyles, Representative Sandra Prater, Senator Mary Ann Salmon, Representative Shirley Borhauer, Dr. Cornelia Beck, and Gwynn Davis.~~

~~Representative Prater with assistance and encouragement from Representative Borhauer spent numerous hours creating and sponsoring the legislation that made possible the training provided by way of this curriculum, including the requisite funding. Without her initial impetus and unwavering efforts, Arkansas would still lack this necessary element of CNA training. Senator Salmon, recognizing the value of this necessary training, co-sponsored the legislation and helped shepherd it through the Arkansas Senate.~~

~~During the legislative session, Coach Broyles provided dramatic and very personal testimony of the struggles that he and his family faced while his wife, Barbara, battled with this terrible disease. In doing so, Coach Broyles gave a face and feelings to what can oft times be a purely theoretical discussion. His unselfish act of revealing these personal and intimate moments were instrumental in the swift and virtually unanimous approval of the law.~~

~~Dr. Cornelia Beck and Gwynn Davis, both of UAMS, proved to be invaluable in the actual content and creation of the curriculum. Without their expertise and efforts, not only would this manual have been significantly delayed, the quality would have suffered greatly.~~

~~This Alzheimer's/Dementia curriculum was developed to encompass provisions set forth in Act 1184 of 2005 and will be incorporated into the Arkansas' Office of Long Term Care regulations for Nursing Assistant Training Curriculum. The committee developing the Barbara Broyles Alzheimer's and Dementia Curriculum included the following persons:~~

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~~Lois Bluhm~~	~~RN~~ ~~Arkansas Nursing and Rehabilitation Centers~~
~~Donna Childress~~	~~Director of Member Services,~~ ~~Arkansas Health Care Association~~
~~Carol Compas~~	~~RN, Project Manager, Office of Projects and Analysis~~ ~~Arkansas Foundation for Medical Care~~
~~Renee Davison~~	~~RN~~ ~~Office of Long Term Care~~
~~Carla Downs~~	~~CNA~~ ~~Cabot Nursing and Rehabilitation Center~~
~~Marilou Luth~~	~~RN, Linrock Management~~ ~~President, Arkansas Health Care Foundation~~
~~Kerri Marsh~~	~~Administrative Director~~ ~~Arkansas Health Care Foundation~~
~~Sheila Martin~~	~~RN~~ ~~Cabot Nursing and Rehabilitation Center~~
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~~Peggy Moody~~	~~RN~~ ~~The Catlett Corporation~~
~~Pam Murphy~~	~~RN~~ ~~Pocahontas Nursing and Rehabilitation~~

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~~Donna Rodman~~	~~RN~~ ~~Cooper Management Corporation~~
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~~Elaine Townsley~~	~~RN, C, MSN, MBA, Director of Quality Services~~ ~~ConvaCare Management, Inc.~~
~~Virginia Volmer~~	~~RN, PhD~~ ~~Retired Nurse Volunteer~~
~~Jennifer Wilson~~	~~CNA~~ ~~Cabot Nursing and Rehabilitation Center~~
~~Tommy Wingard~~	~~Program Administrator~~ ~~Office of Long Term Care~~
~~Randy Wyatt~~	~~Executive Vice President~~ ~~Arkansas Health Care Association~~

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Arkansas Department of Health and Human Services
Office of Long Term Care

Barbara Broyles Alzheimer's and Dementia Training Program

Objective: The Trainee shall understand: Alzheimer's disease and dementia terminology, signs of disease progression, care at specific stages; demonstrate

communication skills; discuss principles of nutrition and hydration as related to Alzheimer's disease; discuss common behaviors and interventions associated with Alzheimer's and dementia; and discuss burnout and burnout prevention.

Required Videos: Bathing Without a Battle; Look at Me
Required: Documentation of completion of Bathing Without a Battle

1.0 Introduction to Dementia and Alzheimer's disease

Key Terms

Cognition:	The ability to think quickly and logically
Confusion:	The inability to think clearly, causing disorientation and trouble focusing
Delirium:	A state of severe confusion that is reversible and occurs suddenly
Dementia:	A usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and inability to plan and initiate complex behavior
Irreversible:	A disease or condition that cannot be cured
Onset:	The time when signs and symptoms of a disease begins
Progressive:	The way a disease advances

1.1 Alzheimer's disease (AD) is a progressive disease that is characterized by a gradual decline in memory, thinking and physical ability. The decline occurs over several years.

1.2 Average life span following the diagnosis of Alzheimer's disease is eight (8) years, but survival may be anywhere from three (3) to twenty (20) years.

1.3 Because Alzheimer's disease is progressive, it is broken down into three stages: Early (Mild), Middle (Moderate) and Late (Severe).

a. Symptoms of the early stage include the following:

1. Memory loss begins to affect everyday activities

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2. Difficulty remembering names of people, places or objects
3. Difficulty following directions
4. Disoriented to time and place
5. Increased moodiness, agitation or personality changes due to forgetfulness or embarrassment
6. Has poor judgment and makes bad decisions
7. Develops difficulty maintaining living spaces, paying bills and managing money

b. Symptoms of the middle stage, which is the longest of the three stages, include the following:

1. Increased restlessness during the evening hours (sundowning)
2. Increased level of memory loss; starts losing the ability to recognize family members
3. Requires assistance with activities of daily living
4. Increased problems with communication, ambulation and impulse control
5. Increased behavioral issues; may become violent at times
6. Urinary and fecal incontinence
7. May experience auditory or visual hallucinations and become suspicious of caregivers
8. Finally requires full-time supervision

c. The late stage is considered the terminal stage. Symptoms include:

1. Loses ability to verbalize needs; may groan, grunt or scream
2. Does not recognize self or family members
3. Becomes bed-bound
4. Total dependence for activities of daily living
5. Body function gradually declines
6. Death

1.4 Delirium and Dementia are often confused. Delirium is usually triggered by a rapid onset (acute) of illness or change in physical condition that is life threatening if not recognized and treated. Dementia is usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and inability to plan and initiate complex behavior

1.5 Signs and symptoms of acute delirium are:

a. Rapid decline in cognitive function
b. Disorientation to place and time
c. Decreased attention span
d. Poor short-term memory and immediate recall
e. Poor judgment
f. Restlessness
g. Altered level of consciousness
h. Suspiciousness
i. Hallucinations and delusions

Notify the Charge Nurse immediately of any resident that begins to exhibit the above symptoms or behaviors and stay with the resident. Delirium is a medical emergency.

2.0 Maintenance of Respect, Dignity and Quality of Life

Key Terms

Dignity: Respect and honor
Independence: Ability to make decisions that are consistent, reasonable and organized; having the ability to perform activities of daily living without assistance
Quality of life: Overall enjoyment of life
Respect: Treated with honor, show of appreciation and consideration

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2.1 Every human being is unique and valuable. Therefore, each person deserves understanding and respect. Dementia does not eliminate this basic human need. Person-centered care maintains and supports the person regardless of his/her level of dementia.

2.2 Residents' abilities, interests, and preferences should be considered when planning activities and care. As the disease progresses, adjustments will be required in order to maintain dignity.

2.3 It is important for staff to know who the resident was before the dementia started. An individual's personality is created by their background, including:

a. Ethnic group membership
1. Race
2. Nationality
3. Religion
b. Cultural or social practices
c. Environmental influences such as where and how they were raised as children
d. Career choices
e. Family life
f. Hobbies

2.4 Encourage residents to participate in activities and daily care, but avoid situations where the resident is bound to fail. Humiliation is disrespectful, degrading, and can increase the likelihood of disruptive behaviors.

2.5 To promote independence do things with the resident rather than for them.

2.6 Allow time for the residents to express feelings, and take time to understand what they are feeling. Provide emotional support.

2.7 Long term care facilities must provide care for residents in a manner and an environment that promotes the maintenance or enhancement of each resident's dignity, respect, and quality of life.

2.8 Dignity means that during interactions with residents, Nursing Assistants and other staff assist the resident to maintain and enhance self-esteem and self-worth. By:

a. Respecting the resident's social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with a name of the resident's choice, not excluding residents from conversations or discussing residents in a community setting);
b. Focusing on residents as individuals when staff converse with them and addressing residents as individuals when providing care and services.
c. Grooming residents based on their wishes (e.g., hair combed and styled, beards shaved or trimmed, nails clean and clipped);
d. Assisting residents to dress in their own clothes appropriate to the time of day and individual preference;
e. Assisting residents to attend activities of their own choosing;
f. Promoting resident independence and dignity in dining (such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware; use of napkins instead of bibs; dining room conducive to pleasant dining); and
g. Respecting the resident's private space and property (e.g., not changing radio or television station without the resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting the resident's personal possessions without permission)

3.0 Communication

Key Terms

Communication: Giving or exchanging information with words, body language or writing

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3.1 Residents that are victims of Alzheimer's disease often experience problems in making their wishes known and in understanding spoken words. Communication becomes harder as time goes by.

3.2 Changes that are commonly seen in the Alzheimer's resident include:

a. Inability to recognize a word, phrase

b. Inability to name objects
c. Using a general term instead of specific word
d. Getting stuck on ideas or words and repeating them over and over
e. Easily losing a train of thought
f. Using inappropriate, silly, rude, insulting or disrespectful language during conversation
g. Increasingly poor written word comprehension
h. Gradual loss of writing ability
i. Combining languages or return to native language
j. Decreasing level of speech and use of select words, which may also cause the use of nonsense syllables
k. Reliance on gestures rather than speech

3.3 There are several components when assisting the resident with communication. These components are:

a. Patience with the resident.
b. Show your interest in the subject.
c. Offer comfort and reassurance.
d. Listen for a response.
e. Avoid criticizing or correcting.
f. Avoid arguments with the resident.
g. Offer a guess as to what the resident wants.
h. Focus on the feelings, not on the truth.
i. Limit distractions.
j. Encourage non-verbal communication.

3.4 The Nursing Assistant's method of communicating with the Alzheimer's resident is as critical as the actual communication. Utilizing the following techniques will decrease frustration for both the resident and the Nursing Assistant.

a. Obtain the resident's attention before speaking and maintain his or her attention while speaking.
b. Address the resident by name, approach slowly from the front or side and get on the same level or height as the resident.
c. Set a good tone. Use a calm, gentle, low-pitched tone of voice.
d. If the conversation is interrupted or the Nursing Assistant or resident leaves the room, start over from the beginning.
e. Slow down, do not act rushed or impatient. If the information needs to be repeated, do so using the same words and phrases as before.
f. Speak clearly and distinctly using short, familiar words and short sentences, and avoiding long explanations.
g. Emphasize key words, break tasks and instructions into clear and simple steps, offer one step at a time; and provide the resident time and encouragement to process and respond to requests.

h. Use nonverbal cues, such as touching, pointing or starting the task for the resident. If the resident's speech is not understandable, encourage him/her to point out what is wanted or needed.

3.5 Communication strategies to use when communicating with residents that have dementia include:

a. Listen carefully and encourage them; do not talk down to them, nor talk to others about them as if they were not present.

b. Minimize distractions and noise.

c. Allow enough time for the resident to process and respond; if they have difficulty explaining something, ask them to explain in a different way.

d. Monitor your body language to ensure a non-threatening posture and maintain eye contact. Nonverbal communication is very important to dementia residents.

e. Choose simple words and short sentences, and use a calm tone of voice. Call the person by name, and make sure you have their attention before speaking.

f. Keep choices to a minimum in order to reduce the resident's frustration and confusion.

g. Include residents in conversations with others.

h. Do not make flat contradictions to statements that are not true.

i. Change the way responses are made to avoid confusion, frustration, embarrassment, and behavioral outbursts.

j. Use of communication devices (such as a picture board, books, or pictures) encourages the resident's independence and decreases frustration.

3.6 Communication tips to use when caring for the resident with Alzheimer's disease:

a. Be calm and supportive.

b. Focus on feelings, not facts.

c. Pay attention to tone of voice.

d. Identify yourself and address the resident by name.

e. Speak slowly and clearly.

f. Use short, simple and familiar words, and short sentences.

g. Ask one question at a time.

h. Allow enough time for a response.

i. Avoid the use of pronouns (e.g., he, she, they), negative statements and quizzing.

j. Use nonverbal communication such as pointing and touching.

k. Offer assistance as needed.

l. Have patience, flexibility, and understanding.

4.0 Behavior Issues

Key Terms

~~Behavior: How a person acts~~
~~Catastrophic reaction: An extreme response~~
~~Delusion: A false belief~~
~~Depression: A loss of interest in usual activities~~
~~Paranoia: An extreme or unusual fear~~
~~Sundowning: Increased agitation, confusion and hyperactivity that begins in the late afternoon and builds throughout the evening~~
~~Trigger: An event that causes other events~~
~~Wandering: Moving about the facility with no purpose and is usually unaware of safety~~

~~4.1 Alzheimer's disease progresses in stages, and likewise, so does the behavior. Behavioral responses that may be associated with each stage include, but are not limited too:~~

~~a. Early stage~~

~~1. Depression~~
~~2. Anxiety~~
~~3. Irritability~~

~~b. Middle stage~~

~~1. Wandering~~
~~2. Agitation~~
~~3. Sleep disturbances~~
~~4. Restlessness~~
~~5. Delusions~~
~~6. Hallucinations~~
~~7. General emotional distress~~

~~c. Late stage~~

~~1. Verbal or physical aggression~~
~~2. Agitation~~
~~3. Gradual behavioral decline as the disease progresses to death~~

~~4.2 Behavior is an observable, recordable, and measurable physical activity. People with normal brain function have the ability to control their responses. People with Alzheimer's disease and dementia have lost much of this ability.~~

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4.3 Behavior is a response to a need. The resident is frequently unable to express his or her needs because of the cognitive losses. Nursing Assistants must be attentive to gestures and clues demonstrated by the resident.

4.4 Every behavior is a response to a need or situation. Gestures, sounds, and conversation may reveal the trigger to the behavior. As verbal skills diminish, behavior becomes the communication method.

4.5 Before choosing a specific behavioral intervention, the trigger of the behavior must be identified. Triggers may be environmental, physical, or emotional.

a. Environmental triggers may include:

1. Rearrangement of furniture
2. Increased number of people in the facility
3. Change in the daily schedule

b. Physical triggers may include:

1. New medications
2. Infections
3. Pain

c. Emotional triggers may include:

1. Reactions to loss
2. Depression
3. Frustration
4. Self-perception
5. Past life events
6. Personality

4.6 Effective behavior management includes the following:

a. Identifying of the trigger
b.Understanding the trigger
c. Adapting the environment to resolve the behavior

Changing the environment (such as reducing excessive noise and activity) or providing comfort measures (such as rest or pain medication) may reduce the behavior. The intervention must meet the needs of the resident while maintaining respect, dignity and independence.

4.7 Successful behavioral interventions preserve the resident's dignity and helps staff gain confidence, improve morale, and increase job satisfaction. Behavior control also assists in reducing the use of restraints, decreases abuse and neglect, and increases family satisfaction.

4.8 Common behaviors:

a. Wandering
b. Sundowning
c. Depression
d. Disorientation to person, place, and/or time
e. Inappropriate sexual behavior
f. Emotional outbursts
g. Combativeness (hostility or tendency to fight)
h. Inappropriate toileting (use of inappropriate areas for toileting, such as a plant)
i. Easy frustration
j. Repetitive speech or actions
k. Swearing, insulting, or tactless speech
l. Shadowing (following others)
m. Withdrawal
n. Hoarding (hiding objects or food)
o. Sleep disturbances
p. Paranoia and suspiciousness
q. Delusions and/or hallucinations
r. Decreased awareness of personal safety
s. Catastrophic reactions (extreme emotional responses such as yelling, crying, or striking out that seem out of proportion to the actual event)

4.9 Wandering is a known and persistent problem behavior that has a high risk factor for resident safety. Safety risk factors may include:

a. Falls
b. Elopement
c. Risk of physical attack by other residents who may feel threatened or irritated by the activity

4.10 Residents wander for several reasons and may include:

a. Trying to fulfill a past duty, such as going to work
b. Feeling restless
c. Experiencing difficulty locating their room, bathroom or dining room
d. Reacting to a new or changed environment

4.11 Preservation of resident safety is the main objective when caring for the wandering resident. Interventions:

a. Establish a regular route.
b. Provide rest areas.
c. Accompany the resident.
d. Provide food and fluid.
e. Redirect attention to other activities or objects.
f. Determine if behavior is due to environmental stress.

4.12 Sundowning is a behavioral symptom of dementia that refers to increased agitation, confusion, and hyperactivity that begins in the late afternoon and builds throughout the evening. Interventions:

a. Encourage rest times.
b. Plan the bulk of activities for the morning hours.
c. Perform quieter, less energetic activities during the afternoon.

4.13 Inappropriate sexual activity is another behavior issue. Offensive or inappropriate language, public exposure, offensive and/or misunderstood gestures are the characteristics of this behavior. Interventions:

a. Treat the resident with dignity and respect.
b. Remove the resident from the public situation.
c. Redirect attention to an appropriate activity.
d. Assist the resident to the bathroom.

4.14 Agitation occurs for a variety of reasons. Nursing Assistants must ensure the safety and dignity of the agitated resident while protecting the safety and dignity of the other residents. Interventions:

a. Do not crowd the resident; allow them room to move around while still providing for safety.
b. Ask permission to approach or touch them.
c. Maintain a normal, calm voice.
d. Slow down, do not rush the resident.
e. Limit stimulation in the resident's area.
f. Avoid confrontations and force.
g. Avoid sudden movements outside of the resident's field of vision.

4.15 Disruptive verbal outbursts are one of the most persistent behaviors in a long-term care facility. These outbursts may include:

a. Screaming
b. Swearing
c. Crying
d. Shouting
e. Loud requests for attention

f. Negative remarks to other residents or staff (including racial slurs)
g. Talking to self

4.16 Anger and aggression are often the visible symptoms of anxiety and fear. Interventions:

a. Reassure the resident that they are safe
b. Redirect their attention to an activity
c. Assist the resident with toileting, feeding or fluids
d. Move the resident to a quiet area

Notify the Charge Nurse immediately of aggressive behaviors that may threaten other residents and/or staff and stay with the resident.

4.17 Emotional, environmental, or physical triggers may result in a catastrophic reaction. Warning signs of a possible reaction may include:

a. Sudden mood changes
b. Sudden, uncontrolled crying
c. Increased agitation
d. Increased restlessness
e. Outburst of anger (physical or verbal)

4.18 Catastrophic reactions are out-of-proportion responses to activities or situations. Interventions:

a. Speak softly and gently in a calm voice
b. Protect the resident, yourself, and others as necessary
c. Remove the person from a stressful situation
d. Avoid arguing with the resident
e. Avoid the use of restraints
f. Redirect the resident's attention
g. Change activities if the activity is causing the reaction

4.19 Interventions that should not be used include the following:

a. Arguing with the resident or other staff members
b. Speaking loudly to the resident or other staff members
c. Treating the resident like a child
d. Asking complicated questions
e. Using force or commanding the resident to do something

4.20 The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms (CMS F221; F222).

4.21 Restraints are protective measures to prevent injury, not to limit a resident's mobility for staff convenience. Examples of restraints include:

a. Physical: any item, object, device, garment, or material that limits or restricts a person's freedom of movement or access to their body.

1. Leg restraints;
2. Arm restraints;
3. Hand mitts;
4. Soft ties or vests;
5. Lap cushions;
6. Lap trays the resident cannot remove easily;
7. Side rails that keep a resident from getting out of bed on their own;
8. Tucking in or using Velcro® to hold a sheet, fabric or clothing tightly so that a resident's movement is restricted;
9. Using trays, tables, bars or belts with a chair that the resident cannot easily remove or prevents the resident from rising; or
10. Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or getting out of the bed on their own.

b. Chemical: any drug that is used for discipline or convenience and not required to treat medical symptoms.

4.22 Nursing Assistants DO NOT make the decision of whether or not a restraint is used and are only used as a last resort option.

4.23 Restraints require a physician's order and frequent monitoring. Restraints must be checked every 30 minutes and released according to the care plan, but not to go beyond every 2 hours, for exercise, toileting, positioning, and hydration.

4.24 Caregiver behaviors that should be encouraged and used to decrease or prevent the use of restraints may include:

1. Maintaining a calm and non-controlling attitude.
2. Speaking softly and calmly.
3. Asking one question at a time and waiting patiently on the answer.
4. Using simple, one-step commands, and positive phrases.
5. Avoiding crowding the resident with more people than needed for the task.
6. Providing a distraction such as an activity or music.

5.0 Activities

5.1 The goal in the care of residents with Alzheimer's disease is to give the support needed so that they can participate in the world around them to the best of their ability.

5.2 The Nursing Assistant must focus on the fact that the resident is involved and satisfied, not on the task or activity.

5.3 Activities fall into two categories - "doing" activities and "meaningful" activities. Doing activities keep the person busy and meaningful activities have value to the resident with dementia.

5.4 Activity-based care is care that is focused on assisting the resident to find meaning in their days rather than doing activities just to keep the person busy.

5.5 Principles of activity-based care are:

a. Focuses on giving caregivers the tools to create chances for residents with dementia to be successful in activities and their relations with other people.
b. Uses any daily activity that can be broken down into individual, sequential steps.
c. Works within the remaining abilities or strengths of the resident with Alzheimer's disease, helping to shift emphasis away from the resident's disabilities and impairments.
d. Adjusts an activity based on the resident's ability level.
e. Depends on the caregiver's interest and desire to create opportunities for successful interactions that are planned and guided to encourage the resident's full involvement.
f. Rewards the resident's attempts at participating in activities and provides them with a sense of being capable and alive.

5.6 Timing of activities is important and individualized. Attention/focus activities, physical activities and sensory activities that are provided during each resident's prime time and on a set, routine basis may increase participation and satisfaction with that activity.

5.7 Cultural environment refers to the values and beliefs of the people in an area. Staff, residents, families, visitors and volunteers determine the culture of the facility. Promotion of a positive environment begins with inclusion of the residents and making them feel important to the relationships and activities going on.

6.0 Nutrition

6.1 Residents with Alzheimer's disease may have specialized nutritional needs based on their cognitive and physical status.

6.2 Dementia may lead to decreases in food and fluid intake because:

a. Does not realize hunger or thirst
b. Reduced sense of smell and taste
c. Difficulty swallowing
d. Does not recognize eating utensils
e. Cannot feed self
f. Loses coordination
g. Depression
h. Restless and unable to remain seated during meals

6.3 Water is not the only fluid available to residents. Some residents may not like water and should be offered alternative fluids. Alternative fluids include, but are not limited to:

a. Milk
b. Juices
c. Decaffeinated drinks (tea, coffee, soft drinks)
d. Popsicles
e. Ice cream
f. Gelatins
g. Fruit
h. Soups
i. Broths

6.4 Mealtime is just not a time to eat, but is also a social activity. Providing meals in an environment that encourages and enhances the eating process is beneficial to all residents. Residents that are easily distracted during meals should not be isolated from the rest of the residents; however, they may eat better in a quieter part of the dining room.

6.5 Observe residents for the following warning signs to minimize mealtime difficulties:

a. Change or difficulty in swallowing or chewing
b. Poor utensil use
c. Refuses food and drinks

The Nursing Assistant must report the change and the circumstances surrounding the change to the Charge Nurse immediately.

6.6 Types of assistance may include:

a. Setting up the meal tray
b. Opening containers
c. Verbal cuing or prompting to encourage self-feeding

d. Physical cuing involving hand-on-hand assistance
e. Total feeding

6.7 The resident with Alzheimer's sometimes has little awareness of food in their mouth. To remind the resident to chew, the Nursing Assistant may gently move the resident's chin or touch the tongue with a fork or spoon. To stimulate swallowing, gently stroke the resident's throat.

6.8 Nursing Assistants who are assisting the resident with eating should sit at the resident's level, make eye contact, and talk with the resident during the meal.

6.9 Consistency in meal times, seating arrangements and times will assist in promotion of the resident's independence and may decrease behavioral issues during meal service.

7.0 Staff Stress and Burnout

7.1 Providing care on a daily basis for the resident with Alzheimer's or dementia is extremely stressful. This population may be more prone than others in a facility to becoming victims of abuse or neglect. Because of this, staff that deals with Alzheimer's or dementia residents must take additional precautions to ensure that they do not over-react or react negatively to resident behaviors.

7.2 Regardless of the cause, staff must take the necessary steps to ensure that they do not react inappropriately to resident behaviors. Frustration can lead to:

a. Negative, harsh or mean-spirited statements made to staff or residents
b. Physical abuse of residents
c. Emotional abuse of residents
d. Verbal abuse of residents
e. Neglect of residents

7.3 Staff must always remember that the statements and behaviors of residents suffering from Alzheimer's or dementia are beyond the control of the resident and not personally directed toward staff.

7.4 The usual profile of the employee who is subject to burnout is:

b. Takes work personally and seriously
c. Works over at the end of a shift
d. Works extra shifts
e. Takes on extra projects
f. Very high or unrealistic expectations
g. Perfectionist attitude

7.5 Signs of staff burnout include, but are not limited to, the following:

a. No longer enjoying the work
b. Irritability with residents and co-workers
c. Fear of failure, inadequacy, job loss and obligation to supervisor, coworkers, family, et cetera
d. Feelings of being overwhelmed
e. Viewing work as a chore
f. Frequent complaints of illness

7.6 Strategies to use to assist in preventing burnout include:

a. Maintain good physical and mental health.
b. Get adequate amounts of sleep on off days and before each shift.
c. Remain active within your family and community.
d. Maintain a separation between work and personal relationships.
e. Maintain a sense of humor.

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APPENDIX

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SKILLS PROCEDURES

Difficulty Level I

1. Assisting the Resident with a Urinal:
a. Assemble your equipment: Urinal and cover, soap, towels, disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Ask the resident if he wishes to use the urinal.
f. Give the resident the urinal. If the resident is unable to put the urinal in place, put his penis into the opening as far as it goes. If the resident is unable to hold it in place, you will have to do so. (Wear gloves for these last two steps.) Raise the head of the bed if the resident prefers.
g. Ask the resident to signal when he is finished. Leave the room (if appropriate) to give the resident privacy. Wash your hands.
h. Return when the resident signals.
i. Put on gloves (if not already done).
j. Take the urinal. Be careful not to spill it. Cover it and take it to the resident's bathroom (or hopper room).
k. Check the urine for color, odor, and amount.
l. Measure the urine if necessary or collect specimen if necessary.
m. Rinse the urinal with cold water. Clean it per facility policy and return it to its proper place
n. Remove and dispose of gloves.
o. Wash your hands.
p. Return to the resident. Help him wash his hands in a basin of water or wet washcloth.
q. Make the resident comfortable. Place call bell within reach.
r. Make a notation on the resident's chart that he has used the urinal. Also note anything you have observed about the resident during this procedure.

2. Measuring and Recording of Fluid Intake:
a. Assemble your equipment: I&O record at bedside, pen, graduated pitcher.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Ask the resident to help by recording the amount of fluid taken by mouth (if appropriate).
e. Record intake on the I&O record at bedside. Intake includes:
- amount of liquid resident takes with meals (this includes anything liquid at room temperature such as ice cream or jello).
- amount of water and other liquids taken between meals.
- all other intake including fluids given by mouth, intravenously, or by tube feeding. How it is taken should also be recorded.
f. Record intake after each meal before the tray is removed.

SKILLS PROCEDURES

g. Record other intake as it is consumed.
h. Convert amounts to cubic centimeters (cc).
i. Record information on resident's chart per facility policy.

3. Measuring and Recording of Urinary Output:
a. Assemble your equipment: bedpan, cover and urinal or container for urine, measuring container, pad and pencil, gloves.
b. Wash your hands and put on gloves.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Pour the urine from the bedpan or urinal into the measuring container.
f. Place the measuring container on a flat surface for accuracy in measurement.
g. At eye level, carefully look at the container to see the number reached by the level of urine – remember it.
h. Rinse and return the measuring cup to its proper place. Pour the urine and rinse water into the toilet.
i. Rinse and return the urinal or bedpan to its proper place. Pour the rinse water into the toilet.
j. Remove and dispose of gloves.
k. Wash your hands.
l. Record the amount of urine in "cc" and the character of the urine on the output side of the I&O sheet.

4. Measuring Height and Weight:
a. Assemble your equipment: scale with height rod, pad, and pencil.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Encourage resident to urinate before measuring weight.
f. Cover the platform scale with a paper towel.
g. Raise the height measurement rod.
h. Assist the resident to remove slippers and robe if appropriate.
i. Slide the balance printer on the scale until it balances on the dial.
j. Accurately record the resident's name and weight on the pad.
k. Assist the resident to stand as straight as possible being sensitive to his/her safety.
l. Lower the rod that measures height.
m. Assist the resident to safely step off the scales or move away from the weighing device.
n. Accurately record the resident's height on the pad.
o. Assist the resident to put on robe and slippers if appropriate.
p. Assist the resident back to his/her room. Make resident comfortable. Place call bell within reach.
q. Return scales and equipment to proper storage area.
r. Wash hands.

5. Taking Axillary Temperature:
a. Assemble your equipment: oral thermometer, tissue or paper towel, pad and pencil, and watch.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Remove the thermometer from its case and shake down the mercury so that it is below the numbers and lines.
f. Inspect the thermometer for cracks and chips. Do not use if you see any flaws.
g. Remove the resident's arm from the sleeve. If the axillary region is moist with perspiration, pat it dry with a towel.
h. Place the bulb of the oral thermometer in the center of the armpit in an upright position.
i. Put the resident's arm across his/her chest or abdomen.
If the resident is unconscious or too weak to help, you will have to hold the arm in place.
j. Leave the thermometer in place 10 minutes. Stay with the resident.
k. Remove the thermometer. Read the thermometer and record temperature.
l. Clean the thermometer according to facility policy and procedure and return it to the container.
m. Make resident comfortable. Place call bell within reach.
n. Wash your hands.

6. Taking Radial Pulse:
a. Assemble your equipment: watch with a second hand, pad and pencil.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Have the resident in a sitting or lying position.
e. The resident's hand and arm should be well supported and resting comfortably.
f. Find the pulse by putting the first three fingers of your right hand on the radial artery and press very gently against the artery until the pulse is felt (never use your thumb to take the pulse because it has a pulse beat and you would be counting your own pulse).
g. While looking at the second hand of your watch, keep your fingers gently on the pulse and count the number of beats per minute.
h. Record the pulse rate, rhythm and force immediately.
i. Make the resident comfortable. Place call bell within reach.
j. Wash your hands.

7. Taking Respiration:
a. Assemble your equipment: watch with a second hand, pad and pencil.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Place the resident's arm across his/her chest while holding the wrist. You can feel their breathing.
e. Look at the second hand on your watch.

f. As the resident's chest rises (when they breath in) count one.
g. Count the next time the chest rises.
h. Continue to do this for one full minute.
i. While counting the respirations, observe the characteristics of the resident's breathing.
j. Record your findings immediately.
k. Make the resident comfortable. Place call bell within reach.
l. Wash you hands.

8. Meal Service – Serving a Tray:
a. Wash your hands.
b. Obtain food tray and check for diet card. Diet card must accompany the tray to the resident.
c. Check the diet card to ensure the right food for the right resident.
d. Observe the food content of the tray. Is the food correct? Presentable?
e. Check the tray for necessary items: self help devices, napkin, condiments, and fluids.
f. Adjust the tray for comfort to the resident (height and availability).
g. Assist in the preparation of the food as needed.
h. Encourage and assist the resident as needed. Always encourage independence.
i. Remove the tray when resident has finished.
j. Note and record the food eaten or not eaten. Record fluids on intake record, if required. k. Wash your hands.

9. Handwashing:
a. Assemble your equipment: soap, paper towels, and waste can.
b. Turn on the faucet with a paper towel held between the hand and the faucet. Drop the paper towel into the waste can.
c. Wet hands with fingertips pointed downward.
d. Apply skin cleanser or soap to hands.
e. Hold your hands downward and lower than your elbows while washing.
f. Rub hands together vigorously for at lest 10 seconds.
g. Work up a good lather. Spread it over the entire area of your hands and wrist (two inches above the wrist). Get soap under your nails and between your fingers. Add water while washing.
h. Rinse thoroughly from wrist to fingertips, keeping fingertips down.
i. Dry hands thoroughly with a paper towel.
j. Use a paper towel to turn off the faucet.
k. Discard the paper towel into the waste can.
l. Do not touch the waste can.
m. Do not touch the inside of the sink with clean hands.
n. Do not lean against the sink or splatter uniform.

SKILLS PROCEDURES

Difficulty Level II

10. Application of Protective Restraints:

a. Check to be sure the application of the restraint has been ordered by a physician.

b. Assemble the equipment.

c. Identify the resident and explain what you plan to do. Display a positive, gentle attitude. Use terms that stress the protective nature of the restraint, such as "safety belt" and "postural support".

d. Restrain the resident only in beds or chairs with wheels.

e. Tie the restraint under the chair out of reach of the resident or to the bed frame. Never tie the restraint to side rails or part of the bed that would cause tightening when the positioning of the bed is changed. Do not use a slip knot to secure ties.

f. Check the resident for proper positioning (properly aligned and comfortable).

g. Make sure the restraint is not too tight. The resident should have some movement allowed with the restraint on.

h. Make sure the resident is protected from pressure caused by knots, wrinkles or buckles. Pad areas under restraint to prevent friction.

i. Make sure that water and call bell are within reach.

j. If possible, place the restrained resident in an area where they can be closely observed.

k. Check the resident frequently. Check every thirty (30) minutes making sure to check for restricted circulation. Release every two (2) hours for at least ten (10) minutes for exercise, range of motion and to use the bathroom.

l. Report and chart per facility policy.

11. Collecting a Routine Fecal (Stool) Specimen:

a. Assemble your equipment: bedpan and cover, stool container, label, wooden tongue depressor, tissue, washcloth and towel for resident, and disposable gloves.

b. Make out label including: resident's full name, room number, date and time of specimen (fill in time when actual specimen has been collected), and other information as requested. Put label on container.

c. Wash your hands.

d. Identify the resident and explain what you plan to do. Ask the resident to call you when he/she feels the need to move the bowels.

e. Provide for privacy.

f. Put on gloves.

g. Follow the procedure for giving and receiving the bedpan. If the resident is unable to use the bedpan, place several layers of toilet tissue in the bottom of the toilet and have the resident move their bowels on the paper.

h. Ask the resident not to urinate into the bedpan and not to put toilet tissue into the bedpan. Provide a plastic or paper bag to temporarily dispose of the tissue and discard in the toilet.

i. After the resident has had a bowel movement, take the bedpan into the bathroom (or hopper room).

SKILLS PROCEDURES

j. Using the wooden tongue depressor, take 1-2 tablespoons of stool from the bedpan and place it into the stool specimen container.
k. Cover the container. Do not touch the inside or top of the container.
l. Wrap the depressor in a piece of toilet tissue and discard it into a plastic or paper bag.
m. Empty the remaining feces (stool) into the toilet.
n. Clean the bedpan and return it to its proper place.
o. Remove and dispose of gloves.
p. Wash your hands.
q. Offer the resident a washcloth and towel for his/her hands. Assist as necessary. Make the resident comfortable. Place call bell within reach.
r. Make a notation on the resident's chart that you have collected the specimen, the time and anything that you observed during the procedure.
s. Store the specimen in the correct place until it is take to the laboratory.

12. Collecting a Route Urine Specimen:
a. Assemble your equipment: bedpan or urinal, measuring container, urine specimen container and lid, paper or plastic bag, tissue, label, wet washcloth and towel and disposable gloves.
b. Make out label including: resident's full name, room number, type of specimen, date and time, and other information as requested. Put label on container.
c. Wash your hands.
d. Put on gloves.
e. Identify the resident and explain what you plan to do.
f. Provide for privacy.
g. Explain the procedure. Some residents may be able to collect the specimen themselves and should be allowed to do so. If the resident is able, he can urinate directly into the container. If not, ask the resident to urinate into the clean bedpan or urinal. Remind the resident not o put toilet tissue into the bedpan or urinal and to use the paper bag provided. You will discard the tissue into the toilet.
h. Take the bedpan or urinal into the bathroom (or hopper room).
i. If the resident is on I&O, pour the urine into a clean measuring container and note the amount of urine on the I&O chart.
j. Pour the urine into the specimen container and fill it ¾ full.
k. Put the lid on the container and wipe off the outside of the container.
l. Pour the remaining in the bedpan, urinal or measuring container into the toilet.
m. Clean and rinse the bedpan, urinal and measuring container. Put them in their proper place.
n. Remove and dispose of gloves.
o. Wash your hands.

p. Offer the resident a washcloth and towel to wash his/her hands. Assist as necessary. Make the resident comfortable. Place call bell within reach.

q. Make a notation on the resident's chart that you collected the specimen, the time and anything you observed about the resident during this procedure.
r. Store the specimen in the correct place until it is take to the laboratory.

13. Use of Wheelchair/Geriatric Chair:
a. The resident shall be covered to protect from chilling. Blankets shall be kept away from the wheels. Tuck the blanket firmly around the resident.
b. The wheelchair or gerichair shall be wiped off with a disinfectant after each use, if it is to be used by others.
c. Push the wheelchair or gerichair from behind except when going in and out of elevators. Pull the wheelchair or gerichair into and out of the elevator.
d. If moving a resident down a ramp, take the wheelchair or gerichair down backwards. Glance over your shoulder to be sure of your direction and to prevent collisions and falls.
e. Set the brakes when: assisting a resident into a wheelchair or gerichair, assisting a resident out of a wheelchair or gerichair, when the wheelchair or gerichair is to remain stationary.
f. Put footrests up when assisting resident in and out of wheelchairs or gerichairs.
g. Have the resident's feet on the foot rests when moving to prevent injury. Never push the wheelchair if the footrests are in an up position.
h. If safety straps are needed, they shall be fastened correctly. Observe the resident's feet, elbows and hands when turning or going down corridors.
i. Pay attention where you are going and push chair slowly.
j. Slow down at corners and look before moving the wheelchair or gerichair to prevent collisions with other residents, staff, etc.

14. Moving a Resident in Bed from Side to Side:
a. Wash your hands.
b. Identify the resident and explain what you plan to do.
c. Provide for privacy.
d. Lock the wheels of the bed.
e. Raise the whole bed to the highest position best for you.
f. Lower the backrest and footrest, if this is allowed.
g. Put the side rail in the up position on the far side of the bed.

h. Loosen the top sheets but do not expose the resident.
i. Place your feet in a good position – one in close to the bed – one back. Slide both of your arms under the resident's back to his far shoulder and then slide the resident's shoulders toward you by rocking your weight to your back foot.
j. Keep your knees bent and your back straight as you slide the resident.
k. Slide both your arms as far as you can under the resident's buttocks and slide his/her buttocks toward you in the same way. Use a pull (turning) sheet whenever possible for helpless residents.
l. Place both your arms under the resident's feet and slide them toward you.

m. Replace and adjust the pillow, if necessary.
n. Remake the top of the bed.
o. Make the resident comfortable. Lower the bed to its lowest horizontal position. Place call bell within reach.
p. Record/report completion of procedure and note any observations made about the resident.

15. Oral Hygiene for the Conscious Resident:
a. Assemble your equipment: soft bristle toothbrush, toothpaste, paper cup filled with cool water, mouthwash (if desired), dental floss, emesis basin and towel (if resident is unable to go to the bathroom or sink), and disposable gloves.
b. Wash your hands.
c. Put on gloves.
d. Identify the resident and explain what you plan to do.
e. Provide for privacy.
f. Encourage the resident to do as much of his/her own care as possible.
g. Position the resident sitting upright in a chair or in bed. Drape a towel under the chin and chest.
h. Moisten the toothbrush and apply toothpaste.
i. Clean upper teeth and gums.
j. Clean lower teeth and gums.
k. Gently massage the gums by pointing the bristles toward the gums. Alternate brushing side to side and downward motion for upper teeth and upward motion for lower teeth.
l. Offer water for the resident to rinse as is necessary.
m. Provide the emesis basin for the resident to empty his/her mouth as is necessary.
n. Finish by having the resident rinse the mouth thoroughly with plain water (and mouthwash if desired).

o. Clean and replace equipment in the resident's bedside table.
p. Remove and dispose of gloves.
q. Wash your hands.
r. Make resident comfortable. Place call bell within reach.
s. Record that the procedure was completed and note any observations made about the resident.

16. Oral Hygiene for the Resident with Dentures:
a. Assemble your equipment: water, labeled cup, toothbrush, toothpaste, emesis basin or sink, face towel, and disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Place paper towel in sink to protect dentures.
f. Put on gloves.
g. Rinse dentures under cool water.

h. Fill cup with soaking solution and place dentures in cup.
i. Help resident to rinse and clean mouth.
j. Help resident to replace dentures.
k. Leave labeled cup close at hand for resident.
l. Clean your equipment and replace in proper place.
m. Remove and dispose of gloves.
n. Wash your hands.
o. Make resident comfortable. Place call bell within reach.
p. Make a notation that the procedure was completed and note any observations made about the resident.

17. Taking Oral Temperature:
a. Assemble your equipment: clean oral thermometer in case, tissue or paper towel, pad and pencil, and watch.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.

d. Ask the resident if he/she has recently had hot or cold liquids, or if recently smoked. If yes, wait 10 minutes before taking temperature.
e. The resident should be in bed or sitting in a chair. Do not take a temperature while the resident is walking.
f. Take the thermometer out of the container and inspect it for cracks and chips. Do not use if defective.
g. Shake the mercury down until it is below the calibrations.
h. Run the thermometer under cool water. This will make the thermometer more pleasant in the resident's mouth.
i. Ask the resident to lift up their tongue. Place the bulb end of the thermometer under the tongue. Ask the resident to keep their lips gently around the thermometer without biting it.
j. Leave the thermometer in place for at least three (3) minutes. For the most accurate reading, leave the thermometer in place for eight (8) minutes.
k. Stay with the resident.
l. Take the thermometer out of the resident's mouth. Hold the stem end and wipe the thermometer with a tissue from the stem towards the bulb.
m. Read the thermometer.
n. Record the temperature and any observations made about the resident during the procedure.
o. Shake down the mercury.
p. Clean the thermometer. Replace the thermometer in its container. Store according to facility policy and procedure.
q. Wash your hands.
r. Make resident comfortable. Place call bell within reach.

SKILLS PROCEDURES

18. Shaving a Resident:

a. Assemble your equipment: bedside table, basin of very warm water, shaving cream, safety razor, face towel, mirror, tissues, aftershave lotion (optional), face powder (optional), washcloth, and disposable gloves.

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Adjust a light so that it shines on the resident's face but not in his eyes.

f. Raise the bed to a proper height. Raise the head of the bed if possible.

g. Spread the towel under the resident's chin. If the resident has dentures, make sure they are in his mouth.

h. Put on gloves.

i. Apply shave cream to face.

j. Hold skin tight as you shave in the direction the hair grows. Use short firm strokes. Start under the sideburns and work downward over the cheeks. Continue carefully over the chin. Work upward on the neck under the chin.

k. Rinse razor often in water.

l. If you nick the resident's skin, report this to your supervisor.

m. Wash off remaining shaving cream when you have finished.

n. Apply aftershave or powder (optional).

o. Clean equipment and return it to its proper place.

p. Remove and dispose of gloves.

q. Wash your hands.

r. Lower the bed to lowest position. Make the resident comfortable. Place call bell within reach.

s. Record that the procedure was completed and note any observations made about the resident.

19. Fingernail Care:

a. Assemble your equipment: washbasin ¾ full with warm soapy water, hand or bath towel, paper towel, orangesticks, clippers, nail file or emery board, and lotion.

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Assist the resident to a comfortable position in bed or chair and adjust overbed table in front.

f. Soak the fingers in the basin of warm soapy water for at least five (5) minutes.
g. Either soak both hands together or one at a time. Encourage the resident to exercise fingers while soaking.
h. Rinse the hands with warm clean water and dry with hand or bath towel.
i. If soaking one hand at a time, have the resident start soaking the second hand.
j. Gently remove dirt from around and under each fingernail with an orangestick, cleaning dirt from the orangestick on the paper towel.

SKILLS PROCEDURES

k. Trim nails in an oval shape, taking care not to trim below the skin line or cut the skin. Report any cuts to supervisor.
l. Smooth the nails with an emery board or file.
m. Repeat the same procedure for the second hand.
n. Apply lotion (optional).
o. Clean equipment and return to its proper place.
p. Wash your hands.
q. Make resident comfortable. Place call bell within reach.
r. Record/report completion of procedure and note any observations made about the resident.

Difficulty Level III

20. Foot and Toenail Care:
a. Assemble your equipment: washbasin ¾ full with warm soapy water, bath towel and washcloth, paper towel, orangesticks, clippers, bath mat, and lotion.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. If permitted, assist resident out of bed and into chair.
f. Place bath mat on floor in front of resident. Put water basin on mat.
g. Remove slippers and assist resident to put feet in water. Cover with bath towel to help retain heat.
h. Soak feet for at least five (5) minutes.
i. At the end of the soak period, wash feet with washcloth scrubbing roughened areas. Rinse and dry feet and toes thoroughly.

j. Clean around and under the toenails with an orangestick following the same procedure used for cleaning the fingernails.

k. Check with the charge nurse before trimming the resident's toenails. Residents with poor circulation to the feet or diseases such as diabetes will usually have their toenails trimmed by a podiatrist. For residents without these problems, you will need to trim the toenails regularly, using the same equipment as with the fingernails.

l. If trimming is allowed, trim the toenails straight across to prevent the edges from becoming ingrown.

m. Inspect the feet and in between each toe for condition of skin, presence of corns, callouses or other foot problems and circulation. Apply lotion.

n. Assist resident with putting on clean stockings, socks, shoes or slippers.

o. Clean equipment and return to its proper place.

p. Wash your hands.

q. Return resident to bed (if needed) and make comfortable. Place call bell within reach.

r. Record/report completion of procedure and note any observations made about the resident.

SKILLS PROCEDURES

21. Hair Care – Shampoo in Bed:

a. Assemble your equipment: comb and brush, shampoo, conditioner (optional), containers of warm to hot water, chair, pitcher, large basin or pail to collect dirty water, bed protectors, several large bath towels, washcloth, water trough or 1 & ½ yards of 60" wide plastic, cotton balls (optional), bath blankets, water proof pillow (optional), electric blow dryer (optional), and curlers (optional).

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Raise the bed to the highest horizontal position. Lower the headrest and the side rails on the side you are working.

f. Place a chair at the side of the bed near the resident's head. The chair should be lower than the mattress. The back of the chair should be touching the mattress.

g. Place a towel on the chair. Place the large basin or pail on the towel.

h. Replace pillowcase with waterproof covering (optional).

i. Replace to bedding with bath blanket. Fanfold the top sheets to the foot of the bed without exposing the resident.

j. Ask resident to move across the bed so that his/her head is close to where you are standing. Position pillow under shoulders so that head is tilted slighted backward.

k. Place the bed protectors on the mattress under the resident's head.
l. Loosen the pajamas so the resident is comfortable and clothing is not in the trough. Put small amount of cotton in the resident's ears, if needed.
m. Place towel under the resident's head and shoulders. Give resident a washcloth to cover eyes.
n. Inspect the resident's hair for knots or lice. If the resident has knots, carefully comb them out. If the resident has lice, stop the procedure and report this to your supervisor.
o. Pour some water over the resident's hair using a pitcher or cup. Adjust the water temperature to resident's preference. Repeat until the hair is completely wet.
p. Apply shampoo and using both hands, wash the hair and massage the scalp with your fingertips. Rinse the shampoo off by pouring water over the hair. Have the resident turn from side to side. Repeat until hair is free from soap.
q. Dry the resident's forehead and wrap head in a bath towel.
r. Rub the resident's hair with a towel to dry it as much as possible. If available and not counter indicated, a portable hair dryer may be used to complete the drying process.
s. Comb and prepare hair per the resident's preference.
t. Replace bedding and remove the bath blanket. Bring up the top sheets to cover the resident.
u. Lower the bed to its lowest position and raise the side rails.
v. Clean your equipment and return to its proper place.
w. Wash your hands.
x. Make the resident comfortable. Place call bell within reach.
y. Record/report completion of the procedure and note any observations made about the resident.
SKILLS PROCEDURES

22. Hair Care – Combing the Resident's Hair:
a. Assemble your equipment: towel, paper bag, comb or brush, any hair preparation the resident normally uses, and hand mirror.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. If possible, comb the resident's hair after the bath (and/or shampoo) and before you make the bed.
f. If the resident wears glasses, ask him/her to remove them.
g. Part the hair down the middle to make it easier to comb.
h. Brush the resident' hair carefully, gently and thoroughly. Be sure to brush the back of the head.

i. Ask the resident to turn his/her head from side to side or turn it form them so you can reach the entire head.

j. For the resident who cannot sit up, separate the hair into small sections. Then comb/brush each section separately, using a downward motion, starting at the loose ends and working up towards the head.

k. Complete brushing/combing and arrange attractively per resident's preference. Let the resident use the mirror.

l. If the resident has long hair, suggest braiding it to keep it from getting tangled.

m. Clean equipment and return to its proper place.

n. Wash your hands.

o. Make the resident comfortable. Place call bell within reach.

p. Record/report completion of the procedure and note any observations made about the resident.

23. Assisting the Resident with a Bedpan:

a. Assemble your equipment: bedpan and cover or fracture bedpan and cover, toilet tissue, wash basin with water or wet wash cloth, soap, talcum powder or corn starch, hand towel, and gloves.

b. Wash your hands.

c. Identify the resident and explain what you plan to do. Ask the resident if he/she would like to use the bedpan.

d. Provide for privacy.

e. Put on gloves (optional).

f. Raise the bed to highest horizontal position. Lower the side rails on the side where you are standing.

g. Fold back top sheets so they are out of the way.

h. Raise the resident's gown, but keep the lower part of the body covered with the top sheets.

i. Ask the resident to bend his/her knees and put their feet flat on the mattress. Then the resident to raise their hips. If necessary, help the resident to raise their buttocks by slipping your hand under the lower part of the back.

SKILLS PROCEDURES

j. Place the bedpan in position with the seat of the bedpan under the buttocks.

k. If the resident is unable to lift his/her buttocks to get on or off the bedpan, then turn the resident on their side with their back to you. Put the bedpan against the buttocks. Then turn the resident back on to the bedpan.

l. Replace the covers over the resident. Raise the backrest and knee rest, if allowed, so the resident is in a sitting position.

m. Raise the side rails to the up position.

n. Put toilet tissue where the resident can reach it easily.

o. Remove gloves (if used) and wash your hands.

p. Ask the resident to signal when finished.

q. Leave the room to provide for privacy (unless counter-indicated). Make sure the signal cord is within easy reach. When the resident signals, return to the room and put on gloves.

r. Lower side rails. Help the resident to raise his/her hips so you can remove the bedpan.

s. Help the resident if he/she is unable to clean themselves. Turn the resident on their side and clean the anal area with tissue. Discard tissue in bedpan unless specimen is to be collected. Cleanse resident with warm water and soap.

t. Raise the side rails. Cover bedpan immediately. You can use a disposable pad or paper towel if no cover is available.

u. Take the bedpan to resident's bathroom (or hopper room).

v. Return to the resident. Offer the resident the opportunity to wash their hands and freshen up. Change linens or protective pads as necessary.

w. Note the excreta (feces or urine) for amount, odor, and color.

x. Empty the bedpan into the toilet. Clean the bedpan and other equipment and return to its proper place. Cold water is always used to clean the bedpan.

y. Remove and dispose of gloves. Wash your hands.

z. Make resident comfortable. Place call bell within reach.

aa. Record/report completion of the procedure and note any observations made about the resident.

24. Giving a Back Rub:

a. Assemble your equipment: bath towel, lotion, and basin of water warmed to 105 F. b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Raise the bed to the highest position. Keep the side rails up on the far side of the bed.

f. Place lotion in basin of water to warm.

g. Ask the resident to turn on his/her side or abdomen. Position the resident as close to the side of the bed where you are working as possible.

h. Expose the resident's back.

i. Pour a small amount of lotion in the palm of your hand. If lotion is not warm enough, rub hands together to warm.

SKILLS PROCEDURES

j. Apply the lotion to the back using long firm strokes (advise the resident it may feel cool). Continue strokes from the buttocks to the back of the neck and shoulders.

k. Exert firm upward pressure. Use gentle downward pressure rubbing in small circular motion with palm of hands. Do not lift hands.

l. Give special attention to all bony prominences using circular motion.

m. Continue rhythmic rubbing for one (1) to three (3) minutes.

n. Dry resident's back by patting with a towel.

o. Assist resident with putting on gown or pajamas.

p. Clean equipment and return to its proper place.

q. Wash your hands.

r. Make resident comfortable. Place call bell within reach.

s. Record/report completion of procedure and note any observations made about the resident.

25. Dressing and Undressing a Resident:

a. Wash your hands.

b. Identify the resident and explain what you plan to do.

c. Provide for privacy.

d. Select appropriate clothing and arrange in order of application. Encourage resident to participate in selection.

e. Raise bed to comfortable working position.

f. Assist resident to comfortable sitting position on the edge of bed or lie flat.

g. Remove night clothing, keeping resident covered with bath blanket.

h. To put on a shirt remember to place injured, inflexible or compromised limb in the garment first. Grasp resident's hand and guide it through the armhole by reaching into the armhole from the outside. Repeat procedure with opposite arm.

i. Assist with underwear, trousers or pajamas. If the resident is lying down, they may lift up buttocks while you pull up clothing.

j. Never jerk, pull or yank on a limb.

k. Place socks or stockings on feet. Never use round garters since they reduce circulation. When placing feet in socks and shoes, remember to check for blisters or red areas. l. Wash your hands.

m. Make resident comfortable. Place call bell within reach.

n. Record/report completion of the procedure and note any observations made about the resident.

26. Heimlich Maneuver:

a. Ask the resident, "Can you speak?" If the resident can speak, cough or breathe, do not interfere. If the material does not dislodge, apply the Heimlich Maneuver.

b. Call for "HELP".

c. Stand behind the resident and wrap your arms around them.

d. Put the thumb side of one hand on the abdomen (thumb should be tucked into fist). Place fist, thumb side in, against abdomen between naval and tip of sternum.

SKILLS PROCEDURES

e. Grasp this hand with the other hand while bending resident forward slightly and press it into the abdomen with a quick upward movement.

f. Repeat until the foreign object is expelled (6 to 10 times) or until the resident becomes unconscious.

g. Again call for "HELP". Licensed, trained personnel should be summoned to activate CPR and/or calling 911.

27. Making an Unoccupied Bed:

a. Assemble your equipment: two large sheets (substitute one fitted sheet, if used), pillowcases, bedspread, clean blankets, draw sheet (if used at your facility), mattress pad and cover.

b. Wash your hands.

c. Lock bed wheels so the bed will not roll and place chair at the side of the bed. Arrange linen on chair in order in which it is to be used. Adjust bed to a comfortable working height.

d. Remove soiled linen holding it away from your uniform and discard immediately into laundry bag.

e. Position mattress to head of bed by grasping handles on side.

f. Place mattress cover on mattress and adjust it smoothly. If mattress cover is not used, check the mattress for any soiling or wetness. Wipe mattress with slightly dampened cloth and allow to dry.

g. Unfold each piece of clean linen centered on the bed beginning with the bottom sheet. Hem seams face the mattress.

h. Hem is even with the foot of the mattress and the fold is in the exact center of the bed from head to foot. Open the sheet from the fold until the sheet covers the entire mattress evenly. Tuck the sheet under the mattress lightly.

i. Work entirely on one side of the bed until that side is finished.

j. Place the draw sheet (if used) about 14 inches down from the head of the bed. Tuck it in.

k. Place the top sheet so that the fold is in the center. The wide hem is at the top with the seam on the outside.

l. Place the spread at the foot of the bed with a square corner at the bottom end.
m. Tuck in the spread at the foot of the bed with a square corner at the bottom end.
n. Smooth the sheet and spread from the bottom to the top and fold down the top hem of the sheet over the top of the spread.
o. Go to the opposite side of the bed and proceed to make that side of the bed in the same manner. Pull sheets tight.
p. Put the pillowcases on the pillows holding the pillow away from your body and uniform. Place pillow at head of bed with open end away from the door.
q. Place chair and bedside table at assigned location.
r. Wash your hands.
s. Record/report completion of the procedure.

SKILLS PROCEDURES

28. Taking Rectal Temperature:
a. Assemble your equipment: rectal thermometer in a case, tissue or paper towel, lubricating jelly, pad and pencil, watch, and disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Place the bed in a flat position, if possible.
f. Put on gloves.
g. Take thermometer out of its container. Hold the stem.
h. Inspect for any cracks or chips. Do not use if you see any defects.
i. Shake down the mercury until it is below the calibrations.
j. Put a small amount of lubricating jelly on a piece of tissue. Lubricate the bulb of the thermometer with the jelly.
k. Ask the resident to turn on his/her side. Assist as necessary. Turn back top covers just enough that you can see the resident's buttocks. Avoid overexposing the resident.
l. With one hand, raise the upper buttock until you see the anus. With the other hand, gently insert the bulb one inch through the anus into the rectum.
m. Hold the thermometer in place for three (3) minutes.
n. Remove the thermometer from the resident's rectum. Hold the stem end of the thermometer and wipe it with a tissue form stem to bulb to remove particles of feces. o. Read the thermometer.
p. Remove your gloves.

q. Record the temperature. Note that this is a rectal temperature by writing an "R" after the figure. Report any abnormal readings immediately to your charge nurse. Note any other observations made about the resident.

r. Clean and store thermometer in its proper place.

s. Wash your hands.

t. Make resident comfortable. Place call bell within reach.

29. Taking Blood Pressures:

a. Assemble your equipment: sphygmomanometer, stethoscope, antiseptic pad to clean earpiece of stethoscope, pad and pencil.

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Wipe the earplugs of stethoscope with the antiseptic pad.

f. Have the resident resting quietly. He/she should be either lying down or sitting in a chair.

g. If you are using mercury scale apparatus, the measuring scale should be level with your eyes.

h. The resident's arm should be bare up to the shoulder, or the resident's sleeve should be well above the elbow (but not tight).

SKILLS PROCEDURES

i. The resident's arm from the elbow down should be fully extended on the bed. Or, it might be resting on the arm of the chair or your hip, well supported, with the palm upward.

j. Unroll the cuff and loosen the valve on the bulb. Then squeeze the compression bag to deflate it completely.

k. Wrap the cuff around the resident's arm above the elbow snugly and smoothly. Do not wrap it so tightly that the resident is uncomfortable from the pressure.

l. Leave the area clear where you place the bell or diaphragm of the stethoscope.

m. With your fingertips, find the resident's brachial pulse. Hold your fingers there and inflate the cuff until the pulse disappears.

n. When the pulse disappears, pump the cuff up another 30 points. At this point tell the resident they may feel a numb, tingling sensation in his/her arm.

o. Gently but quickly place the bell of the stethoscope over the brachial pulse, holding it firmly in place with three fingers.

p. Open the valve carefully and slowly allow the cuff to deflate.

q. Listen intently while observing the sphygmomanometer scale.

r. Continue to loosen the control valve slowly and observe the pressure dropping as you listen for the systolic beat (first beat). The first clear definite beat, though faint, will be the systolic pressure of the heart. Remember the number.

s. As you continue to deflate the cuff slowly, the mercury column or pointer will drop evenly and the eats will become soft and muffled.

t. The last definite beat that you hear is the diastolic pressure of the heart. Remember the number.

u. At this point, deflate the cuff quickly until all the air is out.

v. Record your finding s by writing the systolic pressure over the diastolic pressure, for example 120/80.

w. Remove the cuff.

x. Clean the earpiece of the stethoscope and store it according to facility policy.

y. Wash your hands.

z. Make the resident comfortable. Place call bell within reach.

30. Transfer/Discharge of the Resident:

a. Before transferring a resident to another unit, be sure that the receiving unit has been properly prepared.

b. Inform the resident of the move, answering questions as your instructions permit.

c. Collect all personal items that are to be moved with the resident.

d. Depending on whether the resident is to be moved in his/her own bed, a wheelchair or a stretcher, use procedures learned on moving and transporting.

e. You may be expected to go with the resident to provide for their physical and emotional comfort. The resident may need reassurance and some assistance in getting acquainted in their new unit.

f. Before discharging a resident, gather the resident's personal possessions. Secure valuables per facility policy.

SKILLS PROCEDURES

g. Offer to help the resident pack. Help the resident dress, if necessary.

h. Before the resident leaves the unit, ask the charge nurse to confirm that all discharge procedures have been completed. When the resident leaves, the nursing assistant should direct their efforts to making this a pleasant experience, leaving the resident with a happy memory.

i. Record/chart per facility procedure.

Difficulty Level IV

31. Checking for a Fecal Impaction:

Note: Check the facility policy to make sure this procedure is allowed to be performed by a nursing assistant.

a. Assemble your equipment: washcloth and towel, basin of warm water, toilet tissue, bath blanket, protective pad, lubricant, and disposable gloves.

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Raise bed to a comfortable position. Lower side rails on side closed to you.

f. Ask resident to raise hips. Place bed protector under hips.

g. Turn resident to lay on side (assist as necessary) facing away from you.

h. Cover with bed blanket and fanfold top bedclothes to foot of the bed.

i. Put on gloves. Lubricate index finger of dominant hand.

j. Ask resident to take a deep breath and bear down as you insert lubricated finger into the rectum. Note: Rectum should feel soft and pliable. You may feel no feces or you may feel a soft stool, a large solid mass, or multiple hard formations.

k. Withdraw finger. Note: If a spontaneous bowel movement occurs, note amount and character.

l. Remove gloves, wash hands and put on clean gloves.

m. Wash the resident's buttocks with warm water and dry.

n. Assist resident onto back. Ask resident to raise hips and withdraw bed protector.

o. Remove protector and gloves, folding down from outside to inside out, and place on chair.

p. Pull bedding up and remove bath blanket. Raise side rails.

q. Clean equipment and return to its proper place. Dispose of protector and gloves according to facility policy.

r. Wash your hands.

s. Make resident comfortable. Leave call bell within reach.

t. Record/report completion of procedure and findings to charge nurse. Note any observations made about the resident.

32. Administering a Pre-packaged (Saline Solution) Enema:
Note: Check the facility policy to make sure this procedure is allowed to be performed by a nursing assistant. Enemas should be given only at the charge nurse's instruction and direction.
a. Assemble your equipment: pre-packaged enema, bedpan and cover, towels, soap, basin of water, toilet tissue, bath blanket, bed protector, and disposable gloves.
b. Wash you hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Fanfold the covers to the foot of the bed as you cover the resident with a bath blanket.
f. Place chair at foot of bed, cover with a towel and place bedpan on chair.
g. Place bed protector under buttocks.
h. Have the resident turn on his/her left side, if possible (assist as necessary). Have resident's hips near the edge of the bed on the side where you will be working.
i. Turn back the bath blanket (or sheet) so that the resident's hips are exposed while the rest of his/her body is covered. Expose the resident's anus.
j. Put on gloves.
k. Follow instructions on the pre-packaged solution. Instruct resident to take a deep breath while you insert pre-lubricated tip into the anus. Squeeze container until all the solution has entered the rectum.
l. When the solution has been inserted, remove the tip and dispose of the container.
m. Encourage the resident to remain on side. Tell the resident to try to hold the solution for 20 minutes. Provide privacy if the resident is able to be left alone. Place call bell and toilet tissue within reach. Remove gloves and wash hands.
n. Check resident every 5 minutes until solution has been retained for 20 minutes.
o. Position resident on bedpan or assist to bathroom. If resident is on bedpan, raise head of bed to comfortable position. Place toilet tissue and call bell within easy reach. If resident is in the bathroom, stay nearby.
p. Report immediately if the resident has had difficulty expelling the solution.
q. Put on gloves and remove bedpan or assist resident to return to bed. Observe and note contents of bedpan or toilet. Cover pan and dispose of in flush toilet.
r. After you are finished, remove and dispose of all articles properly according to facility policy. Clean bedpan and return to its proper place. Remove and dispose of gloves. s. Wash your hands.
t. Assist resident to wash his/her hands.
u. Remove the bath blanket. Straighten the bed covers.
v. Make resident comfortable. Place call bell within reach.
w. Record/report completion of procedure and note any observations made about the resident.

33. Admission of a Resident:

a. Assemble your equipment: pad and pencil, stethoscope, blood pressure cuff, thermometer, scales, watch with second hand, inventory record, resident's record, and other equipment/supplies needed for admission.

b. Prepare the unit for the resident by making sure that all necessary equipment and furniture are in its proper place, in good working condition and clean. Make sure bed is made with clean linen and all space is clean. Check for adequate lighting and provide ventilation. Apply resident's name label on door, etc. as needed.

c. Wash your hands.

d. Identify the new resident by asking his/her name and by checking the identification. Identify yourself. Greet the resident and family courteously. Call resident by proper or preferred name.

e. Take the resident and family to the unit/room.

f. If semi-private room, introduce roommate. Provide privacy by screening unit.

g. Ask the new resident to be seated, or if ordered, help resident undress and assist into bed from stretcher or wheelchair. Adjust side rails.

h. Explain the call bell system and standard regulations. Place call bell within easy reach.

i. Care for clothing and personal articles according to facility policy. Assist with unpacking and labeling clothing. Label all personal articles and store in bedside table (or appropriate place). Be certain resident, if awareness level permits, knows where you place these articles, if not the resident, then a family member.

j. Follow and explain to the resident and family the facility policy for inventory and safekeeping of valuables.

k. Give instructions to resident and/or family as to time and place of meals and, as appropriate, provide other orientation such as facility premises, introduction to other staff, etc.

l. Check the resident's weight and height.

m. Take temperature, pulse, respiration, and blood pressure.

n. Clean and replace equipment according to facility policy.

o. Wash your hands.

p. Make resident comfortable. Place call bell within reach. Leave fresh water if permitted.

q. Record/report completion of procedure. Report to charge nurse: resident's vital signs; any bruises, sores, etc. on the resident's body; any special observations made about the resident.

34. Feeding a Resident (Requiring Total Feeding):

a. Identify the resident and explain what you plan to do.
b. Offer the bedpan/urinal before tray time.
c. Wash your hands.
d. Wash the resident's hands.
e. Roll the head of the bed up unless the resident's condition disallows it. Adjust the resident to a comfortable position.

f. Obtain the food tray and check the diet card to be certain that the tray is for the right resident.
g. Place the tray on the overbed table. Remove unnecessary items from the overbed table.
h. Place a napkin under the resident's chin.
i. Tell the resident what is on the tray. Season the food according to resident's taste unless otherwise ordered. Follow the resident's preference for the order in which food is offered.
j. Test the food for temperature. Warn the resident if the food or liquid is hot.
k. Alternate solids and liquids in a manner in which the resident prefers. Feed the resident slowly. Do not offer food until the last bit has been swallowed.
l. Talk to the resident.
m. Allow resident to assist as much as possible.
n. Use napkin to wipe resident's mouth and hands as often as necessary.
o. If the resident is paralyzed on one side, offer the food on the unaffected side of mouth and allow time for swallowing.
p. When serving a liquid with a straw, hold the straw in place while the resident sucks in.
q. Encourage the resident to eat as much as possible without forcing.
r. Remove tray as soon as resident is finished. Make sure to note what the resident has or has not eaten.
s. Wash the resident's hands and face.
t. Take the tray to the proper place. Return to the room and tidy the bed and overbed table.
u. Wash your hands.
v. Make resident comfortable. Place call bell within reach.
w. Record/report completion of the procedure. Note the amount of food and liquid intake. Note any other observations made about the resident.

35. Incontinence Care:
a. Assemble your equipment: wash basin with warm water, washcloth, hand towel, soap, talcum powder or cornstarch, skin lotion, clean clothes, adult undergarment (optional), clean bed

lines, protective pad for bed, disposable gloves, room deodorizers (optional). b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Demonstrate calm, pleasant and matter of fact attitude. DO NOT scold or treat the resident like a child. Provide for dignity of the resident.

f. Put on gloves (optional).

g. Wash and dry all affected skin areas.

h. Remove and dispose of gloves, if used. If gloves were not used, wash hands.

i. Maintain good skin condition by applying power, cornstarch and lotion as necessary.

j. Assist resident to put on clean, dry clothes. May use adult undergarment.

k. Change bed lines as necessary. Use protective pad on bed.

l. Remove all soiled linen and clothing according to facility policy.

m. Wash your hands.

n. Make resident comfortable. Place call bell within reach.

o. Provide the resident with room deodorizers as needed to assure an odor-free environment.

p. Record/report completion of procedure. Note frequency and character of the bowel movement. Record observations made about the resident's behavior.

q. Check the resident at least every two hours.

36. Urinary Catheter and Tubing Care:

a. Assemble your equipment: basin of water, mild soap or cleaning solution, wash cloth or gauze pads, paper or plastic bag for waste, lotion and/or cornstarch powder, and disposable gloves.

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Position the resident on his/her back so the catheter and meatus are exposed.

f. Observe the area around the catheter for lesions (sores), crusting, leakage or bleeding. Report any unusual observations to your charge nurse immediately.

g. Put on gloves.

h. Wash the area gently. Do not pull on the catheter, but hold it with one hand while wiping it with the other.

i. Wipe away from the meatus. Wipe from the meatus to the anus. Wipe one way, not back and forth. Use different area of washcloth or separate gauze pad for each wipe.

j. Remove and dispose of gloves.

k. Dry the area. Apply lotion and/or cornstarch powder to the thighs in small quantities. Ask charge nurse if this area should be kept dry or moist.
l. Make sure the catheter tubing is secured (not pulling on meatus) and draining properly.
m. Dispose of the dirty water into the toilet. Clean equipment and return to its proper place.
n. Wash your hands.
o. Make resident comfortable. Place call bell within reach.
p. Record/report completion of procedure and note any observations made about the resident.

37. Postmortem Care:
a. Assemble your equipment: basin of warm water, washcloth, towels, shroud or clean sheet, clean dressings, and container for valuables.
b. Wash your hands.
c. Provide for privacy.
d. Remove all equipment and used articles. Check facility policy regarding removal of catheters.
e. Maintain an attitude of respect.

f. Remove all pillows except one under the head. Place the body on the back, head and shoulders elevated. Move the body gently to avoid bruising.
g. Close eyes by grasping eyelashes. Do not press on the eyeballs.
h. Place dentures in the mouth, if possible. If not possible, clean, place in cup and give to the family. Secure jaw if needed.
i. Bath as necessary. Remove any soiled dressings and replace with clean ones.
j. Fold the arms over the abdomen.
k. Put the shroud on the body.
l. Collect all belongings. Wrap and label them. Care for resident's valuables according to facility policy.
m. Wash your hands.
n. Record/report completion of procedure.

38. Transfer a Resident from Bed to Stretcher:
a. Assemble your equipment: stretcher, bath blanket, sheet, turning sheet (optional). b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.

e. Lock wheels of bed and raise to horizontal position equal to height of stretcher. Lower side rails of bed on the side you are working on.
f. Place a sheet or bath blanket over the resident. Working under the sheet or bath blanket, fold the top covers to the height of stretcher. Lower side rails of bed on the side you are working on.
g. Position stretcher against bed. Lock wheels and lower side rails of stretcher.
h. Facing the bed, lean across the stretcher holding it against the bed with your body.
i. If resident is able, instruct him/her to slide slowly toward you onto the stretcher, moving hips, then head and shoulders then legs.
j. If resident is unable to help move themselves, enlist help from two other nursing assistants. Position one assistant on the opposite side of bed and one at end of bed. The third assistant will be positioned on opposite side of stretcher.
k. Roll turning sheet close to resident's body. Assistant on opposite side of stretcher uses both hands to grasp turning of resident and, with the other hand, grasps turning sheet to guide resident. Assistant at foot of bed lifts resident's feet and legs. All assistants must coordinate their activities and move together as signal is given.
l. Position resident on stretcher. Place a pillow under the resident's head unless they object or it aggravates condition.
m. Tighten stretcher restraints and provide blanket/cover as needed. Raise side rails.
n. Transport the resident as directed. Assume a position at the head and push the stretcher.
o. Transport the resident to the assigned area. Do not leave the resident alone. Wait until another health care worker assumes responsibility for the resident's care.
p. Wash your hands.

q. Record/report completion of procedure and note any observations made about the resident.

39. Range of Motion Exercises:
a. Wash your hands.
b. Identify the resident and explain what you plan to do.
c. Provide for privacy.
d. Prior to starting the procedure, offer the resident the bedpan or urinal.
e. Raise the bed to a comfortable working position. Lower the side rails on the side you are working on.
f. Move the resident close to you. Position yourself close to the resident, using good body mechanics.
g. Place the resident in a supine position with knees extended and arms at side.

h. Proceed with the exercises as you have been instructed. Be sure you have specific instructions as to the type of motions to be carried out.
i. Do not expose the resident unnecessarily during the procedure.
j. Always be gentle as you do each exercise, supporting the area above and below the moving joint. Do not complete an exercise if the resident complains of pain or discomfort or if there is resistance in the joint movement.
k. When finished, lower side rails on bed. Make the resident comfortable. Place call bell within reach.
l. Wash your hands.
m. Record/report completion of the procedure and note any observations made about the resident.

40. Assisting the Resident with a Shower:
a. Assemble your equipment: soap, washcloth, bath towels, bath mat, chair or stool, bath powder (optional), clean clothing (gown, robe, slippers).
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Take supplies to the bathroom and prepare it for the resident. Check the shower and wash it if necessary.
f. Assist the resident to the bathroom and help them to remove robe and slippers.
g. Turn on the shower and adjust water to safe temperature and resident's preference. Check water temperature with hand or elbow before the resident enters shower. The water temperature should be comfortably warm.
h. Assist the resident into the shower. Offer chair/stool, if necessary.
i. Give the resident soap and washcloth so he/she can wash as much as possible. Give the resident as much privacy as is safely possible. Assist as necessary.
j. Turn off the water and assist the resident out of the shower.
k. Assist the resident with drying parts of body they have difficulty reaching. Apply powder if requested or instructed.
l. Help the resident dress as needed.
m. Assist resident back to their room. Make resident comfortable. Place call bell within reach.
n. Return to the shower room. Clean shower and bathroom as necessary. Return supplies to proper place.
o. Wash your hands.

p. Record/report completion of the procedure and note any observations made about the resident.

41. Assisting Resident to and from Chair/Wheelchair to Bed:
a. Assemble your equipment: chair or wheelchair, bath blanket, robe and slippers nearby. b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Cover the chair or wheelchair with bath blanket.
f. Place chair or wheelchair near the head of bed facing the foot of the bed. Lock the wheelchair and raise foot rest.
g. Elevate head of bed and lock wheels. Lower the bed to lowest horizontal position.
h. Drape resident with a bath blanket and fanfold top bedclothes to foot of bed.
i. Assist the resident to a sitting position by placing one arm around the resident's shoulders. Place the other arm under the resident's knees and pivot (rotate) the resident toward the side of the bed. Remain facing the resident to prevent a fall.
j. Assist the resident in putting on robe and slippers.
k. Have resident place feet on floor with both hands on your shoulders. Place your hands on either side of the resident's underarms. Assist the resident to a standing position.
l. Keeping hands in the same position, help resident to turn slowly until the resident's back is toward the chair.
m. Lower the resident gradually to a sitting position in the chair, bending at your hips and knees.
n. Make the resident comfortable. If the resident is in a wheelchair, place both feet on the footrest and lock the wheelchair securely. Cover resident with a bath blanket. Place call bell and drinking water within reach.
o. Stay with resident until you are sure there are no adverse side affects. Report anything unusual to supervising nurse.
p. Wash your hands.
q. Record/report completion of procedure and note any observations made about the resident.

To assist the resident back to bed, just reverse the directions. Your body mechanics and positioning are the same as in helping the resident into the chair. a. Wash your hands.
b. Prepare the bed. Adjust bed to lowest horizontal position and wheels are locked. Raise head of bed, fanfold top bedclothes to foot of the bed, and raise opposite side rails.

c. Position chair or wheelchair at foot of the bed. Lock wheels of wheelchair and lift footrest.
d. Remove bath blanket and have resident place feet flat on the floor.
e. Assist resident to a standing position, pivot toward the bed slowly and smoothly. Assist resident to sit on edge of bed.
f. Remove robe and slippers.
g. Assist resident onto center of bed. Lower head of bed and raise side rails.
h. Make resident comfortable. Place call bell within reach.
i. Wash your hands.
j. Record/report completion of procedure and note any observations made about the resident.

42. Giving a Bed Bath:
a. Assemble your equipment: soap and soap dish, washcloth, wash basin, face towels, bath towels, bath blanket (optional), clean gown or clothing, talcum powder or cornstarch (optional), lotion, comb or hairbrush, items for nail care, items for oral hygiene, disposable gloves (if indicated), and clean bed linen.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Offer bedpan or urinal. Empty and clean before proceeding with bath. Wash hands.
f. Make sure any windows or doors are closed to prevent chilling the resident.
g. Take everything to the bedside before starting the procedure. Put tow4els and linen on chair in order of use.
h. Raise the bed to a comfortable working height with the side rail up on the side opposite from where you are working. Lower the headrest and knee rest of the bed, if permitted. The resident should be as flat as is comfortable and permitted.
i. Remove and fold blanket and spread leaving the resident covered with bath blanket. Place folded blanket and spread over back of chair. Leave one pillow under resident's head.
j. Assist resident to move closer to you so you can work easily without straining your back.
k. Remove the gown, but keep the resident covered to avoid chilling.
l. Fill the washbasin 2/3 full of water at 105 degrees F.
m. Put a towel across the resident's chest and make a mitt with the washcloth. Wash the eyes from the nose to the outside of the face. Wash the face (use soap at resident's preference, being careful not to get soap in resident's eyes) neck and ears. Rinse and dry gently with bath towel. Rinse washcloth. Apply lotion/cream as needed.

n. Expose resident's far arm. Protect bed with bath towel placed underneath arm. Wash, rinse and dry arm and hand. Be sure armpit is clean and dry. Apply deodorant and powder if resident needs them or request them. Repeat for other arm.

o. Place the basin of water on the towel on the bed. Put the resident's hand into the water. Wash, rinse, and dry the hand well. Provide fingernail care.

p. Put bath towel over resident's chest, and then fold blanket to waist. Under towel, wash, rinse and dry chest. Rinse and dry folds under breasts of female resident carefully to avoid irritating skin. Use powder/lotion as needed.

q. Fold the blanket down to the pubic area and wash resident's abdomen. Be sure to wash the naval and any creases of the skin. Dry the abdomen, then pull the blanket up over the abdomen and chest and remove the towel.

r. If necessary, empty the dirty water. Rinse the basin and fill it with clean water (105 degrees F).

s. Fold the blanket back from the resident's leg farthest from you. Bend the knee, and wash, rinse and dry the leg and foot. If the resident can easily bend the knee, put wash basin on towel and place resident's foot directly into the basin to wash it.

t. Observe the toenails and the skin between the toes. Look for redness and cracking. Care for toenails as necessary. Remove the washbasin and dry the leg and foot and between the toes. Cover the leg and foot and remove the towel. Repeat the entire procedure for the other leg and foot.

u. If necessary, empty the dirty water. Rinse the basin and fill it with clean water (105 degrees F).

v. Assist resident to turn on side away from you and to move toward center of bed. Place towel lengthwise next to resident's back. Wash, rinse and dry neck, back and buttocks. Use long firm strokes when washing back.

w. A back rub is usually given at this point. Look for reddened areas and other skin conditions. Remove towel, apply powder/lotion as needed, and assist resident to turn over.

x. Place towel under buttocks and upper legs. Offer the resident a soapy washcloth to wash the genital area. Offer a clean wet washcloth to rinse with, and a dry towel for drying. If the resident is unable to do this, you must wash for them. Allow privacy at all times. Put on gloves when washing the genital area (remove gloves when completed).

y. Cover pillow with towel and comb or brush resident's hair. Oral hygiene is usually given at this time.

z. Follow the procedures for dressing the resident and transferring to a wheelchair (if instructed). If resident is to remain in bed, put a clean gown on the resident.

aa. Change the linens and make the bed.

bb. Dispose of used towels, washcloths and dirty linen in appropriate place. Clean your equipment and put it in its proper place. Discard disposable equipment.
cc. Make resident comfortable. Raise side rails. Place call bell within reach. Leave room/unit orderly. dd. Wash tour hands.
ee. Record/report completion of procedure and note any observations about the resident.

43. Assisting the Resident with a Tub Bath:
a. Assemble your equipment: soap, washcloth, towels, bath thermometer (if available), chair bath mat, powder, lotion, clean clothing, disinfectant solution.
b. Take supplies to the tub/bath room and prepare it for the resident. Make sure tub is clean (use disinfectant solution).
c. Wash your hands.
d. Identify the resident and explain what you plan to do.
e. Take the resident to the tub room, being sure that he/she is covered to avoid chilling. Provide for privacy.
f. Fill the tub half full of water at 105 degrees F. Test temperature with a bath thermometer, if available, or by touch.
g. Place a towel on the floor where the resident will step out of the tub to prevent slipping. Have a towel or mat in bottom of the tub to prevent slipping.
h. Assist resident to undress and get into the tub. Get additional assistance if necessary.
i. Let the resident stay in the tub according to your instructions (usually about 15 minutes). Assist the resident with washing as needed. Never leave the resident alone in the tub.
j. Assist the resident out of the tub, holding bath blanket around the resident, and onto the towel-covered chair. Assist in drying as needed. Apply powder/lotion as needed.
k. Assist the resident to dress and return to the room/unit.
l. Make the resident comfortable. Place call bell within reach.
m. Return to the tub room. Clean the tub (use disinfectant). Dispose of used towels, washcloths, and dirty clothes in appropriate place. Return supplies to proper place. n. Wash your hands.
o. Record/report completion of procedure and note any observations about the resident.

44. Feeding with an Asepto Syringe:
a. Assemble your equipment: food tray, syringe, water, washcloth, and swabs.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Raise the bed to a 45 degree angle.

f. Provide washcloth for the resident to wash hands and face if physically able. Assist as necessary.
g. Obtain food tray and check the diet card to make sure the tray, diet and resident's name are correct. Place tray on overbed table.
h. Place a napkin under the resident's chin.
i. Moisten lips or mouth with a dampened swab.
j. Place small amounts of one type of food at a time in the syringe.
k. Be aware that communication is necessary. Tell the resident the food contents of the syringe.
l. Test the temperature of the food before placing in resident's mouth.
m. Place the tip of the syringe between the gums and cheek, not on the tongue.
n. If the resident is paralyzed on one side, offer the food on the unaffected side of mouth and allow time for swallowing.
o. Feed slowly. Be sure all food is swallowed before giving more.
p. Alternate small amounts of food with small amounts of water. When serving liquid with a straw, hold the straw in place while the resident sucks in.
q. Provide as normal an environment as possible to meet total resident needs.
r. Remove the tray as soon as the resident has finished. Make sure to note what the resident has or has not eaten.
s. Wash the resident's hands and mouth.
t. Take the tray to the proper place. Return to the room and tidy the bed and overbed table.
u. Make the resident comfortable. Place call bell within reach.
v. Wash your hands.
w. Record/report completion of the procedure. Record the type and amount of food eaten. Note any other observations made about the resident.

45. Isolation Technique – Preparing the Unit:
a. Isolation is an infectious disease control process and will be carried out according to facility policy and specific technique for a specific disease. Check instructions from the charge nurse.
b. Assemble your equipment: caution sign, cart, disposable masks, disposable gloves, gowns, wastebasket liners, bags (to dispose of contaminated materials), linen bags marked "isolation", resident needs (bath articles, toilet articles, thermometer, antiseptic solution, etc.).
c. Wash your hands (even more frequent handwashing is a necessity for isolation technique).
d. Place a "Barrier", "Isolation", or "Precaution" sign on the door.

~~e. Place a cart or bedside table beside the door and supply it with: isolation gowns, caps, gloves, and masks as ordered; plastic bags; linen/laundry bags specially marked as "isolation".~~
~~f. Follow isolation instructions prior to entering resident's unit/room.~~
~~g. Place all resident care equipment in the usual resident unit places.~~
~~h. Line wastebasket with a plastic bag.~~
~~i. Supply a laundry hamper with a linen/laundry bag specially marked "isolation".~~
~~j. Put antiseptic solution dispenser over or near sink.~~
~~k. Check supply of paper towels and liquid soap.~~
~~l. Place a basin of disinfectant solution for soaking contaminated articles near the sink.~~
~~m. Follow isolation instructions as you leave the resident's unit/room.~~
~~n. Wash your hands.~~
~~o. Record/report completion of procedure and note any observations about the resident.~~

~~Isolation Technique—Handwashing:~~
~~a. Assemble your equipment: soap or detergent, waste can, paper towels, and nail brush.~~
~~b. Open a paper towel near the sink. This is considered your clean area. Put all your equipment on it. Leave it there until you are ready to leave the room.~~

c. Turn on the faucet with a paper towel held between the hand and the faucet. Drop the paper towel into the waste can.
d. Wet your hands and wrist under the running water. Keep your fingertips pointed downward.
e. Apply soap or skin cleanser to hands.
f. Hold your hands downward and lower than your elbows while washing.
g. Work up a good lather. Spread it over the entire area of your hands and wrist (two inches above the wrist). Get soap under your nails and between your fingers. Add water while washing.
h. Use a rotating and rubbing (friction) motion for one full minute:
- rub vigorously.
- rub one hand against the other hand and wrist.
- rub between your fingers by interlacing them.
- rub up and down to reach all skin surfaces on your hands and between your fingers.
- rub the tips of your fingers against the palms to clean with friction around the nail beds.
- use the nail brush on your nails.
- wash at least two inches above your wrist.
i. Rinse thoroughly from wrist to fingertips, keeping fingertips down.
j. Dry hands and wrist thoroughly with a paper towel.
k. Use a paper towel to turn off the faucet.
l. Discard the paper towel into the waste can.
m. Do not touch the waste can.
n. Do not touch the inside of the sink with clean hands.
o. Do not lean against the sink or splatter uniform.

Isolation Technique – Mask, Gown, and Gloves:
a. Assemble your equipment: mask, gown, gloves, plastic bag, and paper towel.
b. Remove any rings and secure them inside uniform pocket.
c. Remove watch and place in a plastic bag or on a clean paper towel.
d. Wash your hands.
e. Adjust mask over nose and mouth and tie securely.
f. Unfold the isolation gown so that the opening is at the back. If you are wearing a longsleeved uniform, roll your sleeves above your elbows.
g. Put on gown, slipping arms into sleeves. Fit the gown at the neck, making sure your uniform is covered. Reach behind and tie the neck back with a simple bow or fasten the adhesive strip. Reach behind and overlap the edges of the gown to cover uniform completely. Secure ties in a bow or fasten adhesive strip.
h. Obtain and place plastic gloves in front of you on table so thumbs are pointing in opposite directions. Make a cuff on each glove. Slip fingers into left glove, easing glove over hand and fingers as you pull glove on with opposite hand. Pick up right glove with left hand by slipping

fingers of gloved hand under the cuff. Insert right hand into glove, spreading fingers slightly to slide into proper areas.

i. Upon completion of resident care, remove contaminated gloves, mask and gown.

j. Remove gloves, turning them inside out (slip gloved fingers of right hand under cuff of opposite hand, touching the glove only. Pull glove down to fingers, exposing thumb. Slip uncovered thumb into opposite cuff. Pull glove down over right hand. With right hand touching the inside of the left glove, pull down over the left hand). Dispose of gloves according to facility policy.

k. Undo waist ties and loosen gown at waist.

l. Turn on faucets, holding a clean paper towel. Discard paper towel in waste can.

m. Wash hands carefully and dry with paper towel. Dispose of paper towel. Turn off faucet with a paper towel. Dispose of paper towel.

n. Using paper towel to operate dispenser, wet hands with anti septic and rub together. Air dry.

o. Undo mask. Holding by ties only, deposit in proper container.

p. Undo neck ties and loosen gown at shoulders.

q. Slip fingers of the right hand inside the left cuff without touching the outside of the gown. Pull gown down and over the left hand. Pull gown down over the right hand with the gown covered left hand.

r. Fold gown with contaminated side inward. Roll and deposit in laundry bag or waste container, if disposable.

s. Rewash hands using same technique.

t. Remove watch from plastic bag or paper towel. Dispose of paper towel.

u. Open door with clean paper towel. Prop door open with foot and drop paper towel in waste can.

46. Making an Occupied Bed:

a. Assemble your equipment: cotton draw sheet or turning sheet for selected residents, bed protectors (if used), bath blanket (if available), pillow cases, regular and fitted sheet, bedspread, blanket, and container for dirty linen.

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.

e. Place bedside chair at foot of bed. Place linen/supplies on chair in order of use.

f. Adjust the bed to a flat position (unless otherwise indicated) and lock wheels. Raise to comfortable working horizontal height.

g. Loosen all sheets around the entire bed.

h. Take the bedspread and blanket off the bed and fold them over the back of the chair. Leave the resident covered with top sheet or bath blanket.

i. Raise the side rail on the opposite side from where you will be working.

j. Turn the resident to the side toward the raised rail, with a pillow under the head. Assist as necessary.

k. Fold the cotton draw sheet toward the resident and tuck it against resident's back. Protect resident from any soiled matter on the bed.

l. Raise the plastic draw sheet (if it is clean) over the bath blanket and the resident.

m. Roll the bottom sheet towards the resident and tuck it against his/her back. This strips your side of the bed down to the mattress.

n. Take the large clean sheet and fold it in half lengthwise. Do not permit the sheet to touch the floor or your uniform.

o. Place it on the bed, still folded, with the fold running along in the middle of the mattress. The small hem end of the sheet should be even with the foot edge of the mattress. Fold the top half of the sheet toward the resident (this is for the other side of the bed). Tuck the folds against the back, below the plastic draw sheet.

p. Tuck the sheet around the head of the mattress by gently raising the mattress with the hand closet to the foot of the bed and tucking with the other hand.

q. Miter the corner at the head of the mattress. Tuck in the bottom sheet on your side form head to foot of the mattress.

r. Pull the plastic draw sheet toward you, over the clean bottom sheet and tuck in.

s. Place the clean cotton draw sheet over the plastic sheet, folded in half. Keep the fold near the resident. Fold the top half toward the resident, tucking the folds under resident's back, as you did with the bottom sheet. Tuck the free edge of the draw sheet under the mattress.

t. Have the resident roll over the "hump" onto the clean sheets facing toward you. Assist as necessary.

u. Raise the side rail on your side of the bed and lock in place.

v. Go to the other side of the bed and lower side rail.

w. Remove the old bottom sheet and cotton draw sheet from the bed. Put them into the container for dirty linen. Pull the fresh bottom sheet toward the edge of the bed. Tuck it under the mattress from the head to foot. Do this by rolling the sheet up in your hand toward the mattress and pull it as you tuck it under.

x. One at a time, pull and tuck each draw sheet under the mattress.

y. Have the resident turn on his/her back. Assist as necessary.

z. Change the pillowcase and place under the resident's head.

aa. Be sure side rails are up and secure. Lower bed to lowest horizontal position. Replace bedside table and chair. Remove dirty linen according to facility policy.

bb. Make the resident comfortable. Place call bell within reach.

cc. Wash your hands.

dd. Record/report completion of the procedure and note any observations made about the resident.

47. Oral Hygiene for the Unconscious Resident:

a. Assemble your equipment: towel, emesis basin or small basin, disposable gloves, mouth care kit of commercially prepared swabs, or if such kit is not available obtain; tongue depressor, applicators or gauze sponges, lubricant such as glycerine, or a substance used by your facility, or a solution of lemon juice and glycerine.

b. Wash your hands.

c. Identify the resident and explain what you plan to do. Even though a resident seems to be unconscious, he/she may still be able to hear you.

d. Provide for privacy.

e. Stand at the side of the bed and turn the resident's face toward you.

f. Support the resident's face on a pillow covered by a towel.

g. Put the emesis basin (or small basin) on the towel under the resident's chin.

h. Put on your gloves.

i. Place the mouth care equipment near you so you do not have to move.

j. Press on the cheeks and hold the tongue in place with a tongue depressor.

k. Open the commercial package of swabs (if commercial swab is not available, use applicators moistened with solution) and wipe the resident's entire mouth, roof, tongue, and inside the cheeks and lips. Put the used swabs in the basin.

l. Dry the resident's face with a towel. Using a clean applicator put a small amount of lubricant on the resident's lips.

m. Clean your equipment and put it back in proper place. Discard disposable equipment in the proper container.

n. Remove your gloves.

o. Make the resident comfortable. Place call bell within reach.

p. Wash your hands.

q. Record/report completion of the procedure and note any observations made about the resident.

48. Using a Portable Mechanical Resident Lift:

SPECIAL NOTES:

- Never operate a mechanical lift without the assistance of another staff person. Safety requires two people.
- Lock all brakes after positioning lift.
- Check slings and straps for frayed areas or poorly closing clasps.
- Be sure that all locks and straps are fastened securely.
- Reassure resident while moving. Falling is a great fear of residents so be aware of this fact.

a. Assemble your equipment: mechanical lift, sling, blanket or sheet.

b. Wash your hands.

c. Identify the resident and explain what you plan to do.

d. Provide for privacy.
e. Place wheelchair or chair at right angles to foot of bed, facing head of bed. Cover the chair with blanket or sheet.
f. Take lift to resident's bedside. Lock wheels on bed.
g. Roll resident toward you and slide the sling under the resident. Position sling beneath body behind shoulders and buttocks. Be sure that sling is smooth and positioned properly.
h. Attach suspension straps to sling. Check fasteners for security.
i. Position lift frame over bed with base legs in maximum open position and lock.
j. Elevate head of bed and bring resident to semi-sitting position.

k. Attach suspension straps to frame (attach the sling to the lift with the hooks in place facing out). Position resident's arms inside straps. Secure restraint straps, if needed.
l. Have resident fold both arms across chest, if possible. Using the crank, slowly lift resident from the bed. Talk to the resident to comfort them.
m. Guide lift away from the bed. Guide the resident's legs.
n. Position the resident close to chair or wheelchair (with wheels locked). Slowly lower resident into chair or wheelchair. Pay particular attention to the position of the resident's feet (guide the resident's legs).
o. Unhook suspension straps and remove lift.
p. Leave the resident safe and comfortable in the chair for the proper amount of time, according to your instructions.
q. Wash your hands.
r. To get the resident back into the bed, re-hook suspension straps (place the hooks facing out) which are still under the resident.
s. Raise the resident by using the crank on the mechanical lift. Lift resident from the chair into the bed. Have your partner guide the resident's legs. Lower resident into the center of the bed.
t. Remove the hooks from the frame. Remove the sling from under the resident by turning the resident from side to side (assist as necessary).
u. Remake the top of the bed. Put a pillow under the resident's head. Properly position the president. Raise side rails.
v. Make resident comfortable. Place call bell within reach.
w. Record/report completion of the procedure and note any observations made about the resident.

SKILLS PROCEDURES

ABRIDGED GLOSSARY

abuse/maltreatment	- any willful or negligent act which results in an injury or damage.
active exercise	- exercise the resident does for self.
activities of daily living	- needs of the resident for daily care.
admission procedures	- measures taken when a person enters a long-term care facility.
aging process	- changes in the body caused by growing older.
ambulatory	- able to walk.
apathy	- lack of interest or concern.
appetizing	- food that looks appealing.
asepsis	- state of being free of pathological organisms.
aspiration	- materials/particles drawn into the lungs on inspiration.
assault	- threat or attempt to injure another in an illegal manner.
attitude	- a mood or feeling; mental position with regard to a fact or state.
axillary	- armpits; area under the arms.
bacteria	- germs, microscopic organisms.
base of support	- part of the body that bears the most weight.
battery	- physical abuse to resident; unlawful touching of another person with consent, with or without resultant injury.

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ABRIDGED GLOSSARY

~~behavior – non-verbal and/or verbal expression of thoughts and feelings.~~

~~blood pressure – refers to two different pressures in the blood system/ systolic pressure (heart contracts) and diastolic pressure (heart in full relaxation).~~

~~body alignment – arrangement of the body in a straight line.~~

~~body language – gestures that function as a form of communication.~~

~~body mechanics – proper use of the human body to do work to avoid injury and strain.~~

~~catheter – a tube which is used to withdraw fluid from a body cavity.~~

~~charge nurse – the nurse who has the total responsibility for residents during the tour of duty.~~

~~chronic – marked by long duration; frequent reoccurrences; not acute.~~

~~chronological – relating to arranged in/or according to the order of time.~~

~~cognition – process involved in knowing.~~

~~coma (unconscious) – lack of awareness; not able to respond, but possible can hear.~~

~~communicate – exchange of ideas between two or more people.~~

~~comprehension – to understand.~~

~~conduct – the way you do things.~~

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ABRIDGED GLOSSARY

~~confidentiality~~ ~~- containing information whose unauthorized disclosures could be harmful.~~

~~confusion~~ ~~- clouding of level of thought;~~

~~conscious~~ ~~- state of awareness;~~

~~consent~~ ~~- permission granted voluntarily by a person in his/her right mind.~~

~~contagious~~ ~~- easily transmitted by contact;~~

~~contaminated~~ ~~- soiled; contains microorganisms (germs);~~

~~contractures~~ ~~- shortening of tissue causing deformity or distortion. Ex. muscle.~~

~~constipation~~ ~~- failure of bowels to excrete residue at proper intervals.~~

~~convulsion~~ ~~- temporary loss of conscious with severe muscle contractures; fit or generalized spasm.~~

~~corn~~ ~~- thickening of the skin, hard or soft; according to location on the foot.~~

~~cyanosis~~ ~~- blue/gray color of the skin, lips and/or nailbeds.~~

~~death~~ ~~- the end of life; permanent cessation of vital body functions.~~

~~decubitus ulcer~~ ~~- pressure sore; bed sore; tissue breakdown;~~

~~defamation of character~~ ~~- making damaging or false statements about another person which injures the reputation.~~

~~deformity~~ ~~- malformation;~~

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~~dehydration~~ ~~- there is not a sufficient amount of fluid in the body.~~

~~delirium~~ ~~- mental disturbance usually occurring in the course of some infectious disease or under influence of poisonous drugs.~~

~~denial~~ ~~- refusal to admit the truth or reality;~~

~~dependability~~ ~~- reliable; capable of being depended on.~~

~~depression~~ ~~- feeling of dejection which can be characterized by anxiety, discouragement or of inadequacy.~~

~~diagnosis~~ ~~- determination of a resident's disease (made by the physician).~~

~~diarrhea~~ ~~- water, loose bowel movement (feces);~~

~~diastolic~~ ~~- period of relaxation of the heart during which it fills with blood; last thump sound heard when taking blood pressure (bottom reading).~~

~~diet- the prescribed allowance of food ordered by the resident's physician.~~

~~diabetic~~ ~~- a person who has a disease of the pancreas which does not produce sufficient amounts of insulin.~~

~~discharge procedures~~ ~~- measures taken when a resident leaves a long term care facility.~~

~~disinfection~~ ~~- killing germs by antiseptics or other methods.~~

~~disease~~ ~~- sickness; illness;~~

~~disorientation~~ ~~- confusion of time, place and person;~~

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ABRIDGED GLOSSARY

~~edema~~ ~~- abnormal swelling of a part of the body caused by fluid collecting in that area.~~

~~elimination~~ ~~- discharge of waste products from the body by the skin, by the kidneys, by respiration and/or by the intestines.~~

~~emotion~~ ~~- subjective feelings; ex. hate, anger, love joy, sadness.~~

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ABBRIDGED GLOSSARY

empathy – understanding; feeling for but not as another feels.

ethics, nursing – system of

excrement – feces; prod

exploit

extremity

fever – cle

flex

fragile – easily

frustration – an emotion se an individual is goal.

goal – the

grooming –

hallucination – a mistaken se five senses can b is the auditory (hearing).

harassment – mental and

hierarchy

health – state of wel social

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~~health team~~ ~~made up of~~ ~~services for~~ ~~assistant is a vital part of this health team.~~

~~hygiene~~ ~~conditions of practices conductive to health.~~

~~hyper-~~

~~hypo-~~

~~illness~~ ~~poor health of~~

~~impaction~~

~~impairment~~ ~~to make~~

~~impending~~

~~incompetence~~ ~~legal term: in~~ ~~his pe~~ ~~impairment.~~

~~infection~~ ~~implantation~~

~~infirmity~~

~~inflammation~~ ~~changes that~~ ~~invaded by ger~~ ~~heat and pain.~~

~~influenza (flu)~~

~~intake~~

~~integrity~~

~~integumentary system~~ ~~protective cove~~

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~~intestine~~ ~~- digestive tract~~

~~invasion of resident privacy~~ ~~- public knowledge of a resident's information without consent of wronged resident.~~

~~isolation technique~~ ~~- a method of ke~~ ~~spreadi~~

~~jaundice~~ ~~- yellow tinge to~~

~~kidney~~ ~~-~~

~~legible~~

~~libel~~ ~~- a written or o~~ ~~representati~~ ~~unfavorable impression.~~

~~long term care facility~~ ~~- a health facilit~~ ~~intermediate~~ ~~care on a 24 hour basis to residents whose primary need is for availability of nursing care on an extended basis.~~

~~masturbation~~ ~~- self stir~~

~~muscle~~ ~~- bundle of contr~~

~~need~~ ~~- a condi~~

~~negligence~~ ~~- failure to us~~ ~~prudent and ca~~ ~~similar situation.~~

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~~nutrition~~ ~~- the process of~~

~~obese~~

~~occlude~~

~~organic disease~~ ~~- a disease associated with observable or detectable changes in the organs or tissues of the body.~~

~~ostomy~~ ~~- artificially~~ ~~abdominal wal~~ ~~intestinal organs to discharge waste products.~~

~~output~~ ~~-flu~~

~~pallor~~ ~~- pal~~

~~paralysis~~ ~~- loss of power~~

~~paralyze~~ ~~- to cause l~~

~~passive exercise~~ ~~- exercise that th~~ ~~and m~~

~~physical findings~~ ~~- normal, no~~

~~policy~~ ~~- a definite~~

~~positioning~~

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~~procedure~~ ~~- a series of~~

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~~prostheses~~

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~~range of motion~~ ~~- exercises wh~~ ~~the~~

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~~reality~~ ~~- the environm~~

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~~reality orientation~~ ~~- awareness of e~~

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~~recall~~ ~~- remembering a past experience.~~

~~respiration~~

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~~responsibility~~ ~~- moral, lega~~ ~~something for wh~~

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~~restraint~~ ~~- any device~~ ~~restrict, or l~~

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~~device or method used to keep a resident from injuring self.~~

~~rheumatism~~ ~~- pain, swellin~~

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~~rigidity~~

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~~role~~ ~~- a behavior~~ ~~individual's st~~

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~~roles have specific behavior associated with them.~~

~~saliva~~ ~~- fluid secreted~~

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~~scalp~~ ~~- part of the hun~~

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~~secrete~~

~~self-abuse~~

~~self-neglect~~ ~~- failing to~~

~~sensitive~~ ~~- easily hurt emo~~

~~socialization~~ ~~- learning to li~~

~~stethoscope~~ ~~- instrument us~~

~~stimulate~~

~~stoma~~ ~~- artificially~~ ~~body passage with the outside.~~

~~stress~~ ~~- a physical, ch~~ ~~that causes b~~ ~~may be a factor in causing disease.~~

~~sympathy~~ ~~- understanding~~ ~~fe~~

~~symptoms~~ ~~- something th~~

~~systolic~~ ~~- period duri~~ ~~heart takes~~ ~~when taking blood pressure (top reading).~~

~~therapeutic~~ ~~- an act whi~~

~~transfer procedures~~ ~~- measures taken~~ ~~from one ro~~ ~~facility.~~

~~urine~~ ~~- liquid wastes~~

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~~vertigo~~

~~vital signs~~ ~~- temperature, p~~

~~void~~

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COMMON MEDICAL ABBREVIATIONS

Time Abbreviations

a.m.	morning	stat	immediately
p.m.	afternoon or evening	noc	night
a.c.	before meals	P.R.N.	whenever necessary
p.c.	after meals	q.d.	every day
B.I.D.	twice a day	q.h.	every hour
T.I.D.	three times a day	q.o.d.	every other day
Q.I.D.	four times a day	q3h	every three hours
H.S.	bedtime (hour of sleep)	q4h	every four hours

Resident Orders

amt	amount	NPO	Nothing by mouth
ax	axilla		(sometimes NBM)
BM	bowel movement	P.T.	physical therapy
BRP	bathroom privileges	R	rectal or right
c	with	ROM	range of motion
s	without	spec.	specimen
ad lib	as desired	T.W.E.	tap water enema
DC	discontinued	S.S.E.	soap suds enema
ht	height	w/c	wheelchair
wt	weight	TPR	temperature, pulse, respiration
I&O	Intake and Output	ADL	activities of daily living
BP	blood pressure	V.S.	vital signs (TPR & BP)

Diagnostic Terms

MI	Myocardial infarction (heart attack) or mental illness	GI	gastro intestinal
		GU	genito urinary
CVA	cerebrovascular accident or stroke	CHF	congestive heart failure
H.O.H.	hard of hearing	Ca	cancer
S.O.B.	short of breath	CV	cardiovascular

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~~fx~~ ~~fracture~~

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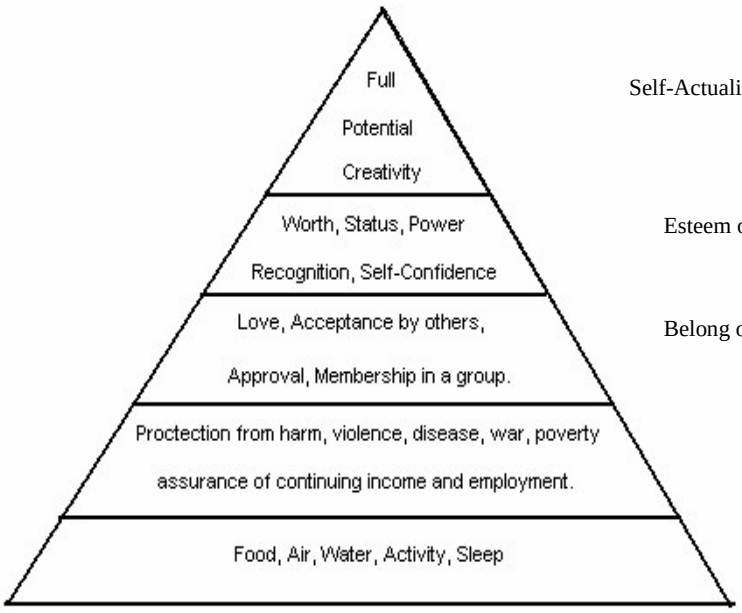
~~MASLOW'S HIERARCHY OF NEEDS~~



~~5th Level~~ Self-Actualizing Needs

~~4th Level~~

~~3rd Level~~ Esteem or Ego Needs

~~2nd Level~~

Belong or Social Needs

~~Security or Safety Needs~~

~~1st Level Physiological or Survival Needs~~

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The following is a list of references which were consulted in the development of the Arkansas Long Term Care Facility Nursing Assistant Training Program. This is not intended to be a complete listing of all texts consulted.

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North Texas State University
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Experience:

Supervisor, Nursing Administration, Geriatrics Areas
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Senior Instructor, Nursing Education, Registered Nurse Student
Psychiatric Nursing Affiliation

Director, Continuing Education
Arkansas League for Nursing

Organizations:

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~~American Nurses Association~~

~~Arkansas State Nurses Association~~

~~National League for Nursing~~

~~Arkansas League for Nursing~~

~~Arkansas Nursing Home Nurses Association~~

~~American Association of Retired Persons~~

~~CURRICULUM COMMITTEE~~

~~RUTH ERELENE HAMILTON, RN~~
~~Mountain Home, Arkansas~~

~~Education:~~

~~Bethel Deaconess Hospital, Newton, Kansas~~
~~Diploma Nurse~~

~~Eastern Mennonite College Harrisonburg, Virginia~~
~~Bachelor of Science in Nursing~~

~~Experience:~~

~~Patient Care Coordinator~~
~~Baxter Manor Nursing Home~~

~~Supervisor and Teacher~~
~~Promise Land Academy~~

~~Director of Nursing~~
~~Baxter Manor Nursing Home~~

~~Director of Nursing~~
~~Baxter General Hospital~~

~~Director of Nursing~~
~~Marion County Hospital~~

~~Surgical Floor Nurse and In-Service Education Director~~
~~Boone County Hospital~~

~~Organizations:~~

~~Advisory Council Practical Nurses School~~

Twin Lakes Vocational Technical School of Mountain Home, Arkansas

Arkansas Nursing Home Nurses Association

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University of Arkansas at Little Rock
B.A., Sociology/Gerontology, 1974
State of Arkansas Licensed Social Worker

Experience:

Program Supervisor, Division of Aging and Adult Services.
Planning and program development for Alternatives Services in Long Term Care and case management since 1976.

Organizations:

Central Arkansas Alzheimer's Disease and Related Disorder Association Board since 1984.

Southwest Society on Aging

Arkansas Gerontological Society

Little Rock Women's City Club

Ad Hoc Committee on Women's Concerns, Association of Area Agencies on Aging

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~~Associate Degree in Nursing~~

~~Experience:~~

~~Administrator~~
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~~Administrator~~
~~Lonoke Nursing Home~~

~~CURRICULUM COMMITTEE~~

~~Director of Nursing~~
~~Lonoke Nursing Home~~

~~Staff Nurse~~
~~Memorial Hospital North Little Rock~~

~~Nurse Aide~~
~~Arkansas Children's Hospital~~

~~Organizations:~~

~~Arkansas State Board of Nursing~~

~~Arkansas League for Nursing~~

~~Arkansas Nursing Home Nurses Association~~

~~Diploma Nurses of Arkansas~~

~~National Association of Directors of Nursing Administration in Long Term Care~~

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~~Diploma Nurse~~

~~Experience:~~

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~~Arkansas Department of Health~~
~~Division of Health Facility Services~~

~~Nursing Services Inspector~~
~~Office of Long Term Care~~
~~Division of Economic and Medical Services – Arkansas Department of Human Services~~

CURRICULUM COMMITTEE

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~~Metropolitan Vocational Technical Education Center~~
~~Little Rock School District~~
~~Little Rock, Arkansas~~

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~~Little Rock, Arkansas~~

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~~Jonesboro, Arkansas~~

~~Director of Nursing~~
~~Pioneer Nursing Home~~
~~Melbourne, Arkansas~~

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~~Kabul, Afghanistan~~

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~~Advisory Committee for Continuing Education in Nursing~~
~~Arkansas State University~~
~~Jonesboro, Arkansas~~

~~Advisory Committee for Nursing~~
~~Delta Vocational-Technical School~~
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~~Pediatric Nurse Clinician Program – Certificate~~

~~University of Arkansas for Medical Sciences~~
~~Family Nurse Practitioner Program – Certificate~~

~~University of Arkansas for Medical Sciences~~
~~Master of Nursing Science~~

~~Experience:~~

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CURRICULUM COMMITTEE

~~Executive Director~~
~~Arkansas State Nurses' Association~~

~~Staff Nurse~~
~~University Hospital~~

~~Head Nurse~~
~~University Hospital~~

~~Nurse Practitioner~~
~~C & Y Project and Child Study Center~~
~~Instructor UAMS College of Medicine Instructor~~
~~UALR Department of Nursing~~

~~Assistant Professor~~
~~UAMS College of Nursing~~

~~Organizations:~~

~~American Nurses Association~~

~~Arkansas State Nurses Association~~

~~Sigma Theta Tau International Honor Society for Nursing~~

~~UAMS College of Nursing Curriculum Committee~~

~~**********~~

~~REVISION COMMITTEE July, 1992~~

CURRICULUM COMMITTEE

~~This curriculum was revised in July 1992 to encompass provisions of the federal regulations issued by the U.S. Department of Health and Human Services (Health Care Financing Administration). Other modifications were made based upon suggestions received from nursing facilities and training providers since implementing this program in July 1989.~~

~~The revisions committee included the following individuals:~~

~~Ruth Erlene Hamilton~~	~~(see previous committee listing)~~
~~Kay Hayes~~	~~RN, Office of Long Term Care~~
~~Peggy Moody~~	~~(see previous committee listing)~~
~~Idavonne Rosa~~	~~(see previous committee listing)~~
~~Thomas Wingard~~	~~Program Coordinator, Office of Long Term Care~~

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ACKNOWLEDGEMENTS

Patricia Dismukes
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Baxter Manor Nursing Home, Mountain Home, Arkansas
W. Pat Flippo, Administrator

Cabot Manor Nursing Home, Cabot , Arkansas
Catlett Corporation
Sheila Martin, R.N., DON and Staff

Little Rock Nursing Center, Little Rock, Arkansas
J.T. Rose

East Arkansas Area Agency on Aging
Jonesboro, Arkansas

To those who wrote and/or came to committee meetings, sharing their knowledge and their experiences with their individual nursing assistant training programs.

To committee member's families who supported their hours of labor.

To our sister states who were so gracious to share their nursing assistant course materials.

STATE OF ARKANSAS

LONG TERM CARE FACILITY NURSING ASSISTANT TRAINING CURRICULUM

Written by
The Curriculum Committee for the
Nursing Assistant Training Program

July 1988
(Revised July 1992)
(Revised July 2006)
(Revised January 2019)

For information and implementation of this curriculum contact:
Quality Assurance, Workforce Assessment, & Provider Engagement
Division of Provider Services and Quality Assurance
Department of Human Services
Post Office Box 8059 Slot S405
Little Rock, Arkansas 72203

AUTHORITY

I.

1. The following rules and regulations for the Long Term Care Facility Nursing Assistant Training Program are duly adopted and promulgated by the Department of Human Services pursuant to Arkansas Code 20–10–701 et seq.

2. This initiative is pursuant to the Federal mandates of Public Law 100–203

The Nursing Home Reform Act, Subtitle C of the Omnibus Budget and Reconciliation Act of 1987 and technical amendments of OBRA 1989 and 1990 concerning the training and competency evaluation of nursing assistants employed in long term care facilities and the registry of certified nursing assistants.

3. The Federal Omnibus Budget Reconciliation Act (OBRA) of 1987, 1989, and 1990 and regulations issued by the U.S. Department of Health and Human Services – Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration, or HCFA) established the minimum requirements for nursing assistant training and competency evaluation programs in Section 1819(a) – (f) and 1919(a) – (f) of the Social Security Act.

II.

1. The Arkansas Nursing Assistant Scope of Practice identifies the Standards of Practice that Certified Nursing Assistants (CNA) must follow in delivering care. If a CNA delivers care outside of the defined Standards of Practice, whether it is on the CNA's own initiative or at the direction of a licensed nurse, the CNA may have violated the Arkansas Adult and Long–Term Care Facility Resident Maltreatment Act as defined in Arkansas Code Ann. 12–12–1707 et seq.

TABLE OF CONTENTS

UNIT 1

Lesson # 1 (1 hour)

Title: Introduction to the Role of the Nurse Aide

Lesson Objectives:

I. The student will be able to describe Long Term Care in comparison with other healthcare settings.

II. The student will be able to describe the role of the Nursing Assistant, including the Scope of Practice and the role of facility policies and procedures which may govern care and conduct.

III. The student will be able to explain the members and roles of the Interdisciplinary Care Team and the Chain of Command.

IV. The student will be able to describe the importance of both verbal and non–verbal communication, barriers to effective communication, and interpersonal skills.

V. The student will be able to explain culture change/resident-centered care and the need to incorporate into daily care.

Key Terms:

Abuse – any intentional unnecessary physical act that inflicts pain on, or causes injury, to an endangered person or an impaired person (nursing home resident);

A. Any intentional and unnecessary physical act that inflicts pain on or causes injury to an endangered person or an impaired person, excluding court-ordered medical care or medical care requested by the patient or long-term care facility resident or a person legally authorized to make medical decisions on behalf of the patient or long-term care facility resident;

B. Any intentional act that a reasonable person would believe subjects an endangered person or an impaired person, regardless of age, ability to comprehend, or disability, to ridicule or psychological injury in a manner likely to provoke fear or alarm, excluding necessary care and treatment provided in accordance with generally recognized professional standards of care;

C. Any intentional threat that a reasonable person would find credible and non-frivolous to inflict pain on or cause injury to an endangered person or an impaired person except in the course of medical treatment or for justifiable cause; or

D. Any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

Activity Director (AD) – an individual who plans the activities for the residents and assists them to socialize and to stay physically and mentally active.

Activities of Daily Living (ADLs) – personal daily care tasks, including bathing, dressing, caring for teeth and hair, toileting, eating, and drinking.

Acute – a current illness that has severe symptoms and may be as a result of a sudden onset.

Administrator – manages all departments within the facility.

Adult Day Care – care given at a facility during day time hours; generally for individuals who need some assistance and/or supervision but are not seriously ill or disabled; usually reside outside of the facility.

Advanced Practice Nurse – a registered nurse having education beyond the basic nursing education and certified by a nationally recognized professional organization in a nursing specialty, or meeting other criteria established by a Board of Nursing.

Assisted Living – facilities where residents live who need limited assistance, but do not require skilled care.

Bedfast – Bedridden. Confined to bed, especially for a long or indefinite period of time, due to illness or injury

Call Light – a device used to communicate a need for assistance to staff.

Certified Nursing Assistant (CNA) – an individual who has completed a state-approved course and has successfully completed certification testing. A CNA provides direct care under the supervision of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

Certified Occupational Therapist Assistant (COTA) – helps patients develop, recover, and improve the skills needed for daily living and working. Occupational therapy assistants provide therapy to patients under the direct supervision of occupational therapists.

Chain of Command – the line of authority in the facility which addresses to whom each employee/department reports.

Chronic – the disease or condition is long term or will be long lasting.

Clichés – phrases that are used frequently and which often have a different meaning, making it difficult for the resident to understand.

Communication – the process of exchanging information with others.

Criminal Record Check – the process of reviewing an individual's criminal history in order to determine if he/she is eligible for employment in a long term care facility. State and/or national records may be reviewed for this process.

Cultural Differences – beliefs, values, habits, diet and health practices that relate to a person's culture or religion.

Cultural Diversity – the variety of people living and working together in the facility.

Culture – the way of life, especially the general customs and beliefs, of a particular group of people at a particular time.

Culture Change – a philosophy that focuses on providing person–centered care to residents and creating a positive work environment for healthcare workers.

Denial – rejection of a thought or feeling.

Dependent – requires staff assistance to carry out activities of daily living.

Displacement – transferring a strong negative feeling to something or someone else.

Endangered Adult – A long-term care facility resident or an Arkansas State Hospital resident who:

A. Is found to be in a situation or condition that poses an imminent risk of death or serious bodily harm to the long-term care facility resident; and

B. Demonstrates a lack of capacity to comprehend the nature and consequences of remaining in that situation or condition.

Exploitation – illegal or unauthorized use or management of an endangered person's or an impaired person's (nursing home resident) funds, assets, or property;

A. Misappropriation of property of a long–term care facility resident, that is, the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a long–term care facility resident's belonging or money without the long–term facility resident's consent.

Health Insurance Portability and Accountability Act (HIPAA) – federal law that protects the privacy of individually-identifiable health information; sets national standards for the security of electronic, protected health information; and protects identifiable information being used to analyze patient safety events and improve patient safety.

Home Health Care – care provided in a person's home.

Hospice Care – care for individuals who have an estimated six months or less to live. Hospice provides physical and emotional care and comfort.

Housekeeping Department – responsible to maintain the facility in a clean and sanitary manner.

Impaired Person – a person eighteen (18) years of age or older who as a result of mental or physical impairment is unable to protect himself or herself from abuse, sexual abuse, neglect or exploitation. A long–term care facility resident is presumed to be an impaired person.

Independent – able to carry out activities of daily living without staff assistance.

Intermediate Care Facilities/Individuals with Intellectual Disabilities (ICF/IID) – facilities that specialize in providing care to developmentally disabled individuals.

Interdisciplinary Team – professionals from each discipline within the nursing facility who meet to discuss and plan the care of the resident.

Laundry Department – oversees laundering of facility linens and residents' personal clothing.

Licensed Practical Nurse (LPN) – A licensed professional who has completed 1 to 2 years of nursing education and has passed an exam for licensure; nurse who provides care under the direction of registered nurses or physicians.

Long Term Care (LTC) – care for persons who require 24-hour care and assistance.

Long Term Care Facility Resident – means a person, regardless of age, living in a long–term care facility.

Long Term Care Facility Resident Maltreatment – abuse, exploitation, misappropriation of a resident's property, neglect, or sexual abuse of a long–term care facility resident as defined by Arkansas law.

Maintenance Department – maintains facility and grounds in good repair.

Medical Director – physician who provides oversight to the nursing staff regarding care provided to the residents.

Medical Doctor (MD) – physician

Medication Assistive Person (MAP) – a certified nursing assistant who has completed required state training and has completed examination in an effort to administer medications and certain treatments in accordance with the specific scope of practice of the MAP.

Neglect – an act or omission by a caregiver responsible for the care and supervision of an endangered person or an impaired person (nursing home resident) constituting:

A. Negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered person or an impaired person;

B. Negligently failing to report health problems or changes in health problems or changes in the health condition of an endangered person or an impaired person to the appropriate medical personnel;

C. Negligently failing to carry out a treatment plan developed or implemented by the facility; or

D. Negligently failing to provide goods or services to a long-term care facility resident necessary to avoid physical harm, mental anguish, or mental illness.

Non–Verbal Communication – communication without using words, such as facial expressions, tone of voice, posture, gestures, touch, body language, etc.

Objective Information – information based on what is factually seen, heard, touched or smelled. A direct observation.

Occupational Therapist (OT) – a therapist who helps residents to learn to compensate for their disabilities and assist them with activities of daily living.

Office of Long Term Care – state agency that oversees the long term care facilities in Arkansas; commonly called OLTC.

Ombudsman – resident advocate who investigates complaints and assists to achieve agreement between parties, often defending the rights of residents.

Optometrist – health care professional who examines eyes for defects, prescribes correctional lenses, and treats diseases of the eye.

Palliative Care – care that focuses on the comfort and dignity of the person rather than on curing him or her.

Person–Centered Care – a philosophical approach to nursing home care that honors and respects the voice of elders and those working closest with them. It involves a continuing process of listening, trying new things, seeing how they work, and changing things in an effort to individualize care and de–institutionalize the nursing home environment.

Physical Therapist (PT) – provides therapy in the form of heat, cold, massage, ultrasound, electricity and exercise to residents with muscle, bone and joint problems. A PT may help a person to safely use a walker, cane, or wheelchair

Podiatrist – a physician who examines and cares for the residents' feet.

Policy – a course of action determined by the facility that should be taken every time a certain situation occurs.

Post–Acute Head Injury Facility – a facility which specializes in care and services for persons with acute head injuries.

Procedure – the steps to be taken to carry out a task. A particular way of doing something.

Professionalism – how a person behaves when he/she is on the job.

Projection – seeing feelings in others that are really one's own.

Rationalization – making excuses to justify a situation.

Registered Dietitian (RD) – a professional who creates special diets for residents with specific needs and plans menus to ensure residents' nutritional needs are met.

Registered Nurse (RN) – a licensed professional who has completed 2 to 4 years of nursing education and has passed an exam for licensure; professional who can provide all levels of nursing care under the direction of a physician.

Regression – going back to an old, immature behavior.

Repression – blocking painful thoughts or feelings from the mind.

Residential Care Facility (RCF) – facility licensed to provide services 24 hours a day to individuals older than 17 who are not capable of independent living and who require assistance and supervision. Individuals in RCF must be independently mobile, capable of responding to reminders and guidance from staff and capable of self-administering medication.

Respiratory Therapist – provides breathing treatment(s) and special equipment for respiratory conditions.

Sexual Abuse – deviant sexual activity, sexual contact, or sexual intercourse, as those terms are defined in §5–14–101, with another person who is not the actor's spouse and who is incapable of consent because he or she is mentally defective, mentally incapacitated, or physically helpless as those terms are defined in §5–14–101.

Scope of Practice – the tasks for which a person is trained, thus, allowed to perform.

Skilled Care – medically-necessary care given by a nurse or therapist.

Slang – terms/words used that may be specific to a generation and not easily recognized and/or easily misinterpreted by the resident.

Social Worker (SW) – an individual who helps residents with psycho–social needs and assists to arrange needed services.

Speech Therapist (ST) or **Speech Language Pathologist (SLP)** – a therapist who helps residents with speech, language and swallowing problems.

Subjective Information – information that could not be or was not observed. Information based on what a person thinks, or something that was reported by another person that may or may not be true.

Terminal illness – a disease or condition that will eventually cause death.

Tuberculosis (TB) – a bacterial infection that usually attacks the lungs, but can attack any part of the body, such as the kidneys, spine, and brain. An airborne disease, carried on droplets suspended in the air, that causes coughing, difficulty breathing, fever and fatigue.

Verbal Communication – written or spoken messages.

Content:

I. Introduction to Long Term Care

- A. Long Term Care – Acute, chronic and terminal illness
- B. Skilled Care
- C. Adult Day Care
- D. Assisted Living
- E. Residential Care Facility
- F. Home Health Care
- G. Hospice Care
- H. Palliative Care
- I. Intermediate Care Facilities/Individuals with Intellectual Disabilities (ICF/IID)

II. The Role of the Nurse Aide

- A. Requirements for working in Long Term Care
  1. Criminal records check performed per the Office of Long Term Care (OLTC) guidelines
  2. Tuberculosis (TB) Skin Test (or health screen and physical) and annual flu vaccination

3. Completion of a state-approved training program

4. Pass the state competency examination within one year of training completion; only three test attempts will be allowed; certificate must remain active and in good standing (no flags/disqualifications)

B. Professionalism

Examples of professional interactions with the resident include, but are not limited to:

1. Keeping a positive attitude while doing the assigned tasks you are trained to perform.

2. Keeping information about the resident confidential

3. Being polite – not discussing your personal problems with a resident or with a co–worker in front of a resident

4. Not using profanity, even if a resident uses profanity.

5. Listening to the resident.

6. Calling the resident by Mr., Mrs., Ms., or by the name he/she prefers.

7. Always explaining the care, you will be providing before beginning to provide the care.

8. Presenting a positive image through personal hygiene, appearance and state of mind.

9. Accountability

10. Confidentiality–Health Insurance Portability and Accountability Act (HIPAA)

C. Scope of Practice – The Arkansas Nursing Assistant Scope of Practice identifies the Standards of Practice that Certified Nursing Assistants (CNA) must follow in delivering care. If a CNA delivers care outside of the defined Standards of Practice, whether it is on the CNA's own initiative or at the direction of a licensed nurse, the CNA may have violated the Arkansas Adult and Long Term Care Facility Resident Maltreatment Act as defined in Arkansas Code Ann. §12–12–1707 et seq.

D. Provide care according to the resident's comprehensive care plan.

1. Direct care needs/Use of a Nurse Aide Assignment Sheet

E. Actively listen to and communicate with the resident, the family, and the health care team.

F. Observe and report any change in the resident's appearance, behavior or mood to the nurse.

1. Objective observation/information

2. Subjective observation/information

3. Observations that indicate an acute condition requiring immediate attention from the nurse include but are not limited to: severe pain, fall/accident, seizures, swelling, bleeding, loss of consciousness, difficulty breathing.

4. Acute change in mental status – confusion, lethargy, delirium.

G. Participate in care planning, when requested.

H. Follow policies and procedures.

I. Follow the nurse aide assignment for your shift.

III. The Care Team and the Chain of Command

A. Interdisciplinary Team – often includes Activity Director, Certified Nursing Assistant, Licensed Practical Nurse, Medical Doctor, Social Worker, Occupational Therapist, Physical Therapist, Medication Assistive Person, Dietary Manager and/or Registered Dietitian, Registered Nurse, Speech Therapist, Administrator.

1. Resident and Family Member/Responsible Party.

2. Ombudsman, upon resident request.

B. Chain of Command

1. Administrator

2. Director of Nursing

3. Licensed Nurse (charge nurse/supervisor)

4. Certified Nursing Assistant/ Medication Assistive Person

IV. Communication and Interpersonal Skills

A. Effective Communication

1. Formulate the message.

2. Receive the message (listen).

3. Observe for feedback.

B. Verbal and Non–Verbal Communication

C. Barriers to Communication

1. Clichés

2. Slang

3. Impairments

a. A person who is visually impaired relies on verbal cues, including words and tone of voice.

i. State your name before beginning a conversation.

ii. Describe persons, things and environment.

iii. Inform the resident when you are entering or leaving the room.

iv. Explain in detail what you are doing and ask the resident what they would like to do independently.

v. Touch the resident, if appropriate.

vi. Read resident's mail or personal documents, only if asked

vii. Sit where resident can easily see you if resident has partial vision.

b. A person who is hearing impaired relies on nonverbal cues including body language, sign language, and writing.

i. Speak slowly and distinctly.

ii. Use short sentences.

iii. Face the resident.

iv. Use facial expressions and gestures.

v. Reduce outside distraction

vi. Use sign language and communication boards, if appropriate.

vii. Be certain that the resident's hearing aid is in place and is working properly, if applicable. (Glasses also)

4. A person who is cognitively impaired relies on both verbal and nonverbal cues and may need messages repeated frequently, using short sentences and simple words.

5. Denial – refusal to acknowledge existence of something: a refusal to believe in something or admit that something exists.

6. Displacement – transfer of emotions or behavior: the transfer of emotion from the original focus to another less threatening person or object, or the substitution of one response or piece of behavior for another.

7. Rationalization – a defense mechanism whereby people attempt to hide their true motivations and emotions by providing reasonable or self–justifying explanations for irrational or unacceptable behavior.

8. Regression – reversion to earlier state: a return to an earlier or less developed condition or way of behaving.

9. Repression – a mechanism by which people protect themselves from threatening thoughts by blocking them out of the conscious mind.

D. Call Lights as the resident's means to Communicate with Staff

1. Ensure residents have access to their call light when they are in their room; always place call light on the resident's unaffected side and within easy reach.

2. Staff should respond immediately to call lights and provide any necessary/requested assistance upon answering.

E. Promoting resident's independence

1. Independence versus Dependence – relying on self vs. others to perform tasks

2. Activities of Daily Living (ADLs) – allow residents to perform as much of the skill/duty as possible, offering assistance as needed.

V. Resident–Centered Care (Person–Centered Care)

A. Respecting resident choice/preference

1. Provide a home–like and safe living environment with daily routines designed to meet the resident's specific needs and in accordance with former lifestyle.

B. Practices which reflect resident–centered care includes, but not limited to:

1. Time to awake/retire to bed

2. Frequency of bath/shower

3. Preferred activities

4. Choice of clothing

5. Choice of mealtimes

6. Choice of toileting times

C. Cultural Diversity

D. Respecting Cultural Differences

E. Respecting Religious Preferences

Review Questions --- Lesson #1

1. To whom does the CNA report?

2. What is the difference between an objective and a subjective observation?

3. Give examples of resident choices which could be honored by the facility to promote person–centered care.

Lesson # 2 (1.5 hours)

Title: Resident Rights

Lesson Objectives:

I. The student will be able to explain the importance of residents' rights.

II. The student will be able to describe the components/areas that are residents' rights.

III. The student will be able to demonstrate ways to protect residents' rights.

IV. The student will be able to describe the types of abuse, neglect and misappropriation.

Key Terms:

Abuse – the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish; abuse can be verbal (something said–oral, written or gestured), physical (something done to the resident–rough handling/treatment, hitting, slapping, pinching, etc.), emotional/mental (humiliation, harassment, threats of punishment or deprivation) or sexual (harassment, coercion or sexual assault). Any sexual relationship with a resident is considered to be abuse.

Confidentiality – maintaining information as private.

Consensual – agreed to by the people involved; done with the consent of the people involved.

Health Insurance Portability and Accountability Act (HIPAA) – federal law that protects the privacy of individually-identifiable health information; sets national standards for the security of electronic, protected health information; and protects identifiable information being used to analyze patient safety events and improve patient safety.

Informed Consent – a person, if competent, after having been informed of potential negative outcomes, makes informed decisions about their healthcare.

Involuntary Seclusion – separation of a resident from other residents or from his/her room or confinement to his/her own room against the resident's will, or the will of the resident's legal representative.

Misappropriation – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

Neglect – failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness; failure to follow a prescribed order of treatment or the care plan; negligently failing to provide necessary treatment, rehabilitation, care, food clothing, shelter, supervision , or medical services; negligently failing to report health problems or changes in health problems or changes in health condition of a resident to the appropriate medical personnel, and failing to carry out a prescribed treatment plan developed or implemented by the facility.

Omnibus Budget Reconciliation Act (OBRA) – law passed by federal government establishing minimum standards for nursing home care and for nursing assistant training.

Privacy – free of being observed or disturbed by other people.

Residents' Rights – rights identified by OBRA relative to residents in long term care facilities; informs residents and others of the residents' rights within the facility.

Restraints – to physically restrict voluntary movement or use chemicals to revise/restrict resident behavior.

Content:

I. Residents' Rights

A. Origin – Omnibus Budget Reconciliation Act (OBRA) —passed in 1987 due to reports of poor care and abuse in nursing homes.

B. Purpose

1. Inform a resident how he/she is to be treated.

2. Provide an ethical code of conduct for healthcare workers.

C. These rights include the resident's right to:

1. Exercise his or her rights;

2. Be informed about what rights and responsibilities he or she has;

3. If he or she wishes, have the facility manage his or her personal funds;

4. Choose a physician, treatment and participate in decisions and care planning;

5. Privacy and confidentiality;

6. Voice grievances and have the facility respond to those grievances;

7. Examine survey results;

8. Work or not work;

9. Privacy in sending and receiving mail;

10. Visit and be visited by others from outside the facility;

11. Use a telephone in privacy;

12. Retain and use personal possessions to the maximum extent that space and safety permit;

13. Share a room with a spouse or another, if mutually agreeable;

14. Refuse a transfer from a distinct part, within the facility;

15. Be free from any physical or chemical restraints; and

16. Be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.

D. Protection of Residents' Rights:

1. Never abuse — know your limits.

2. Types of abuse (Refer to Lesson 30) (*Arkansas Adult Maltreatment Act, Act 584 of 2013, codified as Ark. Code Ann. § 12-12-701 et seq.*)

3. Report signs/symptoms of abuse, neglect and misappropriation (examples provided later).

E. Privacy

1. Avoid unnecessary exposure.

2. Do not open mail without permission.

3. Knock and request permission before entering room.

F. Confidentiality

1. No gossip.

2. No sharing of resident information except with care team members.

a. Health Insurance Portability and Accountability Act (HIPAA) – law to keep health information private.

b. Social Media – posting any resident's information without that resident's consent is considered a violation of privacy rights and may lead to abuse as defined in the Abuse Maltreatment Act.

G. Resident Care

1. Involve resident in care.

2. Explain procedures.

3. Respect refusal in care.

4. Report refusal in care.

Note: Introduce CARE SKILLS #1 and #2– "Initial Steps" and "Final Steps" to reinforce acknowledgement of Resident Rights. Following these steps will help to ensure that residents' rights are observed when providing care.

H. Report and Document

1. Be honest and truthful.

2. Notify supervisor immediately of abuse, neglect and/or misappropriation.

3. Contact nurse with questions about caring for residents.

4. Report changes in condition.

5. Mandated reporter- person legally required to report suspected or witnessed abuse and/or neglect. Nursing assistants are mandated reporters. Failure to report abuse or neglect is a crime that can result in criminal charges.

II. Abuse, Neglect, and Personal Possessions/Misappropriation

A. Types of Abuse

1. Physical - something done to the resident – rough handling/treatment, hitting, slapping, pinching, etc.

2. Sexual - harassment, coercion or sexual assault. Any sexual relationship with a resident is considered to be abuse.

3. Mental - humiliation, harassment, threats of punishment or deprivation

4. Verbal - something said – oral, written or gestured

5. Financial – improper or illegal use of the resident's money or possessions. Accepting money from the resident for special care or stealing from the resident is considered financial abuse.

B. Neglect/Negligence

C. Involuntary Seclusion

D. Misappropriation

1. Personal property

2. Gifts

3. Temporary or permanent misuse of a resident's property.

E. Signs and Symptoms

1. Abuse

a. Conditions– suspicious marks, bruises, bite marks, fractures, dislocations, burns, scalp tenderness, nose bleeds, swelling, welts

b. Observations– fear, pain, withdrawal, mood changes, acting out, anxiety, guarding

c. Catastrophic reactions- are extraordinary reactions of residents to ordinary stimuli, such as the attempt to provide care.

2. Neglect

a. Conditions – pressure ulcers, dehydration, weight loss, anger, sadness, fear

b. Observations – unclean, soiled bedding or clothing, unanswered call lights, wrong clothes, no glasses/hearing aids, uneaten food/snacks, no water available

c. Negligently failing to carry out a prescribed treatment plan developed or implemented by the facility

3. Misappropriation

a. Conditions – anger, sadness, fear

b. Observations – missing items, comments from resident or family

F. Reporting

1. Know federal requirements, state requirements and requirements in the Adult and Long–Term Care Facility Resident Maltreatment Reporting Acts, Act 584 of 2013, codified as Ark. Code Ann. § 12-12-701 et seq.

CARE SKILLS:

Introduce the students to:

- Initial Steps – #1
- Final Steps – #2

Review Questions --- Lesson #2

1. Give examples of Resident Rights.
2. How can Resident Rights be protected?
3. What are the different types of abuse?
4. Give examples of neglect.
5. Give an example of misappropriation.
6. What is the first thing that should be done if you feel a resident has been abused?

Lesson #3 (2 hours)

Title: Infection Control

Lesson Objectives:

I. The student will be able to explain the importance of Infection Control.

II. The student will be able to describe the chain of infection.

III. The student will be able to explain the importance of hand hygiene.

IV. The student will be able to describe the importance of personal protective equipment (PPE).

V. The student will be able to explain both Standard and Transmission-Based Precautions.

VI. The student will be able to describe conditions that are associated with infections.

VII. The student will be able to demonstrate proper handwashing technique and proper use of PPE.

VIII. The student will be able to describe the importance of a clean environment.

IX. The student will be able to verbalize rationale related to following proper technique for handwashing and use of PPE.

Key Terms

Acquired Immune Deficiency Syndrome (AIDS) – a disease of the human immune system caused by Human Immunodeficiency Virus (HIV). The illness interferes with the immune system, making those with AIDS much more likely to get infections. Although considered a sexually transmitted disease, it is also spread through blood, infected needles, or to the fetus from its mother.

Airborne Precautions – measures used to protect against diseases that are transmitted through the air after expelled.

Aseptic– preventing infection; free or freed from pathogenic microorganisms.

Blood-borne Pathogens – microorganisms in human blood which can cause infection and disease in humans.

Body Fluids – saliva, sputum, urine, feces, semen, vaginal secretions, and pus or other wound drainage.

Causative Agent – a biological agent (pathogen) that causes a disease.

Centers for Disease Control and Prevention (CDC) – federal agency that issues guidelines to protect and improve health.

Chain of Infection – an illustration to describe how a disease is transmitted from one person (or source) to another.

Clostridium Difficile (C–Diff) – bacteria which causes severe watery diarrhea and other intestinal disease when competing bacteria have been wiped out by antibiotics; It is spread by spores that are difficult to kill and can be carried on the hands of caregivers who have direct contact with residents or an environmental surface (i.e., floors, toilets, bedpans).

Contact Precautions – measures used when there is risk of transmitting or contracting a microorganism from touching an infected object or person.

Direct Contact – touching an infected person, or his/her secretions.

Disinfect – to decrease the spread of pathogens and disease by destroying pathogens.

Disinfection – process used to decrease the spread of pathogens by destroying them. Chemicals are often used in this method of cleaning.

Disposable – a product designed for short–term or single use.

Droplet Precautions – measures used to protect against disease-causing microorganisms that do not stay airborne and only travel a short distance after being expelled.

Hand Hygiene – washing hands with soap and water or using alcohol–based hand rub.

Healthcare-Associated Infection (HAI) – infection acquired in a hospital or other healthcare setting; also known as a nosocomial infection.

Hepatitis – inflammation of the liver caused by infection.

Indirect Contact – transmission of a disease without physical contact (e.g., touching a common object).

Infection Control – methods used to control and prevent the spread of germs that are present in the environment.

Influenza – an infectious disease caused by a virus. The most common symptoms include chills, fever, sore throat, muscle pains, severe headache, coughing, weakness/fatigue, and general discomfort. Influenza is a more severe disease than the common cold.

Isolation – measure taken to separate (isolate) the potentially harmful microorganism and prevent spread to other residents.

Jaundice – a yellow/gold tint to the skin and eyes often seen in liver disease, such as hepatitis, or liver cancer.

Localized Infection – an infection contained to a specific body part.

Methicillin-Resistant Staphylococcus Aureus (MRSA) – an antibiotic resistant infection often acquired in hospitals and other facilities; spread by direct physical contact.

Mode of Transmission – how the pathogen travels from one person to another. Transmission can happen through the air, or through direct or indirect contact.

Nosocomial Infection – infection acquired in a hospital or other healthcare setting; also known as HAI (healthcare-associated infection).

Occupational Safety and Health Administration (OSHA) – federal agency that protects workers from hazards on the job.

Pathogen – harmful microorganism; the causative agent.

Pediculosis – an infestation of lice.

Personal Protective Equipment (PPE) – barrier between a person and a potentially harmful microorganism.

Portal of Entry – the way pathogens enter the body (e.g., mouth, nose, skin breaks, urinary tract and anus).

Portal of Exit – the ways pathogens leave the body (e.g., urine, feces, saliva, tears, drainage from wounds, sores, blood, excretion from respiratory tract or genitals).

Reservoir – where pathogens live and multiply.

Scabies – a contagious skin infection that occurs among humans and other animals. Caused by a tiny and usually not directly visible parasite which burrows under the host's skin, causing intense allergic itching.

Standard Precautions – treating all blood, body fluids, non–intact skin and mucous membranes as if they are infected.

Sterilization – technique that destroys all microorganisms, not just pathogens.

Susceptible Host – the person who could be infected (e.g., elderly, persons who are not in good health, people who do not follow proper infection control precautions).

Systemic Infection – infection that occurs when pathogens enter one's bloodstream and move throughout the body causing general symptoms.

Transmission-Based Precautions – special precautions implemented on the basis of how the disease spreads.

Tuberculosis – a bacterial infection that affects the lungs, causing coughing and difficulty breathing, fever and fatigue. It is an airborne disease, carried on droplets suspended in the air.

Vancomycin-Resistant Enterococcus (VRE) – a strain of enterococcus that cannot be controlled with antibiotics; it is spread through direct and indirect contact.

Content:

I. Introduction to Infection Control

A. Definition of Infection Control — methods used to prevent and control the spread of disease, especially in a healthcare setting.

B. Role of Centers for Disease Control and Prevention (CDC)

1. CDC is the nation's health protection agency, working 24/7 to protect America from health and safety threats, regardless of the origin of the threat.

C. Chain of Infection Links

1. Causative Agent – a pathogen or microorganism that causes disease.

2. Reservoir – a place where a pathogen lives and grows.

3. Portal of Exit – a body opening on an infected person that allows pathogens to leave.

4. Mode of Transmission – method of describing how a pathogen travels from one person to the next person.

5. Portal of Entry – a body opening on an uninfected person that allows pathogens to enter.

6. Susceptible Host – an uninfected person who could get sick (e.g., elderly, persons who are not in good health, people who do not follow proper infection control precautions.

D. Types of infections

1. Systemic – an infection that is in the bloodstream and spreads throughout the body, causing general symptoms.

2. Localized – an infection that is confined to a specific location in the body and has local symptoms.

3. Healthcare-Associated Infections (HAIs)/Nosocomial – infections that patients acquire within healthcare settings that result from treatment for other conditions.

E. Facility Infection Control Policy

1. Key components

a. Procedures – steps or methods that will be followed.

b. Reporting – contacting or informing required parties (such as a nurse, doctor, Administrator, local health unit/department, OLTC, etc.) when concerns arise or to provide updates on previously-informed information.

c. Surveillance – monitoring surroundings and individuals to identify potential concerns, such as the onset or first appearance of an infection or signs that an infection has spread.

d. Compliance – process of ensuring that steps are being followed accordingly.

F. Infectious Disease/Infectious Condition

1. **Acquired Immune Deficiency Syndrome (AIDS)** – a disease of the human immune system caused by human immunodeficiency virus (HIV). The illness interferes with the immune system, making those with AIDS much more likely to get infections. Although considered a sexually transmitted disease, it is also spread through blood, infected needles, or to the fetus from its mother.

a. Transmission – blood or body fluids; usually through contact with blood or sexual contact.

b. Prevention– Standard Precautions

2. **Clostridium Difficile (C–Diff)** – bacteria which causes severe watery diarrhea and other intestinal disease when competing bacteria have been wiped out by antibiotics; It is spread by spores

that are difficult to kill and can be carried on the hands of caregivers who have direct contact with residents or an environmental surface (i.e., floors, toilets, bedpans).

a. Transmission – spores which may survive up to six months on inanimate objects.

b. Prevention – Contact Precautions; requires caregiver to wash hands; do **not** use alcohol–based hand rubs.

3. **Hepatitis** – inflammation of the liver caused by infection.

a. Transmission – fecal/oral; contaminated blood or needles; sexual intercourse.

b. Prevention – Standard Precautions; requires caregiver to wash hands; do not use alcohol–based hand rubs

4. **Influenza** – an infectious disease caused by a virus. The most common symptoms include chills, fever, sore throat, muscle pains, severe headache, coughing, weakness/fatigue and general discomfort. Influenza is a more severe disease than the common cold.

a. Transmission – direct or indirect contact; may also be airborne; when a person with the flu coughs, sneezes, or talks, tiny droplets can land in the mouths or noses of people nearby; the virus can also enter a person's body if they touch an object that has droplets on it and then touch their eyes, mouth, or nose

b. Prevention – Standard Precautions; may require Droplet Precautions. Frequent handwashing

5. **Methicillin-Resistant Staphylococcus Aureus (MRSA)** – is bacteria that is resistant to many antibiotics. Infectious – with symptoms. Colonized – without symptoms

a. Transmission – direct or indirect contact

b. Prevention—Standard Precautions (colonized); Contact Precautions (infectious) dependent upon provider type; Droplet Precautions for a respiratory infection.

6. **Pediculosis** – an infestation of lice.

a. Transmission –direct or indirect contact; common use of combs/brushes, hats, linens.

b. Prevention – Contact Precautions

7. **Scabies** – a contagious skin infection that occurs among humans and other animals. Caused by a tiny and usually not directly visible parasite which burrows under the host's skin, causing intense allergic itching.

a. Transmission – direct and indirect contact, by sharing clothing, towels, or bedding

b. Prevention – Contact precautions

8. **Tuberculosis** – is a disease caused by a bacterium called Mycobacterium tuberculosis.

a. Transmission–airborne; a resident who is suspected as having active Tuberculosis will be immediately transferred to a location where respiratory precautions (such as air exchange limited only to the room of the resident and use of respirators by caregivers) can be implemented.

b. Prevention – Airborne Precautions; relocation to an appropriate environment.

9. **Vancomycin-Resistant Enterococcus (VRE)** – enterococci that have become resistant to the drug Vancomycin, and thus are called vancomycin–resistant enterococci

a. Transmission – direct or indirect contact

b. Prevention – Standard Precautions; may require Contact Precautions.

II. Infection Control Practices

A. Environmental cleaning

1. High touch areas – bedrails, bedside equipment, remote control.

B. Disposal of contaminated items/infectious waste

1. Sharps containers

2. Bio–hazardous waste containers

C. Linen

1. Handling clean linen

2. Handling/securing soiled linen

III. Hand Hygiene

A. Handwashing – when hands are visibly soiled

1. Washing hands is the single most important infection control practice.

B. Alcohol–based hand rub/ hand sanitizer

C. Five Moments for hand hygiene – World Health Organization (WHO)

1. Before resident/patient contact

2. Before aseptic task

3. After exposure to blood/body fluids

4. After resident/patient contact

5. After contact with resident/patient surroundings

D. Other Handwashing moments

E. Important factors related to Hand Hygiene

1. Visibly soiled with blood or body fluids

2. Exposure to potential pathogens

a. Spores/Clostridium Difficile (C–Diff) – requires handwashing

F. Other factors related to Hand Hygiene

1. Fingernails – long fingernails harbor organisms.

2. Jewelry

3. Intact skin

G. Procedure for handwashing – (See CARE SKILLS #3)

1. Demonstrate proper handwashing.

2. Explain rationale for each step.

IV. Personal Protective Equipment – PPE

A. Purpose of PPE – creates a barrier of protection against infectious materials, so that the caregiver does not become contaminated; when used correctly, PPE minimizes the spread of infection

B. Types of PPE

1. Gloves (See CARE SKILLS #4)

2. Gown (See CARE SKILLS #5)

3. Mask (See CARE SKILLS #6)

C. Procedure for PPE

V. Precautions

A. Standard Precautions - treating all blood, body fluids, non–intact skin and mucous membranes as if they are infected.

1. Hand Hygiene

2. Personal Protective Equipment

3. Disposal of contaminated equipment/supplies

B. Transmission-Based Precautions – special precautions implemented on the basis of how the disease spreads.

1. Airborne Precautions

2. Droplet Precautions

3. Contact Precautions

CARE SKILLS:

- Handwashing/Hand rub – #3
- Gloves – #4
- Gown – #5
- Mask – #6

Review Questions --- Lesson #3

1. What are the links in the "Chain of Infection"?

2. What is the most important action a healthcare worker can take to prevent spread of infection?

3. Describe the 5 Moments of Hand Hygiene.

4. Explain the importance of proper usage of personal protective equipment.

5. Provide examples of how direct contact can spread infection.

6. Provide examples of how indirect contact can spread infection.

7. If a resident has Clostridium Difficile, is an alcohol–based hand rub effective?

Lesson #4 (2 hours)

Title: Fire Safety and Other Resident Safety Concerns

Lesson Objectives:

I. The student will be able to describe fire safety and necessary emergency response should a fire occur and manner of resident evacuation.

II. The student will be able to explain the rationale for use of side rails and potential entrapment dangers associated with side rail use.

III. The student will be able to describe residents at risk of elopement and interventions to help prevent elopement.

IV. The student will be able to explain the smoking policy, safety concerns and interventions to promote safe smoking.

Key Terms:

Evacuation Plan – plan developed by the facility by which residents would be relocated to a safe area within the facility, outside the facility, or to an alternate location.

Entrapment – a resident's body part becomes lodged between the bed frame and/or mattress and the bed rail.

Elopement – a resident exiting the facility whose whereabouts are unknown to the staff.

Fire Drill – plan executed frequently to help workers learn what to do in the case of a fire.

Flammable – easily ignited; capable of burning quickly.

Pacing – walking back and forth in the same area of the facility.

Wandering – walking aimlessly throughout the facility.

Content:

I. Fire Safety

A. General

1. Know the evacuation plan.

2. Know how much assistance is needed, and which residents to relocate first (i.e., ambulatory, those who need assistance, totally dependent).

3. Dangers of smoke inhalation

a. Stay low and cover mouth with wet cloth.

b. Shut residents' doors.

4. Fire drills and procedures

a. Role of the nursing assistant during a fire drill and/or evacuation.

b. Know the locations of all exits and stairways.

c. Know the locations of fire alarms, extinguishers and fire blankets.

5. Never use an elevator in the event of a fire.

6. If your clothing catches on fire, STOP, DROP and ROLL to smother the flames. A fire blanket, if available, can also be used to help smother the flames.

7. A supervisor or charge nurse will give directions during an emergency.

B. Guidelines in case of fire (See CARE SKILLS #7)

1. **R**emove residents from area of immediate danger.

2. **A**ctivate the fire alarm.

3. **C**ontain the fire, if possible (close doors).

4. **E**xtinguish, if possible.

C. Use of the fire extinguisher (See CARE SKILLS #8)

1. **P**ull the pin.

2. **A**im at the base of the fire.

3. **S**queeze the handle.

4. **S**weep back and forth at the base of the fire.

D. Types of fires

A= paper, wood, cloth

B= oil, grease

C=electrical

E. During an emergency, stay calm, listen carefully and follow directions given.

II. Side rails/Entrapment

A. Purpose of side rail use

1. Enabling or self–help if used to assist the resident to move independently.

2. Restrictive if their use results in confining the resident in bed; restricting voluntary movement.

B. Zones/areas of potential bed entrapment

1. Ensure that the resident does not get caught between the bed and/or mattress and/or side rails. Being trapped between the spaces can result in serious injury or death.

2. Refer to the picture in Appendix A to identify zones on the bed where entrapment can occur.

III. Resident Elopement

A. Exit-seeking behavior

1. Frequently remaining at or near exit doors.

2. Shaking door handles.

3. Pacing to and from the exit doors.

4. Voicing a desire to leave the facility and/or return home.

5. Packing clothing/belongings.

6. Wearing shoes, coat, hat, etc., although in the facility.

B. Resident identification and monitoring

1. Facility assessment and identification of residents at risk of elopement.

2. Pictures, logs or other means to identify residents at risk of elopement.

C. Electronic bracelets

1. Worn by residents at risk for elopement.

2. Checked for presence and function per established facility frequency.

3. Exits become secured when a resident with such a bracelet approaches the exit.

4. Be cautious, as residents may remove bracelet with nail clippers, knife, etc.

D. Coded entries

1. Requires a code to be entered to release/open the door.

2. Code should be known/available to alert and oriented residents, visitors and staff.

3. Coded entries are unlocked during a fire alarm and must be monitored.

E. Alarmed doors

1. Staff should suspect a resident has exited unattended when the alarm is heard.

2. Check panel for source door sounding the alarm.

3. Immediately assess grounds near exit. If source of alarm sounding is not visualized, conduct a headcount to confirm all residents are safe within the facility.

4. Never silence an alarm without knowing “why” the alarm sounded.

IV. Smoking

A. Facility policy

1. Supervised vs. unsupervised smoking per resident assessment of ability.

2. If the facility allows unsupervised smoking, the facility should direct how the resident is to store/manage smoking materials (i.e., lighter, cigarettes).

3. The facility may be a “non–smoking” campus.

B. Potential safety concerns/assistive devices

1. Ability to manipulate smoking materials/cigarette extension.

2. Smoking apron if concerned with ashes dropped on clothing.

3. Appropriate non–flammable ashtrays/containers.

4. Oxygen use prohibited when smoking.

a. Oxygen supports combustion (the process of burning).

b. Never allow open flames near oxygen.

5. Monitoring for non–compliance with smoking policy.

a. Smoke odor in room.

b. Burn holes in clothing/bedding.

c. Smoking materials supplied by family members.

6. Electronic cigarettes

CARE SKILLS:

- Fire – #7
- Fire Extinguisher – #8

Review Questions --- Lesson #4

1. Explain the acronym “RACE.”

2. Describe the proper use of the fire extinguisher using the acronym “PASS.”

3. Describe the action to be taken should your clothing catch fire.

Lesson #5 (2 hours)

Title: Medical Concerns/Emergency Procedures

Lesson Objectives:

I. The student will be able to explain the need for safety and prevention measures/interventions.

II. The student will be able to explain risk factors related to different types of accidents.

III. The student will be able to demonstrate prevention strategies for different types of accidents.

Key Terms:

Cardiac Arrest – heart function and circulation stop.

Choking – a complete blockage of the airway requiring immediate action.

Disorientation –confusion related to time and/or place.

Environment – circumstances or conditions that surround an individual.

Fainting – sudden loss of consciousness because of inadequate blood supply to the brain.

Fracture – broken bone.

Hemiplegia – total paralysis of the arm, leg and torso on one side of the body.

Hemorrhage – excessive loss of blood from a blood vessel.

Paralysis – loss or impairment of the ability to move a body part, usually as a result of damage to its nerve supply.

Poisoning – to cause injury, illness, or death by chemical means.

Risk Factor – a characteristic, condition, or behavior that increases the possibility of injury.

Scald – burn caused by hot liquids in contact with the skin.

Seizure (Convulsions) – sudden contractions of muscles due to a disturbance in brain activity.

Shock – state of being when vital parts of the body (brain, heart and lungs) do not get enough blood.

Content:

I. Accidents

A. Types of Accidents

1. Falls/Fainting

2. Burns

3. Poisoning

4. Choking

B. Is the accident Neglect under Arkansas Law?

II. Falls – the consequences of falls can range from minor bruises to fractures and life–threatening injuries.

A. Risk factors

1. Personal

a. Medications

b. Gait or balance problems

c. Diagnosis – paralysis, hemiplegia, weakness, disorientation

d. Fainting – the sudden loss of consciousness because of inadequate blood supply to the brain. The cause can be pain, fatigue, hunger or medical conditions.

e. Bowel/Bladder status – urgency, incontinence

f. Improperly fitting shoes or clothing

2. Environment

a. Clutter

b. Slippery/wet floors or floors that have shiny waxed finishes.

c. Uneven surfaces

d. Poor lighting

e. Call light out of reach

f. Side rails

B. Prevention

1. Know residents that are at high risk for falls.

2. Frequent toileting program.

3. Respond to call lights promptly.

4. Use of proper shoes/clothing.

5. Keep environment clear or free of obstacles.

C. Intervention

1. If a resident begins to fall, never try to stop the fall. Gently ease the resident to the floor and:

a. Call for help immediately, and

b. Keep the resident in the same position until the nurse examines the resident.

D. Falling or Fainting (See CARE SKILLS #9)

III. Choking – a blockage of the airway. This can occur when eating, drinking or swallowing.

The resident often gasps or clutches throat (the universal sign for choking).

A. Risk Factors

1. Diagnosis – stroke, swallowing difficulty

2. Medications

3. Mental Status

a. Unconscious

b. Cognitive impairment – wandering, eating others' food at an inappropriate consistency.

B. Prevention

1. Know residents who are at risk

2. Special diets/thickened liquids

a. Soft/mechanical soft/pureed diets

b. Liquids – consistencies

i. Nectar thick – thicker than water

ii. Honey thick – pours very slowly

iii. Pudding thick – semi–solid (spoon should stand up straight)

C. Choking - (See CARE SKILLS #10)

IV. Burns/Scalds

A. Risk Factors

1. Diagnosis/Conditions – stroke, paralysis, diabetes

2. Mental Status/Cognitive impairment

3. Heating appliances/equipment

4. Smoking

5. Hot liquids

B. Prevention

1. Know residents who are at risk.

2. Check/report use of heating appliances.

3. Check water temperatures (bath, shower).

4. Supervise smoking, when indicated.

5. Encourage use of smoking apron, cigarette extension, etc., when indicated.

6. Know location of nearest fire extinguisher or fire blanket.

7. Pour hot liquids away from residents.

8. Mugs with lids/adaptive devices (specific to resident).

V. Poisoning

A. Risk Factors

1. Diagnosis/Conditions – Dementia, Alzheimer's disease, confusion

2. Other factors

a. Wandering

b. Hoarding

B. Prevention

1. Proper storage of medications/supplies.

2. Lock storage/cleaning rooms, closets and carts.

3. Material Safety Data Sheet (MSDS) — all chemicals have a sheet that details the ingredients, dangers, emergency response to be taken, and safe handling procedure; required by OSHA.

VI. Medical Emergency

A. Types of Medical Emergencies

1. Heart Attack/Cardiac Arrest – symptoms may include crushing pain (like someone sitting on the chest) which may go down left arm, be felt in neck or in jaw and doesn't go away.

a. Notify the nurse immediately.

b. Loosen clothing around the neck.

c. Do not give food or fluids.

d. Be prepared to initiate CPR if qualified.

e. Remain with resident until help arrives.

2. Stroke/Cerebral Vascular Accident (CVA) – symptoms may include dizziness, blurred vision, nausea/vomiting, headache, uneven grip or smile, slurred speech.

a. Report symptoms to nurse immediately.

3. Seizures/Convulsions (See CARE SKILLS #11)

a. Call for nurse and stay with resident.

b. Assist the nurse with positioning the resident on his/her side.

c. Place padding under head and move furniture away from resident.

d. Do not restrain resident or place anything in mouth.

e. Loosen resident's clothing, especially around the neck.

f. After the seizure stops, assist nurse to check for injury.

g. Note duration of seizures and areas involved.

4. Bleeding/hemorrhage

a. Use Standard Precautions.

b. Apply direct pressure over the area with a sterile dressing or a clean piece of linen.

c. Raise the limb above the level of the heart, if possible.

VII. Safety Measures/Prevention Strategies

A. Prevention is the key to safety.

B. Observe for safety hazards, correct or remove hazard, report needed repair.

C. Know residents' risk factors for accidents.

D. Safety measures to follow:

1. Call light available.

2. Clean/clear environment.

3. Report observations that are unsafe and/or equipment in need of repair.

CARE SKILLS:

- Falling or Fainting – #9
- Choking – #10
- Seizures – #11

Review Questions --- Lesson #5

1. What is the universal sign that indicates choking?

2. What document provides first aid/response should a resident drink a chemical?

3. Explain the actions of the caregiver if a resident is having a seizure?

Lesson #6 (3 hours)

Title: Basic Care Skills

Lesson Objectives:

I. The student will be able to explain the importance of individualization of the resident's environment.

II. The student will be able to demonstrate competence in making an unoccupied bed.

III. The student will be able to explain environmental concerns of each resident and any revisions necessary to accommodate the visually impaired resident or the resident at risk for falls.

IV. The student will be able to explain the importance of proper nutrition/hydration.

V. The student will be able to identify measures and demonstrate competence in serving a meal tray.

VI. The student will be able to identify steps to help residents remain independent while eating.

VII. The student will be able to demonstrate competence in assisting the resident with special needs during mealtime (i.e. plate guards, thickened liquids, etc.).

VIII. The student will be able to demonstrate competence in passing fresh ice water and providing thickened liquids to the resident.

Key Terms:

Aspiration – inhalation of food or fluids into the lungs, which has the potential to cause pneumonia or death.

Call Light – a means to call for assistance, when needed

Calories – the fuel or energy value of food

Carbohydrates – the main source of energy for all body functions

Closed Bed – a bed completely made with the bedspread and blankets in place.

Dehydration – excessive loss of fluid from the body.

Draw Sheet – turning sheet that is placed under residents who are unable to assist with turning, lifting or moving up in bed.

Fats – help the body store energy and use certain vitamins.

Fluid Overload – condition in which the body is unable to handle the amount of fluids consumed.

Fluid Restriction – a restriction of the amount of fluids a resident may have per day; usually divided between nursing (i.e. fluids taken with medications) and dietary (i.e. fluids with meals).

Fortified Food – nutrients/calories added to a food; used for weight loss.

Hydration – fluids consumed. The process of providing adequate fluids/liquids to maintain or restore a sufficient balance in the body.

Minerals – compounds found in the diet or dietary supplements; builds body tissue, regulates body fluids, promotes bone and tooth formation, affects nerve and muscle function.

NPO – nothing by mouth (nil per os).

Nutrients – substances found in food which provide nourishment

Nutrition – nourishment; the process by which the body takes in food to maintain health.

Occupied Bed – bed made while a resident is in the bed

Open Bed – folding the linen down to the foot of the bed

Proteins – complex compounds found in all living matter; promote growth and repair of tissue.

Unoccupied Bed – a bed made while no resident is in the bed.

Vitamins – organic compounds obtained from one's diet or dietary supplements; helps the body function.

Water – H20 (one molecule of oxygen and two molecules of hydrogen); most essential nutrient for life.

Content:

I. Points to Remember:

A. When a resident enters a nursing facility, he/she experiences the loss of home and belongings. Familiar things create a positive and home–like environment. The staff should encourage the resident to bring items from home, as space permits.

B. The room should be arranged according to resident preference, as possible.

C. The residents' personal belongings should be safeguarded, as possible.

D. Types of beds may vary in each facility. Most beds have controls to raise, lower and adjust positions. A low bed may be used for a resident at risk for falls.

E. Temperature of the resident's room/environment should be considered. The resident's condition and preferences should determine the appropriate temperature.

F. Lighting should be sufficient for the resident's needs/preferences. Indirect lighting is preferable, in that glare causes fatigue, and contributes to confusion and the potential for falls.

G. The resident's environment should be cleaned of spills immediately, as spills are safety hazards contributing to falls.

H. Excessive noise levels in the environment can provoke irritation and problematic behaviors. Facilities should maintain equipment in good repair and refrain from overhead paging.

I. Fresh ice water should be maintained and within reach in an effort to encourage hydration, unless the resident's fluids are restricted by the physician. (thicken liquids)

J. The call light should be placed within the resident's reach upon completion of care/staff assistance.

K. Defective or unsafe equipment should be taken out of service and reported to the nurse immediately.

II. Unoccupied Bed (see CARE SKILLS #12)

A. Bed making Tips

1. Carry clean linens away from your body and uniform.

2. Do not shake linens when making bed.

3. Do not place clean or dirty linens on the floor.

4. Do not place clean linens on a dirty surface.

5. Check for personal belongings between the linens before removing them from the bed (i.e. dentures, glasses, hearing aid, etc.).

6. Remove gloves after handling dirty linens. A new pair of gloves should be worn to handle clean linens.

7. Avoid bringing unnecessary linens into a resident's room. Unused linens are considered contaminated once they have been in someone's room. Do not attempt to use them in another resident's room, as transferring linens from room to room increases the spread of germs and infection. Discard unused linens as you would soiled linens.

8. Always change soiled linens. Urine, feces, food, etc. that remain on linens can cause irritation and sores to develop on the resident's skin.

9. Report damaged or odorous mattress to charge nurse immediately.

10. Ensure mattress is free of urine/feces/other body fluids. Clean mattress as needed per facility policy.

III. Resident Room/Environment/Fall Prevention

A. Each room may have slightly different equipment. Standard room contents include: bed, bedside stand, overbed table, chair, call light and privacy curtain.

B. Always ensure call light is within the resident's reach, in working condition and answered immediately.

C. Clean the overbed table after use and place within residents reach if commonly used items are stored on the table.

D. Remove anything that might cause odors or become safety hazards, such as trash, clutter, spilled fluids, etc.

E. Clean up spills promptly.

F. Report signs of insects or pests when observed.

G. Fall Prevention - to reduce the risk of falls

1. Clear all walkways of clutter and cords.

2. Use non–skid mats when needed.

3. Assist residents to wear non–skid socks or shoes. Make certain shoes are tied and fit properly.

4. Ensure residents wear clothing that fits properly (e.g. not too tight, not too loose, or not too long).

5. Keep frequently used items in reach of resident.

6. If ordered, ensure any devices or alarms are in place and functional per the care plan.

7. Lock wheelchairs before assisting residents to transfer.

8. Offer to toilet resident frequently/according to toileting schedule to prevent unassisted attempts to toilet.

9. Visual cues or devices may be used, such as a large face clock, calendar, etc. Familiar pictures, symbols, or personal items may be displayed or hung to assist the resident with cognitive impairment to recognize his/her room, restroom, closet, etc.

IV. Promoting Proper Nutrition and Hydration

A. Proper Nutrition

1. Promotes physical health

2. Helps maintain muscle

3. Helps maintain skin and tissues

4. Helps prevent pressure sores

5. Increases energy level

6. Aids in resisting illness

7. Aids in the healing process

B. Six Basic Nutrients

1. **Carbohydrates**

a. Provide energy for the body

b. Provide fiber for bowel elimination

2. **Fats**

a. Aid in absorption of vitamins

b. Provide insulation and protect organs

3. **Minerals**

a. Build body tissue and cell formation

b. Regulate body fluids

c. Promote bone and tooth formation

d. Affect nerve and muscle function

4. **Proteins**

a. Promote growth and tissue repair

b. Found in body cells

c. Provide an alternate supply of energy

5. **Vitamins**

a. Two types: water soluble and fat soluble

b. Body cannot produce

c. Help the body function

6. **Water**

a. Most essential nutrient for life

b. Up to 75% water in the human body

C. Diet Specifics

1. Diet Cards

a. Specific to a resident

2. Basic or “regular”

3. Therapeutic/special/modified diets

a. No Added Salt (NAS)

b. No Concentrated Sweets (NCS) or Restricted Concentrated Sweets (RCS)

c. Fortified

d. NPO (nil per os) (nothing by mouth)

e. Bland

f. High/low fiber

g. Low fat

h. High/low protein

i. Low sodium

j. Modified calorie/calorie count

k. Liquid

l. High potassium

4. Mechanically Altered Diets

a. Mechanical Soft/ground meat

b. Pureed

c. Chopped meat

5. Thickened Liquids (see CARE SKILLS #13)

a. Ordered for residents who have difficulty swallowing.

b. Always check care plan and thicken liquids to the proper consistency ordered for the resident.

c. Three consistencies of thickened liquids

i. Nectar thick

ii. Honey thick

iii. Pudding thick

d. Pudding thick liquids must be spoon-fed to residents.

6. Monitoring meal consumption/recording food consumed

a. Observation

b. Facility policy for recording

D. Proper Hydration

1. Promotes physical health

a. Aids digestion and elimination

b. Maintains normal body temperature

c. Helps prevent dehydration

2. Encourage fluids

a. Implemented by physician's order or nursing care plan

b. Document per facility policy

3. Fluid Restriction

a. Implemented by physician's order due to concerns with fluid overload

b. Daily amount is limited and divided between dietary and nursing

4. Recording Total Fluid Intake (See CARE SKILLS #14)

a. Use metric measurement (cubic centimeters = cc) 30cc = 1 ounce; example 8-ounce glass/carton of milk = 240cc

b. Accurately record intake of oral fluids per care plan

c. Report to charge nurse low fluid intake

d. Approximately 2000-2500cc daily

E. Passing Fresh Ice Water (see CARE SKILLS #15)

Ice pitchers should be refilled/refreshed at least once every shift, or more frequently if needed. Always check the resident's care plan for special instructions before filling the pitcher.

1. Individuals on thickened liquids also need thickened water; prepackaged, thickened water can be kept cool at the bedside per facility policy; if prepackaged water is not available, be sure to thicken liquids according to facility policy and the consistency ordered for the resident.

2. Be sure the ice scoop is stored properly when not in use. It should not be left in the ice when filling the resident's pitchers.

4. Make sure the resident's water is placed within reach when returning it to the room.

5. Know your residents. If the container is too heavy for the resident to hold, then they won't be able to use it. Provide a smaller container such as a cup or glass.

F. Role of the Nurse Aide

1. Review the diet card before serving the meal to the resident to confirm correct diet.

2. Encourage resident to eat as much of their meal as possible.

3. Note foods resident avoids or dislikes and report to the nurse.

4. Be aware of food brought in to the resident from an outside source and potential conflict with ordered diet; report to charge nurse as needed.

5. Record food intake according to facility policy.

6. Remind resident to drink often or offer ice/popsicles, when not on restriction.

7. Have fresh ice water available and within the resident's reach at all times unless on a fluid restriction.

G. Promoting the Use of Proper Feeding Technique/Assisting a Resident with Special Needs

NOTE – The caregiver should provide any necessary care and offer to assist the resident to toilet prior to meal service in an effort to promote a positive experience.

1. Serving a Meal Tray (see CARE SKILLS #16)

   a. Provide oral care before meals. Residents may eat better if they have a clean mouth.

   b. Always check the diet card and the items on the tray before taking the tray to the resident.

   c. As a safety precaution, never leave a resident who needs to be fed unattended with a tray.

   d. If a resident refuses to eat, or even if he/she is not in the facility (in the hospital, on a home visit) when the tray arrives, you are not allowed to eat their food.

   e. Clothing protectors are optional. Ask their preference and honor their decision.

   f. Inform the nurse if the resident complains about the flavor/taste of thickened liquids.

   g. Never blow on a resident's food to cool it. Instead, try spreading the food out over the plate. The increased surface area helps cool the food quicker. Cutting food into smaller pieces also helps it to cool faster.

   h. Encourage residents to do as much for themselves as possible.

   i. Be sure residents are provided with their necessary assistive devices during each meal.

   j. Inform resident of food items on tray, especially if meal is pureed or mechanically altered.

CARE SKILLS:

- Unoccupied bed – #12
- Thickened Liquids – #13
- Measure and Record Fluid Intake – #14
- Passing Fresh Ice Water – #15
- Serving a Meal Tray – #16

Review Questions --- Lesson #6

1. The call light should always be placed within the resident's reach. *(True or False)*
2. Excessive noise levels in the environment can provoke irritation and problematic behaviors. *(True or False)*
3. What is the most essential nutrient for life?
4. What are the three types of thickened liquids?

Lesson #7 (1 hour)

Title: Common Diseases and Disorders – Respiratory and Urinary Systems

Lesson Objectives:

I. The student will be able to describe common disease processes of the respiratory system which affect the elderly resident.

II. The student will be able to describe common disease processes of the urinary tract which affect the elderly resident

Key Terms:

Expiration – breathing out.

Urinary Incontinence – inability to control the bladder.

Inspiration – breathing in.

Sputum – fluid that is coughed up.

Content: Respiratory System

I. Respiratory System – brings oxygen into your body and removes carbon dioxide and other harmful gases; consists of the mouth, nose, trachea, and lungs.

II. Common Conditions of the Respiratory System

A. Upper Respiratory Infection (URI) or cold.

B. Pneumonia – lung infection caused by a bacterial, viral or fungal infection.

C. Bronchitis – swelling of the main air passages to the lung.

D. Asthma – disorder that causes the airways to swell and become narrow.

E. Emphysema – progressive lung disease that causes shortness of breath. A symptom of COPD.

F. Chronic Obstructive Pulmonary Disease (COPD) – chronic disease in which residents have difficulty breathing, particularly getting air out of the lungs.

G. Lung Cancer

H. Tuberculosis (TB) – a contagious bacterial infection of the lungs.

III. Normal Changes with Age

A. Lung capacity decreases as chest wall and lungs become more rigid. Deep breathing is more difficult. Air exchange decreases causing the resident to breathe faster to get enough air when exercising, ill, or stressed.

B. Decreased lung strength

1. Decreased lung capacity.

2. Decreased oxygen in blood.

3. Weakened voice.

IV. Role of the Nurse Aide regarding the Respiratory System

A. Observe and Report:

1. Change in respiratory rate.

2. Coughing or wheezing.

3. Complaint of pain in the chest.

4. Shallow breathing or difficulty breathing.

5. Shortness of breath.

6. Bluish color of lips or nail beds.

7. Spitting or coughing up of thick sputum or blood.

8. Need to rest with mild exertion.

B. Interventions to avoid respiratory problems

1. Encourage fluids.

2. Oxygen should be in use, if ordered.

3. Encourage exercise and movement.

4. Encourage deep breathing and coughing.

5. Frequent hand hygiene, especially during cold/flu season.

Content – Urinary System:

I. Urinary System – gets rid of waste products through urine and helps to maintain water balance in the body; it consists of kidneys, ureters, urinary bladder, and urethra.

II. Common Conditions of the Urinary System

A. Urinary Tract Infection (UTI) or cystitis

B. Calculi (kidney stones)

III. Normal Changes with Age

A. Kidney function decreases, slowing removal of waste. Bladder tone decreases, resulting in more frequent urination, incontinence, bladder infections and urinary retention.

B. Decreased ability of kidney to filter blood.

C. Weakened bladder muscle tone.

D. Bladder holds less urine, resulting in more frequent urination.

E. Bladder does not empty completely.

IV. Problems Caused by Incontinence

A. Skin problems around the buttocks, hips, genitals, and the area between the pelvis and the area between the pelvis and rectum (perineum).

B. Excess moisture in these areas makes skin problems such as redness, peeling, irritation, and yeast infections likely.

C. Bedsores (pressure sores) may also develop.

V. Role of the Nurse Aide regarding the Urinary System

A. Observe and Report to the nurse

1. Changes in frequency and amount of urination.

2. Foul smelling urine or visible change in color of urine.

3. Inadequate fluid intake.

4. Pain or burning with urination.

5. Swelling in extremities.

6. Complaint of being unable to urinate or bladder feeling full.

7. Incontinence or dribbling.

8. Pain in back or kidney region.

B. Interventions to avoid urinary problems

1. Encourage fluids.

2. Frequent toileting.

3. Keep resident clean and dry.

4. Avoid anger or frustration if resident is incontinent.

Review Questions --- Lesson #7

1. Green, yellow or blood-tinged sputum should be reported to the nurse. *(True or False)*

2. Complaints of pain or burning with urination should be reported to the nurse. *(True or False)*

Lesson #8 (1 hour)

Title: Oxygen Use

Lesson Objectives:

I. The student will be able to describe the various manners in which oxygen is supplied for a resident.

II. The student will be able to describe necessary safety precautions to be implemented when oxygen is in use.

Key Terms:

Combustion – the process of burning.

Oxygen – a chemical that is found in the air that has no color, taste, or smell, and that is necessary for life.

Flammable – easily ignited and capable of burning quickly.

Content:

I. Oxygen Use

A. Oxygen is prescribed by a physician; however, a nurse may initiate oxygen in response to a medical emergency.

B. Nursing assistants are never allowed to stop (refers to turning oxygen off and/or removing the nasal cannula or mask from face/nostrils), adjust (refers to increasing or decreasing the amount of oxygen the resident receives), or initiate (refers to turning oxygen on and/or placing the nasal cannula in nares or the mask on the face) the use of oxygen. Nursing Assistants may provide care, such as washing the face or oral care. Ensure NC or mask is properly positioned in nares or on the resident's face after care.

C. Nasal Cannula – Delivery of oxygen through a long tubing from the source to the cannula, with prongs placed in each nostril and the tubing tucked behind the resident's ears.

1. Observe for irritation behind the ears, as the tubing can cause skin breakdown. Notify the nurse, if observed.

2. Provide nasal cannula care per facility policy and resident care plan. (see CARE SKILLS #17)

D. Mask – delivery of oxygen through a long tubing from the source to a mask placed on the resident's face with a band around the back of the head.

1. Observe for irritation around the face mask and notify the nurse, if observed.

E. Concentrator – a device that sits on the floor and plugs into the wall which changes air in the room into air with more oxygen.

F. Liquid Oxygen – at extremely cold temperatures, oxygen changes from gas to a liquid. The liquid oxygen is stored in a vessel similar to a thermos. A large central unit is located in an area away from electrical equipment that is well ventilated. Liquid oxygen can be trans–filled to a bedside unit or can be trans–filled into a portable unit.

1. Contact with liquid oxygen or its vapors can quickly freeze tissues. It is common to see vapors when filling a small vessel from the large vessel. The vapors evaporate quickly and then are harmless. To prevent injury, never touch liquid oxygen, or the frosted parts of liquid oxygen vessels. Avoid getting the vapors in your face.

G. Portable Tank – oxygen that is stored as a gas under pressure in a cylinder equipped with a flow meter and regulator to control the flow rate. This system is generally prescribed when oxygen therapy is required in emergency or for a short period of time (e.g., during transport). Compressed oxygen tanks are under extreme pressure and must be kept upright and handled with care.

H. Vaporizers/Humidifiers – A vaporizer works by heating water until it turns into hot steam, a humidifier creates a cool mist. Either one may be prescribed by a physician to loosen congestion of the resident.

1. When humidifiers and vaporizers are in use, they must be kept clean. Germs thrive wherever there is water, thus, the device must be periodically drained and cleaned according to facility policy. Otherwise, the bacteria that accumulate can become vaporized into the air and affect the resident's lungs, where they can cause infection.

2. Prepare vaporizer/humidifier according to manufacturer's instructions.

3. Position vaporizer/humidifier on the bedside stand or nearby table.

4. Plug vaporizer into electrical outlet.

5. Steam should be permitted to flow generally into the room.

6. Frequently check the water level; refill as necessary.

7. Clean vaporizers/humidifiers routinely according to facility policy.

I. CPAP/BIPAP – Positive Airway Pressure (PAP) is respiratory ventilation used to treat breathing disorders and supply a consistent pressure on inspiration and expiration. As mechanical ventilation, CPAP (continuous positive airway pressure), or BIPAP (Bi–level Positive Airway Pressure) machines, are devices which help residents inhale more air into the lungs. Both of these devices are used for the treatment of medical disorders like COPD, pulmonary edema, etc. Settings of the machines are prescribed by the physician and may only be administered and adjusted by the licensed nurse.

J. Ventilator – a machine that supports breathing. These machines are mainly used in hospitals. Ventilators deliver oxygen into the lungs and remove carbon dioxide from the body. Carbon dioxide is a waste gas that can be toxic. The ventilator breathes for people who have lost all ability to breathe on their own. Settings of the ventilator are prescribed by the physician and may only be adjusted by the licensed nurse.

K. Safety Precautions

1. Remember oxygen supports combustion.

2. Fire hazards should be removed from the resident's room when oxygen is in use.

3. Never allow candles or open flames in the area where oxygen is in use.

4. Never allow smoking in the area where oxygen is in use.

5. Do not use electrical equipment (e.g., electric razors, hairdryers, electric blankets, and electric heaters) in an oxygen–enriched environment. Electrical equipment may spark and cause a fire.

6. Do not use flammable products such as rubbing alcohol, or oil–based products such as Vaseline® near the oxygen. Use a water–based lubricant to moisten the resident's lips or nose.

CARE SKILLS:

- Nasal Cannula Care – #17

Review Questions --- Lesson #8

1. It is permissible for nursing assistants to adjust the level of oxygen administration. *(True or False)*

2. Smoking must never be allowed where oxygen is used or stored. *(True or False)*

3. Oxygen tanks must be kept upright and handled with care. *(True or False)*

Lesson #9 (1 hour)

Title: Common Diseases and Disorders – Nervous, Circulatory & Musculo–Skeletal Systems

Lesson Objectives:

I. The student will be able to describe common disease processes of the nervous system which affect the elderly resident.

II. The student will be able to describe common disease processes of the circulatory system which affect the elderly resident.

III. The student will be able to describe common disease processes of the musculo–skeletal system which affect the elderly resident.

Key Terms:

Arthritis – a disorder that involves inflammation of one or more joints.

Atrophy – wasting away, decreasing in size, and weakening of muscles.

Cerebrovascular Accident (CVA) – stroke; loss of brain function usually caused by an effect on the flow of blood to the brain. Two main types of stroke are the hemorrhagic stroke and occlusive (blockage) stroke.

Congestive Heart Failure (CHF) – the heart is severely damaged and cannot pump oxygen-rich blood to the rest of the body effectively. Blood may back up in other areas of the body, and fluid may build up in the lungs, liver, gastrointestinal tract, arms and legs.

Contracture – permanent stiffening of a joint and muscle.

Epilepsy – brain disorder in which a resident has reported seizures (convulsions). Medication is ordered to control/lessen seizure activity.

Fracture – broken bone.

Heart Attack (Myocardial Infarction) – blood flow to the heart is completely blocked and oxygen cannot reach the cells in the region that is blocked.

Hypertension – high blood pressure.

Hypotension – low blood pressure.

Osteoporosis – condition when the bones become brittle and weak; may be due to age, lack of hormones, not enough calcium in bones, alcohol, or lack of exercise.

Parkinson's Disease – a progressive movement disorder.

Peripheral Vascular Disease (PVD) – condition in which the extremities (commonly legs and feet) do not have enough blood circulation due to fatty deposits in the vessels that harden over time.

Range of Motion – exercises which put a joint through its full range of motion.

Content – Nervous System:

I. Nervous System – control and message center of the body; it controls and coordinates all body functions and senses, and it also interprets information from outside the body; includes the brain, spinal cord, and nerves.

II. Conditions that Affect the Nervous System

A. Dementia

1. Affects thought process: memory, communication

2. As the process progresses it will become difficult for the resident to perform ADLs (e.g., eating, dressing, toileting, etc.).

B. Alzheimer's disease

1. A brain disease that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest task. It begins slowly and gets worse over time. Currently it has no cure.

2. Maintain regular schedule for bathing, toileting, exercise.

3. Use repetition in daily activities.

C. Parkinson's Disease

1. A progressive, degenerative disease that affects the brain.

2. As the disease progresses, it becomes more difficult for the resident to perform ADLs. Hands often tremor, and the limbs and trunk become rigid.

3. Assist by placing food and drink close; use assistive devices.

D. Cerebrovascular Accident (CVA) or stroke

1. A stroke is a "brain attack". It can happen to anyone at any time. It occurs when blood flow to an area is cut off. It is caused by a clot or ruptured blood vessel. When this happens, brain cells are deprived of oxygen and begin to die.

2. F.A.S.T. is an easy way to remember the sudden signs of a stroke.

a. Face Drooping

b. Arm Weakness

c. Speech Difficulty

d. Time to call 911

3. When dressing a resident, address the weaker side first to prevent unnecessary bending or stretching. When undressing, address the stronger side first.

4. Use a gait belt when walking or transferring the resident for safety precautions. Stand on the weaker side.

E. Epilepsy

1. Seizure symptoms can vary widely. Some people with epilepsy simply stare blankly for a few seconds during a seizure, while others repeatedly twitch their arms or legs.

2. Observe for seizure activity; report to nurse.

3. Don't leave the resident unattended during a seizure; have someone else get help, if possible.

4. Keep the resident safe by moving furniture or other objects out of the way; do NOT put anything in his/her mouth.

III. Normal Nervous System Changes with Age

A. Nerve cells die, causing decreased perception of sensory stimuli and less awareness of pain and injury.

B. Slow responses and reflexes.

C. Sensitivity to heat and cold decreases.

D. May experience short–term memory loss.

IV. Role of the Nurse Aide regarding the Nervous System

A. Observe and Report

1. Shaking or trembling.

2. Complaints of numbness or tingling.

3. Inability to speak clearly.

4. Inability to move one side of the body.

5. Changes in vision or hearing.

6. Difficulty swallowing.

7. Depression or mood changes.

8. Memory loss or confusion.

9. Behavior changes.

Content – Circulatory System:

I. Circulatory System – transports blood and body fluids throughout the body; consists of the heart and blood vessels (veins, arteries, capillaries); also called the cardiovascular system.

II. Conditions that Affect the Circulatory System

A. High blood pressure (hypertension)

1. Symptoms: headache, blurred vision, dizziness

B. Heart Attack (Myocardial Infarction)

C. Coronary Artery Disease (CAD)

D. Angina (chest pain)

E. Cerebrovascular Accident (CVA) – stroke

III. Normal Circulatory Changes with Age

A. Blood vessels become more rigid and narrow. Heart muscle has to work harder which may result in high blood pressure and poor circulation.

IV. Role of the Nurse Aide regarding Circulatory System

A. Observe and report

1. Complaint of headache

2. Chest pain

3. Blurred vision

4. Dizziness

5. Nausea

6. Shortness of breath, changes in breathing patterns, problems breathing

7. Weight gain

8. Change in vital signs

9. Swelling of hands and feet

10. Pale or bluish discoloration to hands, feet, or lips

11. Weakness or fatigue

Content – Musculoskeletal System:

I. Musculoskeletal System – gives the body shape and structure, allows the body to move, and also protects the organs; consists of the muscles, bones, ligaments, tendons, and cartilage.

II. Conditions that Affect Musculoskeletal System

A. Fracture

1. Common Types:

a. Open fracture (also called compound fracture) – the bone exits and is visible through the skin, or a deep wound that exposes the bone through the skin.

b. Closed Fracture (also called simple fracture) – the bone is broken, but the skin is intact.

c. Compression – the bone is crushed, causing the broken bone to be wider or flatter in appearance.

d. Stress Fracture – (also called hairline fracture) – the bone has tiny cracks.

2. Symptoms of fracture include: change in skin color, bruising, pain, and swelling.

B. Osteoporosis

1. Bones become brittle and can break easily.

2. Take caution when repositioning and/or transferring the resident.

C. Arthritis

1. Two common types of arthritis include: osteoarthritis and rheumatoid.

2. Encourage independence in ADLs to preserve ability.

3. As needed, use cane or other aids.

D. Contracture

1. A contracture deformity is the result of a stiffness or constriction in your muscles, joints, tendons, ligaments, or skin that restricts normal movement.

2. Impaired mobility can affect all aspects of daily living such as bathing, eating, dressing.

III. Importance of Exercise or Range of Motion (ROM)

A. Maintains physical and mental health.

B. Prevents problems related to immobility.

C. Problems/complications from lack of exercise or range of motion:

1. Loss of self– esteem

2. Depression

3. Pneumonia

4. Urinary Tract Infections

5. Constipation

6. Blood clots

7. Dulling of senses

8. Muscle atrophy or contractures

IV. Normal Musculoskeletal Changes with Age

A. Bones become more brittle and porous and may fracture more easily.

B. Loss of muscle strength and tone causes weakness and feeling tired.

C. Less flexible joints make moving more difficult.

D. Changes in spine and feet result in height loss, postural changes and difficulty walking.

V. Role of the Nurse Aide regarding the Musculoskeletal System

A. Observe and Report:

1. Pain with movement

2. Bruising

3. Change in movement and/or activity

4. Change in range of motion

5. Swelling of joints

6. Aches and/or pains

7. Red, pale, warm, or shiny areas over a joint

B. Fall prevention:

1. Keep mobile

2. Encourage activities and exercise

3. Participate in care

4. Proper positioning

5. Use of assistive devices

6. Keep pathways clear of spills, clutter, etc.

7. Answer call lights immediately

CARE SKILLS:

- Passive Range of Motion – CARE SKILL #69 – to be discussed, demonstrated, and checked-off during Lesson #22

Review Questions --- Lesson #9

1. When a resident complains of headache and blurred vision, the caregiver must report their complaint to the nurse immediately. *(True or False)*

2. When assisting a resident who has had a stroke to dress, the caregiver should dress the stronger side first. *(True or False)*

Lesson #10 (45 minutes)

Title: Common Diseases and Disorders – Gastrointestinal and Endocrine Systems

Lesson Objectives:

I. The student will be able to describe common disease processes of the gastrointestinal system which affect the elderly resident.

II. The student will be able to describe common disease processes of the endocrine system which affect the elderly resident.

Key Terms:

Colostomy – a surgically-made opening on the abdomen that has a section of the colon attached; the opening allows stool to be evacuated from the body and emptied into a bag that adheres to the abdomen;

Diabetes Mellitus – the body does not produce enough or properly use insulin.

Diarrhea – frequent elimination of liquid or semi–liquid stool.

Digestion – the process of breaking down food so that it can be absorbed by the cells of the body.

Elimination – the process of expelling solid wastes that are not absorbed into the cells of the body.

Emesis – vomit.

Gastroesophageal Reflux Disease (GERD) – chronic condition in which the liquid contents of the stomach back up into the esophagus.

Hemorrhoids – enlarged veins in the rectum.

Hyperthyroidism – overactive thyroid gland – excess of thyroid hormone.

Hypothyroidism – underactive thyroid gland – thyroid hormone produces below normal.

Ileostomy – section of the intestine is removed and the stool will be evacuated through a stoma and emptied into a bag adhered to the abdomen of the resident.

Ostomy – creation of an opening from an area inside the body to the outside of the body.

Peptic Ulcer – ulcer that forms in the lining of the stomach, duodenum, esophagus.

Stoma – The opening of an ostomy.

Ulcerative Colitis – chronic inflammatory bowel disease.

Content – Gastrointestinal System:

I. Gastrointestinal System – breaks down the food that is taken into the body and absorbs the water and nutrients needed for energy; rids the body of solid wastes; consists of the mouth, esophagus, stomach, large and small intestines, rectum, and anus; other organs that assist with digestion include the gallbladder, liver, and pancreas; also called the digestive system.

II. Common Conditions of the Gastrointestinal System

A. Gastroesophageal Reflux Disease (GERD)

B. Peptic Ulcer

C. Ulcerative Colitis

D. Hemorrhoids

E. Constipation

1. If a resident has not had a bowel movement within three days, most facilities have protocols for intervention to prevent impaction (hard stool in the rectal vault).

F. Colostomy/Ileostomy

G. Diarrhea

III. Normal Changes with Age

A. Taste buds lose sensitivity causing decreased appetite.

B. Tooth and gum problems result in inability to eat properly.

C. Digestion is less efficient causing constipation and food intolerance.

IV. Role of the Nurse Aide regarding the Gastrointestinal System

A. Observe and Report to the nurse

1. Difficulty chewing and/or swallowing, including problems with dentures and teeth.

2. Loss of appetite.

3. Abdominal pain or complaint of cramping.

4. Diarrhea

a. Frequency, amount, consistency

b. Observe for blood

5. Nausea and/or vomiting

a. If vomitus looks like coffee grounds, immediately report to nurse.

6. Constipation

a. Frequency, consistency and size of bowel movements.

b. Observation of stool for blood; notify nurse.

B. Interventions to avoid problems with digestion

1. Offer fluids frequently, especially while eating.

2. Provide regular oral care, making sure that dentures are clean and fit properly.

Content – Endocrine System:

I. Endocrine System – a collection of glands in the body that produces and secretes hormones that regulate body functions, such as metabolism, growth and development, reproduction, sleep and mood; also responsible for maintaining the levels of sugar in the blood and calcium in the bones; consists of pituitary, thyroid, parathyroid, pineal, and adrenal glands, pancreas, ovaries, testes, thymus, and hypothalamus.

II. Common Conditions that Affect the Endocrine System

A. Diabetes Mellitus

1. Hypoglycemia (low blood sugar)

a. Sign/symptoms: cold, clammy skin, double or blurry vision, shaking/ trembling, hunger, tingling or numbness of skin; increased confusion.

2. Hyperglycemia (high blood sugar)

a. Signs/symptoms: shortness of breath, breath smells fruity, nausea/vomiting, frequent urination, thirst.

3. Hyperthyroidism

a. Sign/symptoms: can't tolerate being hot.

b. Increased heart rate and enlarged thyroid (goiter).

4. Hypothyroidism

a. Sign/symptoms: confusion, tired.

b. Inability to tolerate the cold.

III. Normal Changes with Age

A. Insulin production decreases possibly causing excess sugar in blood.

B. Adrenal secretions decrease reducing ability to handle stress.

C. Thyroid secretions decrease slowing metabolism.

D. Levels of estrogen and progesterone decrease, which signals the onset of menopause.

IV. Role of the Nurse Aide regarding the Endocrine System

A. Observe and Report

1. Diabetic residents who refuse meal/snack or consume less than half of meal/snack.

2. Immediately report resident who has signs and symptoms of hypoglycemia.

3. Diabetic resident eating foods in conflict with ordered diet; could cause hyperglycemia.

B. Interventions to avoid problems

1. Identify residents in your care who are diabetic.

2. Encourage proper nutrition.

3. Eliminate or reduce stress when possible; offer encouragement and listen to the resident.

Review Questions --- Lesson #10

1. List signs/symptoms of hypoglycemia (low blood sugar).

2. The nurse must be notified immediately if (or when) the resident's vomit looks like coffee grounds. *(True or False)*

Lesson #11 (45 minutes)

Title: Common Diseases and Disorders – Reproductive, Immune/Lymphatic Systems

Lesson Objectives:

I. The student will be able to describe common disease processes of the reproductive system which affect the elderly resident.

II. The student will be able to describe common disease processes of the lymphatic system which affect the elderly resident.

Key Terms:

Genitals – the external male or female sexual organs.

HIV/AIDS – life–threatening condition that damages the immune system and interferes with the body's ability to fight disease.

Lymph – clear, yellowish fluid that moves in the lymph system from tiny capillaries in the circulatory system; carries disease–fighting cells called lymphocytes.

Perineum – the area between the anus and the scrotum (male) or vulva (female).

Reproductive Systems

Female – Ovaries – produce estrogen, progesterone and ova (eggs).

A. Fallopian tubes – carry eggs from ovaries to the uterus.

B. Uterus – muscular sac where the eggs can develop.

C. Vagina – muscular canal leading out of the body.

D. Vulva – external genitalia of the female, including the labia and clitoris.

E. Breasts – holds mammary glands which produce nutrients for infants.

Male – Testes – glands that produce testosterone and sperm.

A. Scrotum – sac which contains the testes.

B. Prostate Gland – gland which produces the fluid for sperm.

C. Penis – external organ through which males ejaculate and urinate.

Content: Reproductive System

I. Reproductive System – organs that work together for the purpose of producing new life; consists of testes, scrotum, penis, and prostate gland for males; consists of vulva, vagina, uterus, fallopian tubes, and breasts for females.

II. Common Conditions that Affect the Reproductive System

A. Breast, prostate and ovarian cancer.

B. Vaginitis – inflammation of the vagina; symptoms may include any of the following: burning or discomfort, especially when voiding, itching or irritation to the genital area, increase in vaginal discharge, foul odor.

III. Normal Changes with Age

A. Hormone production decreases.

B. Decreased estrogen in females causes menopause.

C. Decreased testosterone in males slows sexual response.

D. Prostate gland may become enlarged causing difficulty when urinating.

IV. Role of the Nurse Aide regarding the Reproductive System

A. Observe and Report

1. Abnormal bleeding.

2. Complaints of pain.

3. Discharge from the penis or vagina.

4. Swelling of the genitals.

5. Sores on the genitals.

6. Changes in the breast, such as lumps, size, shape, discharge from nipple.

Content – Lymphatic and Immune Systems

I. Lymphatic System – removes excess fluids and waste products from the body's tissues; it works closely with the Immune and Circulatory Systems; consists of the lymph nodes, lymph vessels, lymph, spleen, and thymus gland.

II. Immune System – fights infection, by protecting the body from disease–causing bacteria, viruses, and microorganisms; works closely with the Lymphatic System;

III. Common Conditions of the Immune and Lymphatic Systems

A. HIV/AIDS

1. Requires Standard Precautions unless coming in contact with blood or body fluids for which Contact Precautions would be necessary.

B. Lymphoma (cancer of the immune system).

IV. Normal Changes with Age

A. Increased risk of infection.

B. Increased drying of tissue – causes irritation.

V. Role of the Nurse Aide regarding the Immune and Lymphatic Systems

A. Observe and Report

1. Fever

2. Diarrhea

3. Increased fatigue/weakness

B. Interventions

1. Wash hands before and after care.

2. Encourage resident to eat meals and drink plenty of fluids, assisting as needed.

3. Keep the environment clean.

4. Remove gloves and other Personal Protective Equipment, such as gowns, face masks, etc., before leaving the resident's room.

5. Know and follow the infection control practices of the facility.

Review Questions --- Lesson #11

1. Fever and/or fatigue must be reported to the nurse. *(True or False)*

2. Abnormal bleeding from the vaginal area and/or complaint of pain/cramping must be reported to the nurse. *(True or False)*

UNIT 2

Lesson #12 (5 hours)

Title: Activities of Daily Living (Bathing, Shampoo, Perineal Care)

Lesson Objectives:

I. The student will be able to demonstrate competence in assisting a resident to bathe/shower.

II. The student will be able to demonstrate competence in assisting the resident to shampoo his/her hair.

III. The student will be able to demonstrate competence in providing perineal care.

Key Terms:

Activities of Daily Living (ADL) – personal care tasks performed daily, such as bathing, dressing, caring for teeth and hair, toileting, eating and drinking and moving around.

Perineal Area – the area of the body between the genitals and the anus.

Content:

I. Bathing and Shampooing Points to Remember (see CARE SKILLS #18-22)

A. Bathing is an opportunity to observe the resident's skin. Should a concern, such as lice, a new bruise, blister, rash or open area be noted, the nurse must be notified immediately.

B. The resident's face, hands, underarms, and perineal area should be washed at least daily.

C. The elderly may bathe only twice a week. Since their skin produces less perspiration and oil, frequent bathing could cause excessive dryness.

D. Before beginning the bathing process, the caregiver should make certain the room is warm enough and all linens and supplies are gathered so the resident is not left alone.

E. Respect the resident's privacy when transporting to and from the shower room and during the shower or bath. Be certain the resident's body is not unnecessarily exposed.

F. If no-rinse soap or shampoo is used, be sure that it is diluted and/or used per manufacturer's instructions.

G. Never leave the resident unattended during bathing.

H. Keep the water clean and at a comfortably warm temperature.

I. Back rubs are often performed after bathing. They are a good way to help the resident relax, improve circulation, and decrease pain. When using lotion/oils for back rubs, be sure to warm in hands before applying to resident's skin.

J. Hair should be shampooed at least weekly, unless otherwise noted in care plan. Hair should be combed daily and kept neat at all times.

K. Not all residents can get out of bed to have their hair shampooed in the shower, tub, etc. There are hair products available so that water is not needed when shampooing hair in bed. Follow care plan to ensure proper hair products are being used when shampooing hair in bed.

L. Do not use oils, lotions, powder, or other products that can cause the surface of showers, tubs, whirlpools, etc. to become slippery.

M. Whirlpool baths increase circulation and promote wound healing. Be sure to follow manufacturer's instructions for filling the tub with water, getting the resident in and out of the tub, and for general use of the whirlpool tub.

N. Always check the resident's care plan before providing care. Be sure to follow the care plan instructions at all times.

II. Perineal and Catheter Care Points to Remember (see CARE SKILLS #19)

A. Always wash from front to back.

B. Be sure to change linens if they are soiled.

C. Allow the resident to clean themselves if possible, assisting as needed.

D. Avoid pulling on the catheter and tubing. The tip of the catheter is much larger than what is seen on the outside. If it is improperly pulled out or dislocated, it can be very painful and cause damage to the areas involved.

E. Keep the catheter and tubing free of any kinks that could prevent the urine from draining properly.

CARE SKILLS:

- Shower/Shampoo – #18
- Bed Bath/Catheter Care/Perineal Care – #19
- Back Rub - #20
- Shampoo Hair in Bed – #21
- Whirlpool - #22

Review Questions --- Lesson #12

1. Explain the procedure to cleanse the perineal area (both male and female) and rationale of importance.

Lesson #13 (4 hours)

Title: Activities of Daily Living (Oral Care, Grooming, Nail Care)

Lesson Objectives:

I. The student will be able to explain the importance of and demonstrate competence in the provision of oral care/denture care.

II. The student will be able to explain the importance of and demonstrate competence in the provision of grooming, including hair and facial hair.

III. The student will be able to explain the importance of and demonstrate competence in the provision of fingernail and foot care.

Key Terms:

Foot Care – care of the feet, including inspection for areas of concern to be reported to the nurse.

NPO – nothing by mouth.

Oral Care – care of mouth, teeth and gums. Cleaning the teeth, gums, tongue, inside of mouth and dentures, if used.

Content:

I. Grooming/Personal Hygiene (see CARE SKILLS #23-30)

A. Points to Remember:

1. Always allow the resident to do as much as possible for themselves.

2. Allow the resident to make choices and respect those choices.

3. Be sensitive to established routines of the resident, incorporating those routines into daily care, as possible.

4. Oral care (including denture care) must be performed at least twice a day, but it's recommended to occur more often. Unconscious oral care should be performed more frequently to keep resident's mouth moist.

5. Oral care reduces the number of pathogens in the mouth, improves the resident's sense of well–being and appearance and improves sense of taste, enhancing appetite.

6. Oral care eliminates particles from beneath the gums, preventing injury and improving ability to chew and consume meals.

7. Dentures should be handled carefully and stored in cool, clean water in a labeled denture cup when not in use. Be sure that the cup is kept in a safe place. Always follow manufacturer's instructions for cleaning dentures.

8. The caregiver should observe for ill–fitting dentures and report concerns to the nurse. Ill–fitting dentures could affect speech and chewing ability, thus, ultimately affecting meal consumption and contributing to potential weight loss.

9. More frequent oral care is needed for residents who are unconscious, breathe through their mouth, are being given oxygen, are in the process of dying and/or are NPO.

10. Observe and report to nurse: irritation, raised areas, coated or swollen tongue, sores, complaints of mouth pain, white spots, loose/chipped or decayed teeth.

11. Be certain that the resident wants you to shave him/her or assist him/her to shave before you begin.

12. Wear gloves when shaving a resident.

13. Be sure to dispose of razors in the sharps container accordingly.

14. Always use hair care products that the resident prefers for his/her type of hair.

15. Nail care is provided when assigned or if nails appear dirty or have jagged edges.

16. Check fingers and nails for color, swelling, cuts or splits. Check hands for extreme heat or cold. Report any unusual findings to nurse before continuing procedure.

17. Support the foot and ankle when providing foot care.

18. Poor circulation occurs in the resident with diabetes. Even a small sore on the foot can become a large wound.

19. Careful foot care, including regular daily inspection is important.

20. During foot care, the feet should be checked for irritation or sores and reported to the nurse, if observed.

21. Soak feet in warm water to soften nails. Remove feet one at a time and wash, using a soapy washcloth. Be sure to rinse soap from feet prior to drying them.

22. Toenails are to be cut straight across with heavy nail clippers.

****Check with the charge nurse before trimming the resident's toenails. Residents with poor circulation to the feet or diseases such as diabetes will usually have their toenails trimmed by a podiatrist. For residents without these problems, you will need to trim the toenails regularly.**

CARE SKILLS:

- Oral Care – #23
- Oral Care for Unconscious – #24
- Denture Care – #25
- Shaving with an Electric Razor – #26
- Shaving with a Safety Razor – #27
- Comb/Brush Hair – #28
- Fingernail Care – #29
- Foot Care – #30

Review Questions --- Lesson #13

1. Explain observations made during oral care that should be reported to the nurse.
2. Explain why a nurse aide should not clip the toenails of a diabetic resident.

Lesson #14 (4 hours)

Title: Activities of Daily Living (Dressing, Toileting)

Lesson Objectives:

I. The student will be able to demonstrate competence in dressing or undressing the resident.

II. The student will be able to demonstrate competence in assisting the resident with toileting needs.

Key Terms:

Catheter – tube used to drain urine from the bladder.

Condom Catheter – external catheter that has an attachment on the end that fits over the penis; also called a Texas catheter.

Elimination – process of expelling solid waste not absorbed into the cells.

Enema – specific amount of water flowed into the colon to eliminate stool.

Fecal Impaction – hard stool in the rectum that cannot be expelled.

Fracture Pan – bedpan used for a resident who cannot assist with raising hips onto the regular bedpan.

Hemiparesis – weakness on one side of the body.

Hemiplegia – paralysis on one side of the body, weakness, or loss of movement.

Incontinence – inability to control the bladder or bowels.

Indwelling Catheter – catheter that remains in the bladder for a period of time.

Paraplegia – loss of function of lower body and legs.

Portable Commode (Bedside) – chair with a toilet seat and a removable container underneath.

Prosthesis – artificial body part.

Quadriplegia – loss of function of legs, trunk and arms.

Suppository – medication given rectally to cause a bowel movement.

Void – urination.

Content:

I. Dressing (see CARE SKILLS #31-32)

A. Residents have their own style and preferences and should be honored to the extent possible.

B. Residents should be encouraged to dress in their own clothing of choice each day.

C. Each piece of the resident's clothing should be inventoried according to facility policy, adding new items and deleting discarded items as necessary.

D. Resident clothing should be labeled/identified in an inconspicuous place.

E. Affected limbs should be dressed first and undressed last.

F. Avoid pullover garments if the resident has an affected side or difficulty with the neck or shoulders, unless requested by the resident.

II. Toileting

A. Assist to Bathroom or Bedside Commode (see CARE SKILLS #33-34)

1. Ensure bedside commode is in good repair, clean and odor free and has intact rubber stops to prevent commode from moving with resident weight, potentially causing a fall.

2. After assisting a resident to toilet, it may be necessary for the nursing assistant to perform perineal care.

a. Ensure the resident can stabilize while standing, utilizing a walker, side grab bars, and/or with the assistance of a second caregiver utilizing a gait/transfer belt.

b. Make sure that the resident is standing firmly, with their feet spread apart.

c. Wipe from front to back, using a different part of the washcloth for each stroke. Change the washcloth as necessary.

d. Rinse the resident's perineum and pat it dry prior to raising undergarments or applying a brief.

B. Bedpan/Fracture Pan (see CARE SKILLS #35)

1. A fracture pan is a bedpan that is flatter than a normal bedpan. It is used for residents who cannot assist to raise their hips onto a

regular bedpan. When using a fracture pan, position with the handle toward the foot of the bed. If the resident cannot help, roll the resident onto their far side, slip the fracture pan under the hips and roll the resident back toward you onto the bedpan.

2. A standard bedpan is positioned with the wider part of the pan aligned with the resident's buttocks.

C. Urinal (see CARE SKILLS #36)

1. Keep urinal in easy reach of resident.

2. Empty and clean urinal after each use.

3. Avoid using hot water to rinse the urinal.

D. Bowel and Bladder Training

1. Incontinent residents may be identified as candidates for bowel and bladder training. If so, the following guidelines will apply:

a. A record of the resident's bowel and bladder habits will be maintained and then observed for a pattern of elimination. A pattern will predict the frequency in which the resident will need to be assisted to use the bedpan or to toilet.

b. Explain the training schedule to the resident and attempt to follow the schedule closely.

c. Offer a trip to the commode or bathroom prior to beginning long procedures, as well as before and after meals.

d. Encourage residents to drink sufficient fluids. About 30 minutes after fluids are consumed, offer a trip to the bathroom or use of the urinal or bedpan.

e. Answer the resident's call light promptly, as residents cannot wait long when the urge to void is felt.

f. Provide privacy for elimination.

g. Praise successes and attempts to control bowel and bladder.

E. Emptying urinary drainage bag/leg bag (see CARE SKILLS #37)

1. Be sure to use an alcohol pad to clean the spout once the bag is completely drained.

2. Measure and record output, per facility policy. (See CARE SKILLS #14)

F. Catheter Care (see CARE SKILLS #19)

1. If a resident has a catheter, care is normally provided on each shift.

2. CNAs are NOT allowed to disconnect the urinary drainage bag and/or tubing from the catheter. Only licensed nurses are allowed to change the drainage and/or leg bag.

3. Privacy bags should be used for residents with catheters.

a. Privacy bags keep the catheter bag and its contents hidden from visitors and others in the facility, which improves privacy and dignity.

b. Privacy bags help secure the drainage bag to wheelchairs, beds, etc., so that the drainage bag never touches the floor.

4. Be sure that the tubing and urinary drainage bag are not dragging or touching the floor as residents ambulate, especially when in a wheelchair.

G. Urine Specimen Collection (see CARE SKILLS #38)

1. Random urine specimens do not have to be collected directly into the specimen container. Also, it is not necessary to clean the resident's genitalia before collecting the specimen. (Urine can be poured into the container from a bedpan, bedside commode, urinal, etc.) Clean-catch specimens are collected directly into the specimen container and should not include the first and last part of the urine voided.

2. If a clean–catch (midstream) urine specimen is ordered, using the towelettes supplied, the caregiver will assist the resident to clean the area around the meatus. For females, separate the labia. Wipe from front to back along one side. Discard the towelette. With a new towelette, wipe from front to back along the other side. Using a new towelette wipe down the middle. For males, clean the head of the penis. Use circular motions with the towelettes. Clean thoroughly, changing the towelette after each circular motion. Discard after use. If the male is uncircumcised, pull back the foreskin of the penis before cleaning. Hold it back during urination. Make sure it is pulled back down after collecting the specimen. Ask the resident to begin urination, but to stop before urination is complete. Place the container under the urine stream and ask the resident to begin urinating again. Fill the container at least half full. Remove the

container and allow the resident to finish urinating in bedpan, urinal or toilet.

H. Stool Specimen Collection (see CARE SKILLS #39)

1. Ask the resident to inform you when he or she can have a bowel movement.

2. Be ready to collect the specimen.

I. Application of Incontinent Brief (see CARE SKILLS #40)

1. Ensure brief is appropriate size for resident.

2. Ensure appropriate application in a manner not to cause abrasion due to being too tight or having tape applied to skin.

3. Monitor frequently for needed perineal care and change of brief.

J. Measure and record output (urine and emesis) (see CARE SKILLS #14)

1. Graduated measuring container.

2. Use metric measurement (cubic centimeters =cc).

3. Record all fluids that go into resident (intake). Include oral intake, IV fluids, tube feedings, medications, dialysis fluids, and flushes. Nurses are responsible for measuring and recording fluids related to medication administration.

4. Record all fluids excreted or withdrawn from the body (output). This includes urine, liquid stools, drainage from drains or chest tubes.

CARE SKILLS:

- Change Gown – #31
- Dressing a Dependent Resident – #32
- Assist to Bathroom – #33
- Assist to Bedside Commode – #34
- Bedpan/Fracture Pan – #35
- Urinal – #36
- Empty Urinary Drainage Bag – #37

- Urine Specimen Collection – #38
- Stool Specimen Collection – #39
- Application of Incontinent Brief – #40
- Measure and Record Urinary Output #14

Review Questions --- Lesson #14

1. Explain the difference between a routine urine specimen and a clean–catch (mid–stream) urine specimen.

2. Affected limbs should be dressed first and undressed last. *(True or False)*

Lesson #15 (2 hours, 30 minutes)

Title: Activities of Daily Living (Positioning/Turning, Transfers)

Lesson Objectives:

I. The student will be able to demonstrate the importance of proper positioning and body alignment.

II. The student will be able to recognize four commonly-used resident positions.

III. The student will be able to demonstrate competence in proper transfer techniques.

IV. The student will be able to demonstrate competence in assisting with ambulation.

Key Terms:

Alignment – put in a straight line; shoulders directly above hips, head and neck straight, arms and legs in a natural position.

Ambulation – walking.

Assistive Devices – equipment used to help resident increase independence.

Body Mechanics – using the body properly to coordinate balance and movement.

Cane – assistive device used by the resident with weakness on one side.

Dangle – sitting up with feet over the edge of the bed.

Deformities – abnormally formed parts of the body.

Fowler's Position – head of bed elevated 45 to 60 degrees.

Lateral Position – lying on side, either right or left.

Logrolling – to turn or move the resident without disturbing the alignment of their body.

Pivot – to turn with one foot remaining stationary.

Positioning – the placement and alignment of the resident's body when assisting the resident to sit, lie down or turn.

Semi–Fowler's Position – head of bed elevated 30 to 45 degrees.

Supine Position – lying flat on back.

Transfer – moving the resident from one surface to another.

Transfer Belt (Gait Belt) – a safety belt used to assist the resident who is weak or unsteady during transfers or walking.

Walker – assistive device used for support and steadiness.

Content:

I. Proper positioning and body alignment

A. Positioning

1. Frequency of repositioning

a. Recommended every 2 hours or more frequently, if warranted.

i. Prevent deformities, development of pressure sores, respiratory complications and decreased circulation.

B. Alignment

1. Proper alignment

a. Shoulders above hips, head and neck straight, and arms and legs in natural position.

b. Benefits

i. Promotes physical comfort.

ii. Relieves strain.

iii. Promotes blood flow.

iv. Promotes efficient body function.

v. Prevents deformities and complications (i.e., contractures and prevention of pressure sores, etc.).

C. Role of the Nurse Aide

1. Provide privacy.

2. Check resident's body alignment after position change.

3. Keep resident's body in good alignment, as possible.

4. Support affected limbs during repositioning.

5. Review care plan to determine which position(s) is safe for the resident.

6. Do not cause the resident pain or injury.

a. Be gentle.

b. Do not rush.

c. Do not slide or drag resident on bed linen.

d. Use appropriate side rail when turning resident (if side rail is used).

i. Side rail up on side of bed resident is turning toward.

e. Return bed to appropriate height and position.

7. Encourage resident to assist with positioning, if able.

8. Assist resident in moving to head of bed as needed (See CARE SKILLS #41)

II. Commonly used positions

A. Supine Position (see CARE SKILLS #42) – Flat

1. Ensure resident is placed at the head of the bed to prevent resident's feet/heels from touching or resting against the footboard. This will also help keep the trunk in position should the head of the bed be elevated.

2. Procedures which may require supine position

a. Bed making

b. Bed bath

c. Perineal care

B. Lateral Position (see CARE SKILLS #43) – Resident placed on left or right side

1. Reposition to side

2. Logrolling

3. Reduces pressure on one side.

C. Fowler's Position (see CARE SKILLS #44)

1. Head of bed elevated 45 to 60 degrees

a. Promotes breathing.

b. Caution: this position adds pressure to coccyx (tailbone).

2. Procedures which may require Fowler's position

a. Grooming

b. Oral care

c. Eating

D. Semi–Fowler's Position (see CARE SKILLS #45)

1. Head of bed elevated 30 to 45 degrees

a. Promotes breathing

b. Less pressure to coccyx

III. Proper transfer

A. Role of the Nurse Aide

1. Gather equipment.

2. Arrange furniture.

3. Awareness of catheters, tubing or devices.

4. Resident in shoes with non–skid soles, gripper socks, or shoes.

5. Assess need for assistance from coworker; refer to assignment sheet.

6. Provide for privacy and encourage the resident to help as much as possible to promote independence.

7. Use proper body mechanics.

a. Place feet shoulder-width apart.

b. Bend knees and keep back straight.

c. Keep the weight of the resident close to you.

d. Lift using thigh muscles in a smooth motion.

e. Never lift and twist at same time.

8. Check the resident's care plan and/or assignment sheet before moving the resident.

9. Be patient and give the resident time to adjust to changes in position.

10. Be aware of resident's limbs when transferring.

11. Check condition of assistive devices.

12. Report any misuse of (or refusal of) device to nurse.

13. Observe resident for signs of discomfort or fatigue.

14. When assisting resident to walk with cane, stand on weaker side.

15. Know how to properly use wheelchair and geriatric chair. (See CARE SKILL #46)

a. Nurse aide should know how to remove/replace equipment as necessary (i.e., armrests and footrests on wheelchair), lock/unlock wheels and other parts of chair, and raise/lower adjustable parts of chair.

16. Follow safety guidelines when transporting a resident in a chair.

a. Push the wheelchair from behind, except when going in and out of elevators. Pull the chair into and out of an elevator.

b. If moving a resident down a ramp, take the chair down backwards. Glance over your shoulder to be sure of your direction and to prevent collisions and falls.

c. Always place resident's feet on footrest before moving chair. Never push wheelchair if resident's feet are not on footrests. Doing so could cause serious injury to the resident.

d. Pay attention to surroundings to avoid collisions and injury to resident. Slow down at corners and look before proceeding.

B. Transfer from bed to chair (See CARE SKILLS #47)

1. Determine if resident has weakness on one side.

a. Place chair on unaffected side and transfer resident towards his/her unaffected side.

2. Brace chair firmly against the bed facing the foot of the bed.

3. Lock chair wheels & remove arm and leg rests, if wheelchair.

4. Allow resident to sit on side of bed/dangle (see CARE SKILLS #48) for approximately 10–15 seconds.

a. Feet flat on floor.

b. Regain balance.

5. Apply transfer/gait belt before transferring the resident.

6. Use proper body mechanics.

C. Using transfer/gait belt (see CARE SKILLS #49).

1. Secure belt around resident's waist and over their clothes. Never place gait belt on bare skin.

2. Most used when resident has fragile bones or recent fractures.

a. May not be used when resident has had abdominal surgery or has difficulty breathing.

b. Avoid using gait belt if resident has G-tube or other ostomies/stomas on abdomen.

3. Check for proper fit; not too tight; should not slide.

4. Use proper body mechanics.

D. Ambulation/walking (See CARE SKILLS #50)

1. Encourage/assist throughout the day.

a. Promote physical and mental well–being.

2. Stand to side and slightly behind the resident.

a. Weakness on one side, stand on that side.

3. Arm on residents back (if no gait belt).

E. Assistive devices

1. Fitted to each resident.

a. Measurements obtained by PT or nurse.

2. Walker (see CARE SKILLS #51)

a. Used by resident who can bear weight.

b. Used for support/balance.

c. Design

i. Light weight

ii. Rubber stops should be in good repair.

iii. Wheels

d. Walking sequence

i. Walker is placed at a comfortable distance in front of resident.

ii. Feet/wheels on ground.

iii. Resident moves to the walker, weaker side first.

3. Cane (see CARE SKILLS #52)

a. Used by resident to help maintain balance.

i. Resident should be able to bear weight.

ii. Not for weight bearing.

b. Designs

i. Curved handle

ii. Straight handle

iii. Four feet (quad–cane)

iv. Rubber stops should be in good repair.

CARE SKILLS:

- Assist to Move to Head of Bed – #41
- Supine Position – #42
- Lateral Position – #43
- Fowler's Position – #44
- Semi–Fowler's Position – #45
- Use of Wheelchair and Geriatric Chair – #46
- Transfer to Chair – #47
- Sit on Edge of Bed – #48
- Using a Gait Belt to Assist with Ambulation – #49
- Walking – #50
- Assist with Walker – #51
- Assist with Cane – #52

Review Questions --- Lesson #15

1. What is proper body alignment?
2. List the four commonly used positions.
3. Which position raises the head of the bed 30–45 degrees?
4. Does this position put more or less pressure on the coccyx than Fowler's position?
5. When transferring a resident with right-sided weakness from the bed to the chair, the chair should be placed on the resident's right side. *(True or False)*

Lesson #16 (1 hour, 30 minutes)

Title: Activities of Daily Living (Devices Used for Transfer)

Lesson Objectives:

I. The student will be able to demonstrate competence in transferring a resident using a mechanical lift.

II. The student will be able to explain how to transfer a resident to a stretcher or shower bed.

III. The student will be able to explain how to and when to use a two-person transfer.

Key Terms:

Mechanical Lift – a hydraulic or electric device used to transfer dependent or obese residents between surfaces. The lift may also have a scale to weigh the resident.

Stretcher – gurney; device for transporting residents unable to use a wheelchair or to walk; a means of transporting the severely ill or an immobile resident.

Content:

I. Mechanical lifts

A. Common names and types

1. Sling– some Brand names include Hoyer and Invacare.

2. Sit to Stand– one brand name is Arjo ® Sara Lift.

B. Proper use of mechanical lifts

1. Be sure to always follow:

a. Manufacturer's instructions – normally requires at least two caregivers.

b. Facility policy.

C. Transferring with mechanical lift (See CARE SKILLS #53) – general principles (but may vary with type of lift)

1. Position sling.

2. Base open and under bed, or around/straddling chair.

3. Place the overhead bar above the resident.

4. Attach the sling.

5. Place resident's arms across chest. Stabilize resident's head and neck.

6. Raise sling/resident.

7. Coworker support resident's legs.

8. Lower sling/resident to chair or stretcher (bed).

9. Position for comfort and place sling in a manner to protect the resident's dignity.

D. Role of the Nurse Aide

1. Review assignment sheet before transferring.

2. Be aware of manufacturer's instructions and facility policy.

3. Make sure lift is in proper working order.

4. Provide privacy for the resident during the transfer.

5. Be aware of catheter or tubing the resident may have.

6. Never leave resident alone in device.

II. Transfer resident to stretcher/shower bed

A. From bed to stretcher (see CARE SKILLS #54)

1. Need at least two workers to assist.

B. Return resident to bed.

1. Height of stretcher slightly higher than bed.

C. Role of the Nurse Aide.

1. Explain to the resident what you are about to do prior to transferring.

2. Provide the resident with privacy when transferring.

3. Keep the resident covered.

4. Be aware of any catheter or tubing the resident may have.

5. Use proper body mechanics.

6. Lock wheels on bed.

7. Ensure resident is positioned for comfort prior to exiting the room.

III. Transfer – Two Person Lift (see CARE SKILLS #55)

ONLY TO BE USED IN AN EMERGENCY – IF RESIDENT UNABLE TO BEAR WEIGHT, A LIFT SHOULD BE USED.

A. For transferring resident unable to bear weight (i.e., history of stroke).

B. Role of the Nurse Aide.

1. Explain to the resident what you are about to do prior to the transfer.

2. Lock wheelchair brakes.

3. Be aware of catheter or tubing the resident may have.

4. Use proper body mechanics.

CARE SKILLS:

- Transfer Using Mechanical Lift - #53
- Transfer to Stretcher/Shower Bed – #54
- Transfer: Two Person/Lift– emergency only – #55

Review Question --- Lesson #16

1. The manufacturer's instructions state the mechanical lift can safely be used by two qualified staff persons to transport a resident. The facility's policy states two qualified staff members are required to transport a resident. You were trained on how the lift functions and are competent to use it. Mrs. Smith would like to get up in her wheelchair. You have the lift ready to assist in the transfer. Cindy, another CNA, is coming to help with the transfer. Five minutes have passed, and Cindy has not arrived. It is acceptable for you to transfer Mrs. Smith by yourself. *(True or False)*

Lesson #17 (2 hours)

Title: Resident's Environment

Lesson Objectives:

I. The student will be able to demonstrate competence in making an occupied bed.

Key Terms:

Occupied Bed – bed made while a resident is in the bed.

Content:

I. Occupied Bed (see CARE SKILLS #56)

A. Points to Remember

1. Wrinkles from the linens can cause problems with circulation and result in sores on the resident's skin. Keep sheets as wrinkle-free as possible.

2. Always leave extra room at the foot of the bed for the toes to move freely.

3. Use safety precautions to ensure that the resident does not fall out of the bed. Follow facility protocol regarding side rails.

4. Keep the resident covered throughout the procedure to ensure privacy and comfort are maintained.

5. Before beginning an occupied bed change, check to see if the resident has tubes or lines attached to them. If so, be sure that the lines aren't being pulled or pinched during the linen change.

a. Move the drainage bag to the side of the bed that the resident will be facing while the linens are being changed. Before moving to the second side of the bed, be sure to move the bag, so that the resident will again be facing it once turned onto their other side.

6. The CNA is never allowed to stop a feeding pump or to disconnect the feeding tube for any reason. If necessary, have the nurse stop the pump or disconnect the lines. Always be sure to notify the nurse when you are finished, so that the resident's feeding can be resumed.

7. Report to the nurse if the resident refuses to have the linens changed, or if the resident complains of pain before you begin.

CARE SKILLS:

- Occupied Bed – #56

Review Questions --- Lesson #17

1. Wrinkled sheets under a resident do not cause problems for their skin? *(True or False)*

2. You are beginning an occupied bed change for Mrs. Smith, who has an indwelling catheter with a urinary drainage bag attached. Which side of the bed should you place the bag on, if you are about to turn Mrs. Smith onto her left side?

Lesson #18 (2 hours)

Title: Skin Care/Pressure Prevention

Lesson Objectives:

I. The student will be able to explain the importance of an intact integumentary system and basic skin care.

II. The student will be able to describe residents at risk for skin breakdown.

III. The student will be able to describe the need for pressure reducing devices.

Key Terms:

Bony Prominence – area of the body where the bone is in close proximity to the skin (e.g., ankles, hip bones, elbows, etc.).

Dermis – inner layer of skin.

Epidermis – outer layer of skin.

Friction – skin repeatedly rubs another surface.

Integumentary System – skin and associated structures that form a natural protective covering for the body

Offload – assisting a resident to stand, to completely remove the pressure from the area; Any process in which pressure on the appendage is reduced

Pressure Point – any area on the body that bears the body's weight when lying or sitting and where a bone is close to the skin's surface.

Pressure Sore (also called "Bed Sore" or "Decubitus Ulcer") – a localized injury to the skin and/or underlying tissue. Usually occurs over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.

Reverse Push–Up – asking a resident to lift up off their buttocks using their arms in a reverse push– up.

Shear – skin stays in one position, but underlying bone and tissue roll in the opposite direction.

Subcutaneous tissue – the lowest layer of skin; fatty tissue.

Content:

I. Understanding the Integumentary System and Basic Skin Care

A. The Integumentary System

1. The structure

a. Skin

b. Hair

c. Epidermis

d. Dermis

e. Subcutaneous tissue

f. Nails

g. Glands

i. Oil

ii. Sweat

h. Nerve endings

2. Function

a. Largest organ of the body

b. Sense organ

i. Heat/cold

ii. Pain

iii. Pressure

iv. Touch

c. Internal organ protection

d. Body temperature regulation

e. Bacterial protection

f. Excretes waste

g. Prevents loss of too much water

h. Vitamin D production

3. Changes with age

a. Skin dries

b. Skin becomes more fragile

c. Subcutaneous (fatty) tissue thins

d. Brown spots develop

e. Wrinkles appear

f. Hair grays and becomes thin

g. Nails thicken

4. Care of the skin

a. Skin should be clean and dry.

i. Provide frequent care for residents who are incontinent.

ii. Change linens/clothing.

iii. Check resident at least every 2 hours for needed care and encourage repositioning.

b. Observe for:

i. Rashes

ii. Abrasions

iii. Dryness

iv. Changes in skin color

1. Pale

2. Red

3. Purple/Blue

v. Pressure areas

1. Reposition at least every 2 hours.

2. No wrinkles in bottom sheet.

vi. Temperature

1. Complaints of warmth or burning

vii. Bruising

viii. Swelling

ix. Blisters

1. Ensure resident has proper fitting shoes/slippers.

x. Scratching

xi. Broken skin

xii. Drainage

xiii. Wound or ulcer

xiv. Redness or broken skin between toes or around nails.

II. Risk Factors for Skin Breakdown

A. Sensory Perception

1. The ability to feel pressure. In general, people move regularly to keep pressure from building up.

2. Individuals with limited sensory perception may not realize they have not moved for a while, which increases their risk for pressure ulcers. Medications, medical conditions, or mental status may all cause an individual's sensory perception to change.

B. Moisture

1. Healthy skin stays clean and dry. Individuals at risk of pressure ulcers may have skin that stays moist because of incontinence (urine or stool) or perspiration (sweat). When an area at risk for a pressure ulcer is moist, a pressure ulcer is more likely to form.

C. Activity

1. Activity means an individual's ability to physically move (like walking). Individuals who can walk rarely get pressure ulcers. Individuals who are bedfast or chair bound are at higher risk of developing pressure ulcers.

D. Mobility

1. Mobility refers to the ability to change and control body position. Individuals with good mobility move their bodies regularly. Individuals who are immobile or have limited mobility are at greater risk for developing pressure ulcers because they cannot move to relieve the pressure.

E. Nutrition

1. Everyone needs to eat the right food and drink enough liquids to stay healthy.

   Individuals who do not eat enough of the right foods or drink enough of the right liquids are at greater risk for pressure ulcers because their bodies do not have the energy they need.

F. Friction and Shear

1. Friction happens when skin rubs another surface over and over (like a rough wheelchair seat rubbing the back of the individual's leg).

2. Shear is similar to friction, but it occurs when skin stays in one position but the underlying bone and tissue roll in the opposite direction (like someone sliding across a bed).

3. The rubbing and pulling of friction and shear break down the skin, which contributes to pressure ulcers. Pressure ulcers are more likely to develop when there is increased shear or friction.

G. Additional Risk Factors

1. Chronic conditions or illnesses (diabetes, cancer) – body is fighting several problems at once.

2. Age– skin becomes fragile and breaks down easily.

3. Medical devices– the device may rub the skin over and over or cause pressure to that area.

4. Depression or mental illness– Higher risk due to individuals neglects their own care.

5. History of pressure ulcers– old pressure ulcer scars make the skin in that area weaker and more likely to break down.

III. Pressure Ulcer Development

A. Skin breakdown can develop when individuals stay in one position for too long (as little as two hours) without shifting their weight.

B. The pressure of body weight reduces blood supply, causing skin and surrounding tissue to become damaged or even die.

C. Pressure ulcers can be painful. They can cause infection, damage to muscle and bone, and even death.

1. For the stages of pressure sores, please refer to the picture in the Appendix A.

D. Treatment can take weeks, months, or years.

IV. Prevention of Skin Breakdown

A. Observe skin upon admission and during the provision of daily care

1. Skin Inspection (See CARE SKILLS #57)

a. Drape resident to allow you to see, feel and smell the area you are inspecting. This can easily be done when the individual is dressing or undressing.

b. Remove pressure – Lift heels, turn or move the individual to inspect the skin.

i. Report to the nurse if you find redness that is not relieved within 15 minutes of removing pressure.

c. Inspect – Focus on bony prominences, where pressure ulcers are most likely to develop. Observe and prevent skin–to–skin contact. Additional areas at risk are the ears, under the breasts, the scrotum, and any skin– to–skin contact.

d. Note observations and report to the nurse – When a potential problem is observed, notify the nurse for assessment of the area.

i. Report areas of discoloration, blisters, skin tears, changes in the way the skin feels, or any other area(s) of concern.

B. Encourage and maintain nutrition and hydration.

C. Manage moisture by providing prompt care.

D. Minimize pressure.

1. Pressure–reducing mattress

2. Pressure–reducing cushion to chair

a. Heel boots – specialty devices that surround the feet and calves and create a cushion between the heels and the bed. They should not be used with residents who walk. The manufacturer's instructions must be followed.

b. When using any device, check the other areas of the legs to ensure you are not moving the pressure to another area, like the calves.

3. Other pressure-reducing devices

a. Use pillows to float heels (See CARE SKILLS #58) when residents are in bed. Pillows should also be used to help reduce pressure under top arm when resident is side-lying.

b. Bed cradles (See CARE SKILLS #59) can be used to keep covers from touching toes when residents are in bed. Be sure to use per manufacturer's instructions and drape top covers over the cradle properly.

E. Prevent Friction and Shearing

1. Do not pull residents across surfaces when repositioning or transferring.

2. Use the draw sheet to turn, lift, or move residents who are in bed.

3. Ask for assistance when turning, lifting, or moving residents.

F. Identify residents who have been assessed by nursing as "at risk".

1. Braden Scale– standardized risk assessment tool completed by the nurse.

2. Newly-admitted residents are likely to fall into this category, due to the number of risk factors they face and the sudden change(s) in their body.

CARE SKILLS

- Inspecting Skin – #57
- Float Heels – #58
- Bed Cradle – #59

Review Questions --- Lesson #18

1. Most pressure ulcers develop within a few weeks of admission. *(True or False)*
2. Pressure ulcers can lead to life–threatening infection. *(True or False)*
3. Caregivers should use draw sheets to turn, lift or move the resident up in bed to prevent skin damage caused by shearing. *(True or False)*

Lesson #19 (3 hours)

Title: Activities of Daily Living (Nutrition/Hydration)

Lesson Objectives:

I. The student will be able to demonstrate competence in proper feeding techniques and provision of assistance for the resident with special needs.

II. The student will be able to explain the importance of following care guidelines for a resident receiving tube feedings and observations of resident condition that must be reported, if observed.

Key Terms:

Aspiration – inhalation of food or drink into lungs which has the potential to cause pneumonia or death.

Gastrostomy Tube (G–Tube) – tube placed through the abdomen directly into the stomach and used to provide nourishment.

Jejunostomy (J–Tube) – tube placed into the second part of the small intestines and used to provide nourishment.

Nasogastric Tube – tube placed through the nose to the stomach and used to provide nourishment.

PEG (Percutaneous Endoscopic Gastrostomy) – tube placed endoscopically, directly into the stomach and used to provide nourishment. Often called a “G–tube”.

Content:

I. Promoting Proper Nutrition and Hydration

A. Fluid Balance

1. Observe for signs of dehydration and report to the nurse:

a. Mild symptoms (include but are not limited to): thirst, loss of appetite, dry skin, flushed skin, dark colored urine, dry mouth, fatigue or weakness, chills.

b. Advancing dehydration symptoms (include but are not limited to): increased heart rate, increased respirations, decreased sweating, decreased urination, increased body temperature, extreme fatigue, muscle cramps, headaches, and nausea.

c. severe dehydration symptoms (include but are not limited to)– muscle spasms, vomiting, racing pulse, shriveled skin, dim vision, painful urination, confusion, difficulty breathing, seizures.

2. Observe for and report to the nurse signs of fluid overload which may include:

a. stretched and shiny–looking skin over a swollen area, increased abdomen size (ascites), shortness of breath or difficulty breathing (pulmonary edema), tightness of jewelry, clothing or accessories, low output of urine, even when the resident is drinking as much fluid as normal, a dimple in the skin covering the swollen area that remains for a few seconds after the pressing finger has been released.

b. Symptoms of more serious fluid overload include difficulty breathing, shortness of breath when lying down, coughing, cold hands or feet.

c. Measure Intake & Output accurately.

II. Promoting the Use of Proper Feeding Technique/Assisting a Resident with Special Needs (See CARE SKILLS #60)

NOTE - The caregiver should provide any necessary care and offer to assist the resident to toilet prior to meal service in an effort to promote a positive experience.

A. Tips for feeding

1. As a safety precaution, never leave a resident who needs to be fed unattended with a tray.

2. Add salt, pepper, sugar, condiments, etc., to the resident's preference and in accordance with their prescribed diet. Adding the extra flavor can help increase their appetite.

3. Reheat food if necessary.

4. Do not eat while feeding residents.

5. Avoid talking to coworkers, or others in the room, as it can make the resident feel neglected or unimportant and cause them to stop eating.

B. Assistive Devices

1. Plate guards

2. Utensils with enlarged (built–up) handles

3. Drinking cups (nosey cups)

4. Divided plates

5. Non–skid plate/place mat

C. Visually impaired

1. Speak in a normal tone while facing the resident.

2. Read menu to the resident.

3. Position their food on the plate according to hands of a clock. Explain where food items are on plate.

4. When feeding the resident, ask them to open their mouth at appropriate time.

5. When feeding the resident, tell them what food you are giving them.

D. History of stroke

1. Place food in resident's sight.

2. Supply assistive device(s), as appropriate, to unaffected side.

3. Report any difficulty swallowing and observe for signs of choking.

4. Report to nurse coughing and/or observed pocketing of food.

5. When feeding the resident, make sure the resident swallows before giving more food.

6. If resident's mouth is paralyzed, place food on the unaffected side when feeding.

E. History of Parkinson's Disease

1. Supply assistive devices, as appropriate.

2. Food and drinks should be placed within reach.

3. Assist the resident as needed; promote independence.

III. Caring for a Resident with a Tube Feeding and the Resident at Risk for Aspiration

A. Tube Feedings

1. Feeding tubes are used when food cannot pass normally from the mouth into the esophagus and then into the stomach. The resident who is unable to take food or fluids by mouth, or is unable to swallow, may be fed through a tube.

   The two types of tubes most commonly used in long–term care facilities are nasogastric tubes and gastrostomy tubes.

2. A nasogastric (NG) tube is a tube that is placed through the nose into the stomach. ("Naso" is the medical term for nose and "gastric" means stomach.) It may be abbreviated as NG tube. An NG tube may also be used by the nurse to suction and remove fluids from the body.

3. A gastrostomy tube (g–tube) is a tube that is placed directly into the stomach for feeding. A small surgical opening is made through the abdominal wall into the stomach, and the tube is sutured to hold it in place. This type of tube is often used for a resident who may need tube feedings for a long time. The abbreviation for a gastrostomy tube is G–tube. This tube can also be called a PEG (percutaneous endoscopic gastrostomy) tube.

4. Usually the NG tube or the G–tube will be attached to an electronic feeding pump that controls the flow of fluid. Most pumps have an alarm that sounds when something is wrong. You must notify the nurse immediately if the alarm sounds.

5. The resident who has a feeding tube should be observed frequently. If the pump is not working properly, the resident may receive the wrong amount of food or the fluid may enter too quickly. This can cause nausea, vomiting, and aspiration. The NG tube may have moved out of the stomach and into the lungs. Aspiration pneumonia may result if feeding enters the lungs.

6. Residents with feeding tubes are often NPO. NPO is the abbreviation for nothing by mouth. PO is the abbreviation used when a person can have something by mouth.

7. Do not give the resident who has a feeding tube anything to eat or drink without checking with the nurse.

8. The NG tube is uncomfortable and irritating to the nose and throat. The G– tube may become dislodged from the stomach, or the skin

may become irritated at the site of insertion. Infection can occur with either tube, if infection control practices are not carefully followed.

9. The resident with a feeding infusing should not lie flat. The head of the bed should be elevated at least 30°. Some procedures will need to be changed slightly for the resident with a feeding tube. For example, an occupied bed cannot be flattened to change the linen or to provide incontinence care with the feeding infusing. If the bed must be flattened, seek the nurse's assistance to turn off the pump prior to the procedure and turn the pump back on after the procedure. Your major responsibility concerning the resident with a feeding tube is to make regular observations and promptly report any problem.

10. Report any choking or coughing to the nurse immediately.

B. Observations to be reported to the nurse immediately:

1. Nausea

2. Discomfort during the tube feeding

3. Vomiting

4. Diarrhea

5. Distended (enlarged and swollen) abdomen

6. Coughing

7. Complaints of indigestion or heart burn

8. Redness, swelling, drainage, odor, or pain at the tube insertion site

9. Elevated temperature

10. Signs and symptoms of respiratory distress

11. Increased pulse rate

12. Complaints of flatulence (gas)

C. Comfort Measures

1. The resident with a feeding tube is usually NPO. Dry mouth, dry lips, and sore throat are sources of discomfort. The resident's care plan will include frequent oral hygiene and lubricant for the lips.

D. Risk of Aspiration

1. Any resident with ordered thickened liquids, a pureed or mechanical soft diet, or having a diagnosis of esophageal reflux, GERD, or respiratory difficulty is a resident who is at risk of aspiration. The caregiver must always elevate the head of the bed or assist the resident to an upright position prior to offering food or fluids if the resident is at risk of choking/aspiration. Should a resident begin to cough, gurgle or regurgitate, attempts to feed should STOP and the nurse should be alerted immediately to assess the resident.

2. Residents at risk of choking/aspiration should be encouraged to sit up or remain with the head of the bed elevated for at least 30 minutes (or as long as tolerated) following consumption of food or fluids.

3. Know your residents and ensure residents receive snacks, meals and fluids at the ordered consistency.

CARE SKILLS:

- Feeding – #60

Review Questions --- Lesson #19

1. Name two symptoms of dehydration.

2. When a tube feeding is infusing, the head of the bed must be elevated. *(True or False)*

Lesson #20 (8 hours)

Title: Basic Nursing Skills (Vital Signs, Height and Weight)

Lesson Objectives:

I. The student will be able to demonstrate competence in completion of initial steps to be taken prior to initiating a procedure as well as final steps following any procedure executed.

II. The student will be able to demonstrate competence in taking and recording vital signs.

III. The student will be able to demonstrate competence in measuring and recording height and weight.

Key Terms:

Apical Pulse – located on the left side of the chest, under the breastbone; taken with a stethoscope.

Brachial Pulse – located at the bend of the elbow, used for taking blood pressure measurement.

Carotid Pulse – located on either side of the neck, supplies the head and neck with oxygenated blood.

Diastolic Blood Pressure – the phase when the heart relaxes; the pressure in the arteries between heartbeats. bottom number of blood pressure reading

Expiration – exhaling air out of the lungs.

Hypertension – high blood pressure.

Hypotension – low blood pressure.

Inspiration – breathing air into the lungs.

Orthostatic Hypotension – a drop in blood pressure when a resident suddenly rises from a lying to a sitting or standing position.

Pulse Oximetry – a procedure used to measure the oxygen level (or oxygen saturation) in the blood. It is considered to be a noninvasive, painless, general indicator of oxygen delivery to the peripheral tissues (such as the finger, earlobe, or nose).

Radial pulse – the pulse site found on the inside of the wrist.

Respiration – the process of breathing air into lungs and exhaling air out of the lungs.

Systolic Blood Pressure – the phase when the heart is at work, contracting and pushing blood from the left ventricle; the pressure in the arteries when the heart beats; top number of a blood pressure reading

Content:

I. Initial Steps– These are consistent steps to be taken prior to executing any procedure with a resident. (See CARE SKILLS #1).

A. Includes asking the nurse about the resident's needs, abilities and limitations.

B. Includes following infection control guidelines and providing the resident privacy during care.

II. Final Steps– These are consistent steps to be taken following the completion of any procedure with a resident. (See CARE SKILLS #2).

A. Includes ensuring the resident is comfortable and safe.

B. Includes removing supplies and equipment from the resident's room and reporting any unexpected findings to the nurse and documenting care provided.

III. Vital signs provide important information

A. How the body is functioning

B. How the resident is responding to treatment

C. How the resident's condition is changing

D. Taking and Recording Vital Signs

1. Temperature (oral, axillary, tympanic) – the measurement of heat in the body affected by time of day, age, exercise, emotional state, environmental temperature, medication, illness and menstruation. Types of thermometers include glass, electronic with probe cover, paper/plastic tape, tympanic with probe cover. Glass thermometers are seldom used. NOTE* A facility may have specific instructions in regard to equipment to be used and/or the cleaning and disinfection of common use equipment for those residents who require isolation. The facility policies should be followed in regard to residents in isolation.

a. Oral (by mouth) – normal range 97.6 to 99.6 F (See CARE SKILLS #61)

b. Axillary (placed in the armpit) – normal range 96.6– 98.6 F (See CARE SKILLS #62)

c. Aural/tympanic (placed in ear) – normal range 98.6– 100.6 F

d. The above ranges are for general use. Report values that are more than 2.4 degrees from the resident's baseline (normal) temperature.

2. Pulse rate is the measurement of the number of heart beats per minute – Normal range 60 – 100 (See CARE SKILLS #63)

a. Affected by age, sex, emotions, body position, medications, illness, fever, physical activity and fitness level.

i. Pulse points most often used are: carotid, apical, radial, and brachial

ii. When taking the pulse rate, note the rate (number of beats per minute), rhythm and force.

3. Respirations/Respiratory Rate – the measurement of the number of times a person inhales per minute – Normal rate is 12-20 (See CARE SKILLS #63).

a. Affected by age, sex, emotional stress, medication, lung disease, heat and cold, heart disease, and physical activity.

b. When taking respirations, note rate (number of respirations per minute; rhythm (the regularity or irregularity of breathing); and character (the type of breathing, such as shallow, deep or labored).

c. Without removing your fingers from resident's wrist (or stethoscope from resident's chest), count respirations after taking pulse, so that the resident is unaware that their breathing is being monitored.

d. If resident is agitated or sleeping, place hand on resident's chest to feel it rise and fall during breathing.

4. Pulse Ox – A pulse oximeter continuously measures the level of oxygen saturation of hemoglobin in the arterial blood. (See CARE SKILLS #64)

a. Affected by poor circulation, movement, bright light, nail polish and fake nails (if probe is placed on finger).

b. Place probe on opposite arm of blood pressure cuff.

c. Normal ranges are typically between 95%-100% but can vary from person to person. Report an increase or decrease in oxygen levels to the nurse.

5. Blood Pressure – A measurement of the force the blood exerts against the walls of the arteries. Normal range for Systolic blood pressure is 90–139; Normal range for Diastolic blood pressure is 60–89. (See CARE SKILLS #65)

a. Abnormally high blood pressure is called hypertension. Measurements higher than 140/90 are considered high for adults.

b. Abnormally low blood pressure is called hypotension. Measurements below 90/60 are considered low for adults.

c. Electronic equipment may provide both odd and even numbers for someone's BP. However, a manual cuff only displays even numbers.

d. The above ranges are for general use. It is important to know the resident's baseline (normal) BP range and to report values obtained outside of that range to the nurse.

* Caution: If resident has a history of mastectomy or has a dialysis access, the blood pressure is not to be taken on the affected side/extremity.

IV. Measuring Height and Weight

A. Height (See CARE SKILLS #66)

1. Residents who are able to stand should utilize a standing balance scale.

2. Residents who are unable to stand should be measured while lying flat in bed. Height can be determined by using a tape measure to measure the distance between a mark made at the top of the resident's head and one made at the bottom of the resident's feet.

3. Residents who are unable to lay flat in bed should be measured using a tape measure. Follow the procedure used by the facility to determine height in this manner.

B. Weight – (See CARE SKILLS #67)

1. Have resident wear the same type of clothing each time he/she is weighed.

2. If daily weights are ordered, attempt to weigh at approximately the same time each day.

3. If resident wears a prosthetic device, the weight should consistently be taken with the device in place, or not in place, to eliminate inaccurate weight changes.

4. Follow the manufacturer's guidelines for use of the scale.

CARE SKILLS:

- Review Initial/Final Steps – #1 and #2
- Oral Temperature – #61
- Axillary Temperature – #62
- Pulse and Respiration – #63
- Pulse Oximeter – #64
- Blood Pressure –#65
- Height – #66
- Weight – #67

Review Questions --- Lesson #20

1. What is the normal heart rate for adults?

2. What is the normal blood pressure for adults?

3. If a resident is sleeping, describe how the respiratory rate can be taken?

UNIT 3

Lesson #21 (1 hour)

Title: Restraints

Lesson Objectives:

I. The student will be able to explain the resident's right to be free of physical and chemical restraints.

II. The student will be able to explain the need for monitoring physical restraint use and routine release.

III. The student will be able to describe devices which are enabling versus restrictive.

IV. The student will be able to explain the potential negative outcomes of side rail use.

Key Terms:

Chemical Restraint – any drug that is used for discipline or convenience and not required to treat medical symptoms. A drug used to restrict the freedom of movement of a resident or sedate a resident.

Convenience – any action taken by the facility to control or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.

Discipline – any action taken by the facility for the purpose of punishing or penalizing residents.

Entrapment – the act of getting caught in or trapped in something.

Medical Symptom – an indication or characteristic of a physical or psychological condition.

Physical Restraint – any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Side Rail – a barrier device attached to the side of a bed.

Content:

I. Physical Restraint

A. Resident Rights – The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

B. Types – "Physical restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, and lap trays the resident cannot remove easily. Also included as restraints are facility practices that meet the definition of a restraint, such as:

1. Using side rails that keep a resident from voluntarily getting out of bed;

2. Tucking in or using Velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted;

3. Using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot remove easily, that prevent the resident from rising;

4. Placing a resident in a chair that prevents a resident from rising; and

5. Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed.

C. Medical Symptoms/Rationale for Use – an indication or characteristic of a physical or psychological condition for which the device improves the resident's function or quality of life.

D. Guidelines for Applying Restraints (See CARE SKILLS #68)

1. A restraint shall be applied by an individual who has been properly trained, according to facility policy.

2. A restraint shall be applied in a manner that permits rapid removal in case of fire or another emergency.

3. Check pulse in area to ensure circulation is not occluded (cut off)

4. Nursing Assistants can only use/apply restraint when instructed to do so by the charge nurse.

E. Monitoring and Release

1. A record of physical restraint and seclusion of a resident shall be kept.

2. Each resident under restraint and seclusion shall be visited by a member of the nursing staff at least once every hour and more frequently if the resident's condition requires. If the restraint is not applied correctly, the resident can suffer serious injuries or even death. It is important to check the resident frequently (every 15 minutes) to ensure that circulation and bony prominences are not affected by the restraint. If the restraint is not removed frequently, the skin in the area can easily become irritated and even begin to breakdown. Restraints can also affect the resident mentally. They can cause the resident to suffer from anxiety, stress, depression, sleep disturbances, and loss of dignity.

3. Each physically restrained or secluded individual shall be temporarily released from restraint or seclusion at least every two (2) hours or more often if necessary except when the resident is asleep.

   * When the resident in restraint is temporarily released, the resident shall be assisted to ambulate, toileted, or changed in position as the resident's physical condition permits.

F. Self–Releasing Devices – Devices used as a reminder that the resident needs to call for assistance and/or to assist to keep the resident seated; the resident can self–release the device upon request. Thus, the device does not restrict freedom of voluntary movement.

G. Side rails – Side rails sometimes restrain residents. The use of side rails as restraints is prohibited unless they are necessary to treat a resident’s medical symptoms. Residents who attempt to exit a bed through, between, over or around side rails are at risk of injury or death. The potential for serious injury is more likely from a fall from a bed with raised side rails than from a fall from a bed where side rails are not used. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from the bed. The same device may have the effect of restraining one individual but not another, depending on the individual resident’s condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another. Orthotic body devices may be used solely for therapeutic purposes to improve the overall functional capacity of the resident.

H. Entrapment Zones

1. Ensure that the resident does not get caught between the bed and/or mattress and/or side rails. Being trapped between the spaces can result in serious injury or death.

2. Refer to the picture in the Appendix to identify zones on the bed where entrapment can occur.

I. An enclosed framed wheeled walker, with or without a posterior seat, would not meet the definition of a restraint if the resident could easily open the front gate and exit the device. If the resident cannot open the front gate (due to cognitive or physical limitations or because the device has been altered to prevent the resident from exiting the device), the enclosed framed wheeled walker would meet the definition of a restraint since the device would restrict the resident's freedom of movement (e.g., transferring to another chair, to the commode, or into the bed). The decision on whether framed wheeled walkers are a restraint must be made on an individual basis.

CARE SKILLS

- Application of Physical Restraints – #68

Review Questions --- Lesson #21

1. A resident has the right to be free from any physical or chemical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. *(True or False)*

2. How often must a resident with a physical restraint in place be visited by a staff member?

3. How frequently must the physically restrained resident be temporarily released to ambulate, toilet or change position?

Lesson #22 (1 hour, 30 minutes)

Title: Rehabilitation/Restorative Services

Lesson Objectives:

I. The student will be able to describe the role of rehabilitative services.

II. The student will be able to describe the role of restorative services.

III. The student will demonstrate competence in performance of range of motion exercises.

Key Terms:

Abduction – moving a body part away from the body.

Adduction – moving a body part toward the body.

Ambulation – walking.

Contracture – the permanent stiffening of a joint and muscle.

Dorsiflexion – bending backward.

Extension – straightening a body part.

Flexion – bending a body part.

Occupational Therapy – formal therapy which assists the resident to learn to compensate for their disabilities and assist them with activities of daily living.

Physical Therapy – formal therapy, which uses heat, cold, massage, ultrasound, electricity and exercise, for residents with muscle, bone and joint problems. A physical therapist may help a person to safely use a walker, cane or wheelchair.

Pronation – turning downward.

Range of Motion – exercises which put a joint through its full range of motion.

Active Range of Motion – exercises are done by the resident himself.

Passive Range of Motion – caregivers support and move the resident's joints through the range of motion when the resident cannot move on their own.

Rehabilitation – services managed by professionals to restore a resident to his/her highest practicable level of functioning following a loss of ability to function due to illness or injury.

Restorative Services – a planned approach to keep the resident at the level achieved by formal rehabilitation.

Rotation – turning a joint.

Speech Therapy – formal therapy which assists residents with speech and swallowing problems.

Splint – device that remains in place at the direction of the physician to maintain a body part in a fixed position.

Supination – turning upward.

Content:

I. Rehabilitation

A. Role of Formal Therapy

1. Physical Therapy

2. Occupational Therapy

3. Speech Therapy

B. Assistive or Adaptive Devices– devices made to support a particular disability by helping resident complete ADLs (e.g., long–handled brushes and combs, divided plate, built–up silverware, reacher/grabber, etc.).

II. Restorative Services

A. Ambulation

1. Cane

2. Walker

3. Gait/transfer belt

B. Range of Motion (see CARE SKILLS #69)

1. Active Range of Motion (AROM)

2. Passive Range of Motion (PROM)

C. Points to Remember:

1. Be patient when working with the resident.

2. Be supportive and encouraging.

3. Break tasks into small steps to promote small accomplishments.

4. Be sensitive to the resident's needs and feelings.

5. Encourage the resident to do as much for self as possible.

D. Observe and report to the nurse

1. An increase or decrease in the resident's ability.

2. A change in motivation.

3. A change in general health.

4. Indication of depression or mood changes.

E. Splint Application (see CARE SKILLS #70)

1. Splints vary from resident to resident. Be sure you have the correct splint for your resident and make sure it is applied properly.

2. If you notice redness, swelling, or any other concerns in the area that the splint is to be applied, notify the nurse before putting the device on the resident.

III. Devices which may be applied per Restorative Nursing Program

A. Abdominal Binder (see CARE SKILLS #71) – may be used to secure G–tube and prevent resident from picking at the insertion site or to provide support to the abdomen due to hernia or recent surgery.

B. Abduction Pillow (see CARE SKILLS #72) – may be ordered to be in place following a surgical procedure to maintain lower extremities in an abducted position and prevent the resident from crossing the lower legs or ankles.

C. Knee Immobilizer (see CARE SKILLS #73) – may be ordered to be in place following a surgical procedure to keep the leg straight while the bone is healing. Should only be removed at the direction of the licensed nurse.

D. Palm Cone (see CARE SKILLS #74) – may be ordered to be placed in the palm of a resident who is at risk for developing contractures of the digits

(i.e., prevent the fingers/nails from turning into the palm permanently and causing skin breakdown).

CARE SKILLS:

- Passive Range of Motion – #69
- Splint Application – #70
- Abdominal Binder – #71
- Abduction Pillow – #72
- Knee Immobilizer – #73
- Palm Cones – #74

Review Questions --- Lesson #22

1. Describe the difference in “active” range of motion and “passive” range of motion.
2. The permanent stiffening of a joint and muscle is called a _____.
3. A planned approach to keep the resident at a level achieved by formal rehabilitation is called _____.

Lesson #23 (1 hour, 30 minutes)

Title: Devices/Interventions – Prosthetics, Hearing Aids, Artificial Eye, Eyeglasses, Dentures, Compression Stockings

Lesson Objectives:

I. The student will be able to describe the necessary care and maintenance of various devices used by residents.

II. The student will be able to describe the need to monitor for complications with the use and maintenance of devices used by residents.

Key Terms:

Amputation – the removal of some or all of a body part, usually as a result of injury or disease.

Elastic/Compression Stockings – stockings that decrease blood pooling in the lower extremities. The stockings help with circulation in the lower legs and decrease the risk for blood clots. They are also referred to as TED (thromboembolic deterrent) hose.

Phantom Pain/Sensation – feeling like the limb is still there after the amputation due to the remaining nerve endings.

Prosthesis/Prosthetic Devices – device that replaces a body part that is missing or deformed due to accident, injury, illness or birth defect.

Content:

I. Purpose of a Prosthetic Device

- A. Improve resident's functional ability.
- B. Improve appearance.

II. Types of Prosthetic Devices

- A. Artificial limbs – arm, leg/foot
- B. Other prosthetic devices
  1. Hearing aids
  2. Artificial eyes
  3. Eyeglasses

4. Dentures

III. Role of the Nurse Aide regarding Amputations & Prosthetic Care

A. Be supportive – amputation can be difficult for a resident to accept due to the change in body image.

B. Follow care plan – know what is required related to care and needs.

C. Follow instructions for applying and removing the prosthesis.

D. Keep skin under prosthesis clean and dry – follow care plan.

E. Handle with care – prosthesis is fitted to the resident and specially made. A prosthesis can be very expensive.

F. Observe skin on stump. Watch for pressure, redness, warmth, tenderness, or open area. Report any concerns to the nurse.

IV. Role of the Nurse Aide regarding Hearing Aids

A. Hearing Aid – small battery-operated device that fits into the ear to amplify sound.

B. Assisting with Hearing Aids (see CARE SKILLS #75)

1. Be sure to follow the manufacturer's instructions when inserting the hearing aid into the resident's ear.

2. Be sure to follow the manufacturer's instructions on cleaning the hearing aid.

V. Role of the Nurse Aide regarding Artificial Eye & Eyeglasses

A. Artificial Eye – device that resembles natural eye. The resident cannot see with the artificial eye. The artificial eye is held in the eye socket by suction.

B. Care of artificial eye

1. Artificial eye – can be removed and reinserted. This should be done by the nurse or independently by the resident.

2. Nurse Aide needs to observe that eye is clean.

3. If eye is removed, make sure it is stored in a safe place with proper solution to avoid drying or cracking of artificial eye.

4. Follow directions on care plan.

5. Provide privacy when assisting with eye care.

6. Resident with artificial eye may be able to provide self–eye care – follow directions on care plan.

C. Care of eyeglasses

1. Make sure eyeglasses are clean.

2. Make sure resident has eyeglasses on.

3. Keep eyeglasses in a safe place when not in use.

VI. Role of the Nurse Aide regarding Dentures

A. Dentures – artificial tooth or teeth, necessary when resident's natural tooth or teeth have been removed due to damage or decay. Dentures may be partial or full.

B. Care of dentures (See CARE SKILLS #25)

1. Make sure resident has dentures in place for meals.

2. Resident may want dentures removed at night.

3. Make sure dentures are cleaned.

4. Make sure dentures are in a safe place when not in use.

VII. Role of the Nurse Aide regarding Elastic/Compression Stockings (TED Hose) (see CARE SKILLS #76)

A. Make certain stockings are on when resident is up, if ordered by the physician.

B. Follow care plan directions in regards to when stockings are to be applied and removed.

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CARE SKILLS:

- Assisting with Hearing Aids – #75
- TED Hose Application – #76

Review Questions --- Lesson #23

1. List potential observations of a stump which should be reported to the nurse.

2. When assisting the resident with eyeglasses, it is important to ensure the glasses are clean. *(True or False)*

3. When elastic/compression stockings are applied, the caregiver must ensure there are no wrinkles or twists in the stockings. *(True or False)*

Lesson #24 (1 hour, 30 minutes)

Title: Special Care Needs – Intravenous Fluids, Non–Pharmacologic Pain Interventions

Lesson Objectives:

I. The student will be able to explain the purpose of IV/PICC lines.

II. The student will be able to describe the importance of observing and reporting complications related to IV/PICC lines.

III. The student will be able to explain the signs/symptoms of pain and acknowledge interventions to be attempted to relieve resident pain.

Key Terms:

Antibiotic – compound or substance that kills or slows down the growth of bacteria.

Chemotherapy – treatment of cancer with an antineoplastic drug or with a combination of such drugs into a standardized treatment regimen; often administered intravenously (IV).

Hydration – the supply and retention of adequate water to keep one from dehydrating.

Intravenous (IV) – refers to a soft, flexible catheter (tube) that is inserted by a nurse or physician into a vein.

Pain – an unpleasant sensory and emotional experience arising from actual or potential tissue damage.

Peripherally Inserted Central Catheter –PICC– a soft, flexible catheter (tube) that is inserted by a specially trained nurse or physician into a vein for administration of medication, total parenteral nutrition (TPN), chemotherapy, or blood products for an extended period of time.

IV Pump – device to regulate the flow of the fluid into the vein. The pump will alarm if there is a problem with flow, and must be managed by the licensed nurse.

Total Parenteral Nutrition (TPN) – no food is given by other routes, only intravenously.

Vein – blood vessels that carry blood toward the heart.

Content:

I. IV or PICC Lines

A. Purpose of IV or PICC lines

1. Medication administration, such as antibiotics

2. Nutrition administration

3. Hydration

4. Blood products

5. Solutions are administered by gravity or through a portable pump

II. Role of the Nurse Aide in caring for IV/PICC

A. Observe and Report

1. If the IV or PICC line is not in place, or if it is removed by the resident, or accidentally by staff when providing care.

2. Blood present anywhere in the tubing.

3. Tubing is disconnected.

4. Complaint of pain.

5. Fluid in bag is not observed dripping.

6. Fluid in bag is nearly gone or finished.

7. Pump is alarming.

8. Site is swollen or discolored.

9. Dressing is wet or soiled.

B. Take special caution when moving or caring for resident – avoid pulling the tubing and make sure that it does not get caught on anything when providing care.

C. Never disconnect IV or PICC from pump.

D. Never lower bag below IV/PICC site. Can potentially cause a back flow of fluids from the vein, resulting in blood entering into the tubing and/or bag.

E. Do not take blood pressure in arm with IV or PICC.

III. Infection Control

A. Use proper hand hygiene.

B. Observe site for signs of infections and report to the nurse if observed:

1. Redness

2. Swelling

3. Pain

IV. Pain Factors

A. Vital Signs should be taken, if directed by nurse to do so.

B. Information related to pain:

1. Location

2. When did it start

3. What was resident doing when pain started

4. Rate the pain, i.e., mild, moderate or severe on scale of 1–10

5. How long has resident been having pain

6. Describe the pain, i.e., ache, stabbing, crushing, dull, constant, burning

7. Use resident's words/description to report to nurse

V. Role of the Nurse Aide related to Pain

A. Observe and report to the nurse signs/symptoms of pain, which may include, but are not limited to:

1. Change in vital signs – B/P, Pulse, Respiration

2. Nausea

3. Vomiting

4. Sweating

5. Tearful or frowning

6. Sighing, moaning or groaning

7. Breathing heavy or shortness of breath

8. Restless or having difficulty moving

9. Holding or rubbing a body part

10. Tightening jaw or grinding teeth

11. Anxiety, pacing

B. Interventions to reduce pain

1. Report complaints of pain or unrelieved pain (after receiving pain medication) to the nurse.

2. Position the resident's body in good alignment or assist the resident in changing to a more comfortable position.

3. Offer a back rub to the resident.

4. Assist the resident to the bathroom or offer the bedpan or urinal.

5. Encourage the resident to take slow, deep breaths.

6. Provide a quiet and calm environment.

7. Use soft music to distract the resident.

8. Be patient, caring, gentle and sympathetic in assisting the resident.

9. Observe the resident's response to interventions attempted and report to the nurse.

C. Barriers for resident regarding pain

1. Fear of addiction to pain medication.

2. Feeling caregivers are too busy to deal with pain.

3. Fear pain medication will cause other problems, i.e. drowsiness, sleepiness, constipation.

Review Questions --- Lesson #24

1. What are possible signs/symptoms of pain?
2. What are the reasons for an IV or PICC line?
3. Why would a resident not admit to having pain?

BARBARA BROYLES ALZHEIMER AND DEMENTIA TRAINING PROGRAM FOR NURSING ASSISTANTS

Do not ask me to remember.
Don't try to make me understand.
Let me rest and know you're with me.
Kiss my cheek and hold my hand.

I'm confused beyond your concept.
I am sad and sick and lost.
All I know is that I need you.
To be with me at all cost.

Do not lose your patience with me.
Do not scold or curse or cry.
I can't help the way I'm acting.
Can't be different though I try.

Just remember that I need you.
That the best of me is gone.
Please don't fail to stand beside me.
Love me 'til my life is done.

Author unknown

This Alzheimer's/Dementia curriculum was developed to encompass provisions set forth in Act 1184 of 2005 and incorporated into the Arkansas' Office of Long Term Care regulations for Nursing Assistant Training Curriculum.

Arkansas Department of Human Services

Lesson #25 (15 hours)

Title: Cognitive Impairment/Dementia/Alzheimer's

Lesson Objectives:

I. The student will be able to explain conditions associated with cognitive impairment.

II. The student will be able to describe behaviors related to cognitive impairment.

III. The student will be able to identify therapies/methods used to reduce challenging behaviors.

IV. The student will be able to demonstrate communication strategies and techniques for use with the cognitively impaired resident.

V. The student will be able to identify one out of each six categories on safety checklist.

VI. The student will be able to describe reasons why recreational activities are important.

Key Terms:

Activity therapy – increased activities with a goal.

Agitation – restlessness; emotional state of excitement or restlessness.

Alzheimer's disease – a progressive, degenerative and irreversible disease. Alzheimer's disease is caused by the formation of tangled nerve fibers and protein deposits in the brain.

Aphasia – inability to speak, or to speak clearly.

A. Expressive aphasia – may be slow to speak or to formulate sentences.

B. Receptive aphasia – may be slow to respond to communication attempts due to delay in processing the communication and the response.

Catastrophic reaction – reactions or mood changes of the resident in response to what may seem to be minimal stimuli that can be characterized by weeping, blushing, anger, agitation, or stubbornness.

Cognition – ability to think logically/quickly.

Cognitive impairment – inability related to thinking, concentrating, and/or remembering.

Confusion – inability to think clearly, trouble focusing, difficulty making decisions, feelings of disorientation.

Delirium – state of sudden severe confusion that is usually temporary.

Delusions – believing things that are untrue. Fixed false beliefs.

Dementia – serious loss of mental abilities (thinking, remembering, reasoning and communication).

Depression – state of low mood and lack of interest in activity.

Elopement – a cognitively impaired resident is found outside the facility and whose whereabouts had been unknown to staff.

Hallucinations – seeing/hearing things not there. False sensory perceptions.

Hoarding – collecting and storing items in a guarded manner.

Interventions – actions to be taken by staff in response to an event or behavior.

Pacing – walking back and forth in the same area.

Pillaging – taking items that belong to someone else.

Reminiscence therapy – used to encourage residents to talk about the past.

Repetitive Phrasing – continually repeating the same phrase over and over.

Sundowning – behavioral changes that occur in the evening with improvement or disappearance during the day.

Validation therapy – concept of validation or the returned communication of respect, which confirms that the other person's opinions are acknowledged, respected, and heard, and that they are being treated with genuine respect as a legitimate expression of their feelings.

Wandering – walking aimlessly around the facility.

Content:

I. Conditions:

A. Confusion – characterized by the inability to think clearly, trouble focusing, difficulty making decisions, feeling of disorientation.

B. Delirium – state of sudden severe confusion that is usually temporary. Delirium is a serious condition, occurring rapidly over hours or a few days.

C. Dementia – a general term that refers to serious loss of mental abilities, such as thinking, remembering, judgement, reasoning, and communicating. Dementia is not a normal part of aging.

D. Alzheimer's disease – a progressive, degenerative and irreversible disease.

Alzheimer's disease is caused by the formation of tangled nerve fibers and protein deposits in the brain. Alzheimer's disease is the most common cause of dementia. Alzheimer's disease is characterized by stages:

1. Stage 1 – no impairment (normal function) – the resident does not experience any memory problems.

2. Stage 2 – very mild cognitive decline (may be normal age–related changes or earliest signs of Alzheimer's disease) – the resident may feel as if he or she is having memory lapses – forgetting familiar words or the location of everyday objects.

3. Stage 3 – mild cognitive decline (early stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms) – friends, family or co–workers begin to notice difficulties.

   a. Noticeable problems coming up with the right word or name.

   b. Trouble remembering names when introduced to new people.

   c. Having noticeably greater difficulty performing tasks in social or work settings.

   d. Forgetting material that one has just read.

   e. Losing or misplacing a valuable object.

   f. Increasing trouble with planning or organizing.

4. Stage 4 – moderate cognitive decline (mild or early–stage Alzheimer's disease) – at this point, a careful medical interview should be able to detect clear–cut symptoms in several areas:

   a. Forgetfulness of recent events.

   b. Impaired ability to perform challenging mental arithmetic – for example, counting backward from 100 by 7s.

   c. Greater difficulty performing complex tasks such as planning dinner for guests, paying bills or managing finances.

d. Forgetfulness about one's own personal history.

e. Becoming moody or withdrawn, especially in socially or mentally challenging situations.

5. Stage 5 – moderately severe cognitive decline (moderate or mid–stage Alzheimer's disease) – gaps in memory and thinking are noticeable, and residents begin to need help with day–to–day activities. At this stage, those with Alzheimer's may:

a. Be unable to recall their address or telephone number or the high school or college from which they graduated.

b. Become confused about where they are or what day it is.

6. Stage 6 – severe cognitive decline (moderately severe or mid–stage Alzheimer's disease) memories continues to worsen, personality changes may take place and individuals need extensive help with daily activities. At this stage, residents may:

a. Lose awareness of recent experiences as well as of their surroundings.

b. Remember their own name but have difficulty with their personal history.

c. Distinguish familiar and unfamiliar faces but have trouble remembering the name of a spouse or caregiver.

d. Need help dressing properly and may, without supervision, make mistakes such as putting pajamas over daytime clothes or shoes on the wrong feet.

e. Experience major changes in sleep patterns – sleeping during the day and becoming restless at night.

f. Need help handling details of toileting (for example, flushing the toilet, wiping or disposing of tissue properly).

g. Having increasingly frequent trouble controlling their bladder or bowels.

h. Experience major personality and behavioral changes, including suspiciousness and delusions (such as believing that their caregiver is an imposter) or compulsive, repetitive behavior like hand– wringing or tissue shredding.

i. Tend to wander or become lost.

7. Stage 7 – very severe cognitive decline (severe or late–stage Alzheimer's disease) – in the final stages of this disease, residents lose the ability to respond to their environment, to carry on a conversation and, eventually, to control movement. They may still say words or phrases. At this stage, residents need help with much of their daily personal care, including eating or using the toilet. They may also lose the ability to smile, to sit without support and to hold their heads up. Reflexes become abnormal. Muscles grow rigid. Swallowing impaired.

II. Behaviors, Causes and Interventions

A. Agitation –could be caused by noise, other residents' behaviors, pain, thirst, or hunger, over/under stimulation, infection, need to toilet or be cleaned etc.).

1. Remove trigger(s), if known.

2. Maintain calm environment.

3. Stay calm.

4. Assess basic needs.

5. Patting, stroking may/may not reassure resident.

6. Validate feelings.

B. Pacing/Wandering – could be stress or fear, searching for something or someone, boredom, basic need not met, following past routine (mailman, security officer), a need to exercise, resident has forgotten location of room or chair, hungry, need to toilet, pain, etc.

1. Ensure resident is in a safe area.

2. Ensure resident is wearing appropriate footwear

3. Assess basic needs.

4. Validate feelings then redirect to another activity of interest if resident appears tired and may become at risk for falls.

C. Elopement – may be evident through exit–seeking actions, verbalizing wanting to leave, staying close/near doors, trying to open doors/windows.

1. Redirect and engage in other activities.

2. Ensure doors remain secured/alarms functional.

3. Report missing resident immediately.

D. Hallucinations/Delusions – may be caused by acute illness or psychiatric diagnosis/condition.

1. Ignore harmless hallucinations or delusions. A new onset of hallucinations should be reported to M.D. to make sure there is not a medical cause (illness).

2. Provide reassurance.

3. Do not argue.

4. Stay calm.

5. Validate feelings then redirect to activities or to another discussion.

6. Notify nurse of hallucination(s)/delusion(s).

E. Sundowning – as this occurs in the evening, consider need for increased activities and/or staffing in the evening.

1. Remove trigger(s).

2. Avoid stress in environment.

3. Keep environment calm and quiet.

4. Reduce/remove caffeine from evening fluids/diet, if possible.

5. Validate feelings then Redirect; offer activity or favorite food.

F. Catastrophic Reaction – may be caused by fatigue or over stimulation.

1. Remove trigger(s), if possible.

2. Offer food or quiet activity.

3. Validate feelings then Redirect.

4. May be the result of abuse or neglect and it is reportable according to law and regulations.

G. Repetitive Phrasing – may be caused by habit, sense of insecurity or cognitive impairment. May be caused by the person trying to express a specific concern, ask for help, or cope with frustration (self–soothing), anxiety and insecurity or a habit.

1. Be patient and calm.

2. Look for reason behind repetitive phrase/question.

3. Answer question.

4. Do not try to silence or stop.

5. Validate feelings then Redirect.

H. Violence – may be caused by delusion, hallucination, acute illness, cognitive impairment, provocation by another resident, physical discomfort, etc.

1. Step out of reach.

2. Block blows with open hand or forearm.

3. Do not strike back or grab resident.

4. Call for help.

5. Stay calm.

6. Identify triggers and remove, if possible.

7. Give the resident space.

8. Do not take resident's actions personal.

I. Disruptive actions – may be caused by delusion, hallucination, acute illness, cognitive impairment, provocation by another resident, physical discomfort etc.

1. Remain calm.

2. Avoid treating like a child.

3. Gently direct to a private area, provide distraction or activity.

4. Explain procedure(s) or change in normal pattern.

5. Be reassuring.

J. Challenging Social Acts – may be caused by delusion, hallucination, acute illness, cognitive impairment, provocation by another resident, physical discomfort etc.

1. Remain calm.

2. Identify trigger, if possible.

3. Gently redirect to private area.

4. Report physical or verbal abuse to the nurse.

K. Challenging Sexual Acts – may be provoked by a thought, visual, etc.

1. Do not over–react.

2. Be sensitive.

3. Try to redirect or relocate to a private area.

4. Ensure the safety of other residents, if potentially involved.

5. Report to nurse.

L. Pillaging/Hoarding – note that either activity is not stealing, rather, a behavior often associated with a psychiatric diagnosis.

1. Label personal belongings of all residents.

2. Regularly check rooms for items which might belong to others.

3. Provide direction to resident's own room (a visual cue could be helpful).

4. Mark other residents' room with symbols or labels to avoid residents from entering.

III. Methods/Therapies to Reduce Behaviors

A. Validation Therapy – allowing the resident to express feelings and emotions. Caregiver not only listens but acknowledges and respects the resident's thoughts/concerns.

B. Reminiscence Therapy – encouraging the resident to remember; to talk about the past. Can be accomplished through communication, pictures, music, smells, etc.

C. Activity Therapy – using activities that the resident enjoys to prevent boredom and frustration.

D. Music Therapy – form of sensory stimulation; hearing familiar songs can cause a response in residents that do not respond to other therapies.

E. Re–direction – gently and calmly encouraging the resident to do a different action; change focus of attention.

IV. Tips to Remember when Dealing with Cognitively Impaired Residents

A. Not personal – residents do not have control over words or actions.

B. Talk with family – learn about the resident's life, names of family members, occupation, hobbies, pets, foods, favorites.

C. Team work – report changes or observations; be flexible and patient.

D. Handle behaviors/situations as they occur – remember that the resident has lost the ability to remember prior directions given.

E. Know your limits – watch for signs of stress, frustration and burnout.

V. Communication Strategies

A. Always identify yourself.

B. Speak slowly, calmly in a low tone.

C. Avoid loud, noisy environments.

D. Avoid startling or scaring; approach from the front, remain visible to the resident.

E. Allow the resident to determine how close you should be.

F. Listen to resident; Validate feelings.

G. Avoid arguing.

H. Give visual clues.

I. Ensure your body language and facial expressions are appropriate.

VI. Techniques to Handle Difficult Behaviors

A. Anxiety/Fear

1. Stay calm, speak slowly.

2. Reduce noise or distractions.

3. Explain what you are doing.

4. Use simple words and short sentences.

5. Watch your body language and ensure it is not threatening.

B. Forgetful/ Memory Loss

1. Repeat, using same words.

2. Give short simple instructions.

3. Answer questions with brief answers.

4. Watch tone, facial expressions and body language.

C. Unable to express needs

1. Ask to point or gesture.

2. Use pictures or written words.

3. Offer comfort if resident is becoming frustrated.

D. Unsafe or abusive language or activities

1. Avoid saying “don’t” or “no”.

2. Validate feeling then Redirect to another activity or discussion.

3. Remove hazard, if possible.

4. Don’t take the residents actions/words personally.

E. Depressed, lonely or crying.

1. Take time with resident; do not rush.

2. Really listen and provide comfort.

3. Try to involve in activities to redirect resident focus.

4. If continues or repeats, report to nurse.

VII. Behavior Interventions

A. Bathing

1. Schedule at time that resident is agreeable.

2. Be organized.

3. Explain what you are going to do in simple steps.

4. Allow resident to assist as much as possible.

5. Take your time.

6. Provide privacy.

7. Make sure resident is not afraid of tub/shower.

8. Have resident assist, as able.

9. Maintain safety; do not leave alone.

10. Do not argue with resident; if upset, try again at another time.

B. Dressing

1. Encourage to choose what to wear.

2. Do not rush.

3. Provide privacy.

4. Use simple steps; short step–by–step directions.

5. Allow resident to assist.

6. Take time and be calm.

C. Toileting

1. Encourage fluids – lack of fluids can cause dehydration and constipation.

2. Establish a toileting schedule; for example, take to bathroom every 2 hours.

3. Toilet before and after meals.

4. If incontinent – watch for patterns to determine resident routine for a 2–3-day period (this is also effective for night time incontinence).

5. Identify bathroom with sign or picture.

6. Avoid dark or unlit bathrooms or hallways.

7. Check briefs frequently; change when soiled and observe skin.

8. Document/track bowel movements (constipation may cause increase in behaviors).

9. Document and report any changes in bowel/bladder patterns as it could be a sign of infection/illness.

D. Eating/Meals

Helping with Nutrition:

Many people with Alzheimer's have challenges with eating. An individual might lose his/her appetite or the ability to evaluate if food is too hot or cold. In addition, an individual might forget that he/she has eaten and ask you for another meal.

The individual may be experiencing physical difficulties that are causing the changes in eating habits. Sores in the mouth, poor–fitting dentures, gum disease or dry mouth may make eating difficult. Individuals will lose the ability to recognize and use utensils appropriately.

To ensure the individual with dementia is receiving the proper nutrition, you must work to prevent eating and nutrition problems. Consult with the individual's physician and/or dietician for guidance.

1. Schedule meals at regular times.

2. Provide adequate lighting and space.

3. Avoid delays – have meal ready, i.e., pre–cut, opened cartons or packages.

4. Watch temperatures – avoid very hot foods.

5. Simple (white) dishes, no extra items which could confuse resident.

6. Avoid overwhelming with too many different foods.

7. Give simple instructions.

8. If the resident needs to be fed, use slow, calm, relaxed approach.

9. Watch for chewing, swallowing or pocketing issues and report to nurse. (Pocketing refers to holding food in the mouth, especially in the cheeks.)

10. Ensure adequate fluid intake during meal.

E. Recreational Activities: Recreational activities are an important part of a healthy life with dementia. The benefits include:

1. Improves eating and sleeping patterns.

2. Lessens wandering, restlessness, anxiety.

3. Reduces complications with sun downing.

4. Improved socialization and cooperation.

5. Delays deterioration of skills.

6. Eases behavior management.

7. Source of pleasure and rewards.

*** It is important to find activities that are meaningful and provide success. Meaningful activities create a sense of usefulness and accomplishment and promote self–esteem. To promote this, match activities to the abilities and interests of the individual. Focus on enjoyment, not achievement. Be sure to observe the individual's behavior during the activity to watch for signs of boredom or tiring. Keep activities adult–like but you may have to use children's materials. Do a variety of activities to hold their interest. Alternate active and passive activities.**

1. Card games or board games

2. Reminiscing and memory stimulation

3. Music

4. Crafts and art projects

5. Outings

6. Gardening

7. Pets

8. Visits from others

9. Spiritual activities

VIII. Activity Chart

A. Waking Hours (low key)

1. Personal cares

2. Reading paper

3. Discussing day ahead

4. Having a cup of coffee

5. Engaging in conversation

B. Early Morning (quiet)

1. Clipping coupons

2. Folding laundry

3. Winding yarn balls

4. Craft projects

C. Late Morning

1. Group exercises

2. Board Games

3. Meal prep– set table, pour milk

4. Outside Walks

5. Individual projects

D. Lunchtime/early afternoon

1. Eating and sharing

2. Resting/napping

3. Helping with serving and clean up

E. Midafternoon (active)

1. Physical game skills

2. Exercising/walking

3. Music: singing along, dancing, exercising

4. Crafts

5. Memory stimulation games

6. Cleaning house

F. Late afternoon (quiet)

1. Reminiscing

2. Helping with meal prep

3. Checkers

4. Watering plants

G. Dinnertime

1. Meal prep, serve, clean up

2. Eating and sharing

H. Early evening (quiet)

1. Soothing music

2. Walking through neighborhood

3. Reminiscing

4. Evening cares– washing and dressing for bed

I. Other examples of useful activities

1. Polishing silverware

2. Sorting buttons

3. Putting coins into rolls

4. Shelling nuts

5. Folding and stuffing envelopes, stapling, applying labels

6. Dusting furniture, sweeping floor

7. Organizing closet/drawers

8. Washing and drying dishes

IX. Safety Checklist

A. Kitchen precautions. Proper storage of:

1. Knives, utensils, gadgets; toaster, grill, etc.

2. Remove controls for stove, cover burners

3. Locks on fridge and cupboards

4. Cover for garbage disposal

B. Bathroom precautions. Proper storage of:

1. Shavers, blow dryers, cosmetics, medicines, etc.

2. Non–skid mats in tub/shower and on floor

3. Safety rails

4. Use shower chair

5. Monitor water temperature

C. Fall precautions:

1. Remove scatter rugs

2. Keep pathways clear of clutter

3. Adequate lighting, non–glare

4. Don’t move furniture around

5. Safety rails in halls, bathrooms, and stairways

6. Gates or locks to keep person out of unsafe areas

D. Visual aids:

1. Nightlights placed throughout home.

2. Cover doorknobs with cloth same color as the door; use childproof knobs (personal home only).

3. Camouflage doors by painting them same color as the walls (personal home only).

4. Use black tape or paint to create a two–foot black threshold in front of the door (personal home only).

5. Place STOP sign on door to prevent entrance into restricted area.

E. General:

1. Post emergency numbers by phone (numbers should be 1–5).

2. Lock doors and windows.

3. Cover outlets.

4. Working smoke detectors.

5. Hot water heater secured.

F. General. Proper storage of:

1. Chemicals: cleansers, pesticides, paint

2. Medications– childproof caps

3. Sharps: scissors, glass, knives

4. First aid supplies

5. Yard tools

X. Sleep Changes

A. Common sleep changes

Many people with Alzheimer's experience changes in their sleep patterns. Scientists do not completely understand why this happens. As with changes in memory and behavior, sleep changes somehow result from the impact of Alzheimer's on the brain. Many older adults without dementia also notice changes in their sleep, but these disturbances occur more frequently and tend to be more severe in Alzheimer's. There is evidence that sleep changes are more common in later stages of the disease, but some studies have also found them in early stages.

Sleep changes in Alzheimer's may include:

1. Difficulty sleeping. Many people with Alzheimer's wake up more often and stay awake longer during the night. Brain wave studies show decreases in both dreaming and non–dreaming sleep stages. Those who cannot sleep may wander, be unable to lie still, or yell or call out, disrupting the sleep of their caregivers.

2. Daytime napping and other shifts in the sleep–wake cycle. Individuals may feel very drowsy during the day and then be unable to sleep at night. They may become restless or agitated in the late afternoon or early evening, an experience often called "sun–

downing." Experts estimate that in late stages of Alzheimer's, individuals spend about 40 percent of their time in bed at night awake and a significant part of their daytime sleeping. In extreme cases, people may have a complete reversal of the usual daytime wakefulness–nighttime sleep pattern.

B. Contributing medical factors

A person experiencing sleep disturbances should have a thorough medical exam to identify any treatable illnesses that may be contributing to the problem. Examples of conditions that can make sleep problems worse include:

1. Depression

2. Restless legs syndrome, a disorder in which unpleasant "crawling" or "tingling" sensations in the legs cause an overwhelming urge to move them.

3. Sleep apnea, an abnormal breathing pattern in which people briefly stop breathing many times a night, resulting in poor sleep quality.

* For sleep changes due primarily to Alzheimer's disease, there are non–drug and drug approaches to treatment. Most experts and the National Institutes of Health (NIH) strongly encourage use of non–drug measures rather than medication.

* Studies have found that sleep medications generally do not improve overall sleep quality for older adults. Use of sleep medications is associated with a greater chance of falls and other risks that may outweigh the benefits of treatment.

C. Non–drug treatments for sleep changes

Non–drug treatments aim to improve sleep routine and the sleeping environment and reduce daytime napping. Non–drug coping strategies should always be tried before medications, since some sleep medications can cause serious side effects. To create an inviting sleeping environment and promote rest for a person with Alzheimer's:

1. Maintain regular times for meals and for going to bed and getting up.

2. Seek morning sunlight exposure.

3. Encourage regular daily exercise, but no later than four hours before bedtime.

4. Avoid caffeine and nicotine.

5. Treat any pain. Be alert to verbal and non–verbal cues for pain.

6. Make sure the bedroom temperature is comfortable.

7. Provide nightlights and security objects.

8. If the person awakens, discourage staying in bed while awake; use the bed only for sleep.

9. Discourage watching television during periods of wakefulness.

10. 12 Tips to promote Regular Sleep Patterns

    a. Try keeping bedtime rituals consistent.

    b. Go to bed at similar times each night.

    c. Close blinds to demonstrate differences in light levels.

    d. Keep lighting dim. Use night lights if there is a safety problem or the dark promotes anxiety.

    e. Relaxing in a bathtub or having a warm shower can promote sleep.

    f. A peaceful evening with less stimulation may encourage sleep. Play any music softly, choose relaxing music, T.V. programs.

    g. A snack before bed may help. Hunger can wake and make a person restless.

    h. Restrict caffeine and excess intake of fluids before bedtime.

    i. Use the bathroom before going to bed.

    j. Restlessness during the night may be due to hunger, the need to go to the bathroom, heat or cold, discomfort.

    k. Discourage naps in the day. If a nap is important try to limit the time.

    l. Encourage exercise and stimulating activities in the day.

Review Questions --- Lesson #25

1. Believing something that is not true, for example, that you are the President, is considered a hallucination or a delusion?

2. Should a cognitively impaired resident leave the facility unattended and that resident's whereabouts is unknown to staff, it is called _____.

3. Allowing the resident to believe what he or she believes to be true, without correcting or trying to bring the resident back to current reality is called _____.

4. Behavioral change that occurs in the evening which may result in challenging behavior that improves or disappears during the day is called _____.

Lesson #26 (1 hour, 15 minutes)

Title: Mental Health, Depression and Social Needs

Lesson Objectives:

I. The student will be able to describe interventions to use in response to challenging or problematic resident behavior.

II. The student will be able to describe the difference between mental illness and intellectual disability (mental retardation).

III. The student will be able to explain the importance of immediately reporting challenging or problematic behavior to the nurse.

Key Terms:

Anxiety – uneasiness or fear of a situation or condition.

Apathy – lack of interest.

Bipolar Disorder – a psychiatric diagnosis that describes mood disorders defined by the presence of one or more episodes of abnormally elevated energy levels, cognition, and mood with or without one or more depressive episodes. The resident experiences extreme highs and lows.

Claustrophobia – fear of having no escape and being closed in small spaces or rooms.

Defense Mechanisms – unconscious behaviors used to release tension or cope with stress or uncomfortable, threatening situations or feelings.

Depression – a persistent feeling of sadness and loss of interest.

Intellectual Disability – a developmental disability that causes below average mental functioning.

Manic Depression – fluctuation between deep depression to extreme activity, including high energy, little sleep, big speeches, rapid mood changes, high self–esteem, overspending and/or poor judgment.

Mental Health – level of cognitive or emotional well–being or an absence of a mental disorder.

Mental Illness – disruption in a person's ability to function at a normal level in a family, home, or community, often producing inappropriate behaviors.

Obsessive Compulsive Disorder (OCD) – uncontrollable need to repeat or perform actions in a repetitive or sequential manner.

Panic Disorder – fearful, scared or terrified for no specific reason.

Paranoid Schizophrenia – a schizophrenic disorder in which the person has false beliefs that somebody (or some people) are plotting against them.

Phobias – an extreme form of anxiety/fears.

Post–Traumatic Stress Disorder (PTSD) – anxiety related to a disorder caused by a traumatic experience or event.

Psychotherapy – sessions with mental health professionals during which the resident discusses problems or issues.

Psychotropic Medication – drugs taken which affect the mental state and are used to treat mental disorders.

Schizophrenia – a complex mental disorder that makes it difficult to tell the difference between real and unreal experiences, to think logically, and to behave normally in social situations.

Content:

I. Causes of Mental Illness

- A. Physical factors – illness, disability, aging, substance abuse or chemical imbalance.
- B. Environmental factors – weak interpersonal skills, weak family support, traumatic experiences.
- C. Heredity – possible inherited traits.
- D. Stress – inability to handle or cope with stress.

II. Response to Behaviors

- A. Remain calm.
- B. Do not treat as a child.
- C. Be aware of body language and facial expression.
- D. Maintain a normal distance.
- E. Use simple, clear language.
- F. Avoid arguments.

G. Maintain eye contact.

H. Listen carefully.

I. Show respect and concern.

III. Use of Defense Mechanisms – unconscious behaviors used to release tension or cope with stress or uncomfortable, threatening situations or feelings.

A. Denial – rejection of a thought or feeling.

B. Projection – seeing feelings in others that are really one's own.

C. Displacement – transferring a strong negative feeling to something or someone else.

D. Rationalization – making excuses to justify a situation.

E. Repression – blocking painful thoughts or feelings from the mind.

F. Regression – going back to an old immature behavior.

IV. Types of Mental Illness

A. Anxiety related disorders

1. Anxiety – uneasiness or fear about a situation or condition that cannot be controlled or relieved when the cause has been removed.

2. Panic Disorders – fearful, scared or terrified for no specific reason.

3. Obsessive Compulsive Disorders – OCD – uncontrollable need to repeat or perform actions in a repetitive or sequential manner.

4. Post–traumatic Stress Disorder – PTSD – anxiety related to a traumatic experience.

5. Phobias – intense fear of certain things or situations.

6. Symptoms – sweating, dizziness, choking, dry mouth, racing heart, fatigue, shakiness, muscle aches, cold or clammy feeling, shortness of breath or difficulty breathing.

B. Depression

1. Clinical depression – depression ranges in seriousness from mild, temporary episodes of sadness to severe, persistent depression. The term "clinical depression" is used to describe the more severe

form of depression also known as “major depression” or “major depressive disorder”.

a. Clinical depression symptoms may include:

i. Depressed mood most of the day, nearly every day.

ii. Loss of interest or pleasure in most activities.

iii. Significant weight loss or gain.

iv. Sleeping too much or not being able to sleep nearly every day.

v. Slowed thinking or movement that others can see.

vi. Fatigue or low energy nearly every day.

vii. Feelings of worthlessness or inappropriate guilt.

viii. Loss of concentration or indecisiveness.

ix. Recurring thoughts of death or suicide.

2. Bipolar Disorder – sometimes called manic–depressive disorder – is associated with mood swings that range from the lows of depression to the highs of mania. When the resident becomes depressed, he/she may feel sad or hopeless and lose interest or pleasure in most activities. When the resident’s mood shifts in the other direction, he/she may feel euphoric and full of energy. Mood shifts may occur only a few times a year, or as often as several times a day.

3. Schizophrenia – brain disorder that affects a person’s ability to think and communicate. It affects the way a person acts, thinks, and sees the world.

a. Does not mean “split personality”.

b. Symptoms – delusions, hallucinations, thought disorder, disorganized behavior, loss of interest in everyday activities, appearing to lack emotion, reduced ability to plan or carry out activities, neglect of personal hygiene, social withdrawal, and loss of motivation.

V. Behaviors Associated with Mental Disorders – actions and interventions

A. Combative

1. Actions – hitting, kicking, spitting, pinching, pushing, pulling hair, and cursing.

2. Interventions – remain calm, don't take personal, step out of way, remove other residents, never strike back or respond verbally, leave resident alone to de–escalate (calm)– but only if safe, report to nurse.

B. Anger

1. Actions – shouting, yelling, threatening, throwing things, pacing, withdrawal, sulking.

2. Interventions – remain calm, do not argue, try to understand what triggered anger, empathize with resident, listen, stay at a safe distance, explain what you are doing.

C. Sexual Behaviors

1. Actions – sexual advances, comments, sexual words or gestures, removing clothing, inappropriate touching of self or others, exposing body parts or masturbation.

2. Interventions – do not overreact; be "matter–of–fact" and try to redirect; gently direct to private area, report to nurse, and maintain safety of other residents.

3. Special consideration – check for possible explanation for behavior, such as clothing not fitting, skin irritation, need for toileting, remember to report all inappropriate sexual behavior to the nurse.

VI. Treatment for Mental Illness

A. Medications – numerous medications are available. Physician orders the medication dependent on diagnosis and conditions that need to be addressed. The nursing staff is responsible for monitoring and administration of these medications.

B. Psychotherapy –sessions during which the residents discuss problems or issues with mental health professionals in order to identify and address problems and develop interventions for staff to follow when caring for the resident.

VII. Special Considerations

A. Talk of suicide or death – any verbalization of suicide, “death wish” or self–inflicted injury, **REPORT IMMEDIATELY**.

B. Changes in conditions – any changes in mood, activity, eating, extreme behaviors or reactions, more upset or excitable, withdrawn, hallucinations or delusions. Report to nurse immediately.

VIII. Mental Illness and Intellectual Disability

A. Intellectual Disability– a developmental disability that causes below–average mental functioning.

1. Intellectual Disability vs. Mental Illness:

a. Intellectual Disability is a permanent condition; mental illness can be temporary.

b. Intellectual Disability is present at birth or early childhood; mental illness can develop at any age.

c. Intellectual Disability affects mental ability; mental illness may or may not affect mental function.

d. No cure for Intellectual Disability. Some mental illnesses can be cured or controlled with treatment, such as medication or therapy.

Review Questions --- Lesson #26

1. If a resident verbalizes thoughts of suicide or an intention to cause harm to self, when should this be reported to the nurse?

2. If a resident starts kicking or hitting you, what actions should you take?

Lesson #27 (1 hour, 15 minutes)

Title: Admission/Transfer/Discharge

Lesson Objectives:

I. The student will be able to explain the role of the direct caregiver in familiarizing the newly-admitted resident to their new home.

II. The student will be able to explain the role of the direct caregiver in preparing a resident for transfer to an appointment or to the hospital.

III. The student will be able to explain the role of the direct caregiver in assisting a resident to discharge to home or to another health care facility.

Key Terms:

Admission – resident arrival to reside at the facility.

Discharge – resident departure from the facility; no longer a resident of the facility.

Personal Inventory Record – record of personal items brought to the facility and belonging to the resident.

Transfer – resident relocates to another location or to another area of the facility (e.g., Medicaid to Medicare unit).

Room Change – resident moves to another room in the same facility with the same status.

Content:

I. Admitting a New Resident to the Facility (See CARE SKILLS #77)

A. Role of the Nurse Aide

1. Prepare the room for the resident's arrival.

2. Introduce self to resident and family/responsible party and explain role.

3. Explain surroundings to resident, including the use of the call light to communicate with staff, if needed.

4. Create a trusting relationship.

5. Be available to family.

6. Become a resource and support for the family.

7. Refer family members requesting information about a resident to the nurse.

II. Assisting to Transfer a Resident to a Hospital (i.e., Care Transition)

A. Role of the Nurse Aide

1. Follow any instructions given by the nurse to prepare the resident for transfer, particularly if the transfer is for an emergent condition.

2. If resident is leaving for a non–emergent appointment, ensure that the resident has received appropriate care, assistance with grooming, toileting and is appropriately dressed for the weather conditions during transport.

3. Assist emergency medical personnel, as requested, to ensure safe transfer of the resident.

III. Assisting a Resident to Discharge Home or to Another Facility (see CARE SKILL #78)

A. Role of the Nurse Aide

1. Follow instructions given by the nurse to prepare the resident for discharge.

2. Assist to gather personal belongings, as requested, in preparation for transfer/discharge, using the personal inventory as reference to personal items on site.

CARE SKILLS:

- Admission of a Resident – #77
- Transfer/discharge of the Resident – #78

Review Questions --- Lesson #27

1. Describe ways to welcome a new resident to his/her new environment.

2. The list used to describe the resident's belongings brought to the facility is called the _____.

Lesson #28 (1 hour, 15 minutes)

Title: End of Life

Lesson Objectives:

I. The student will be able to explain the resident's right to formulate an advance directive which must be honored by staff.

II. The student will be able to describe interventions to make the dying resident as comfortable as possible.

III. The student will be able to demonstrate the steps to be taken to provide post mortem care to the deceased resident and prepare belongings for disposition.

Key Terms:

Advance Directive – the resident's spoken and/or written instruction about future medical care and treatment.

Cheyne–Stokes – a pattern of breathing with gradual increase in depth and sometimes in rate, followed by a decrease resulting in apnea (no breathing); the cycles ordinarily are 30 seconds to 2 minutes in duration, with 5–30 seconds of apnea (no breathing).

Cyanotic – bluish discoloration of the skin, mucous membranes, lips or nails due to lack of sufficient oxygen in the blood.

DNR (Do not resuscitate) – no heroic measures are to be taken should the resident's respirations cease.

Hospice – support services provided to a resident with a terminal illness who is anticipated to have six months or less to live.

Mottling – the skin, especially on the hands and feet, appear blue and blotchy; caused by slow blood circulation. The underside of the body may become darker. There may be a bluish gray color around the mouth or paleness in the face.

Content:

I. Advance Directives

A. Purpose – by stating health care choices in an advance directive, the resident helps his/her family and physician understand their wishes about the resident's medical care.

B. Advance directives are normally one or more documents that list the resident's health care instructions. An advance directive may name a

person of choice to make health care choices when the resident cannot make the choices for themselves. If desired, the resident may use an advance directive to prevent certain people from making health care decisions on their behalf.

C. An advance directive will not take away the resident's right to decide his/her current health care. As long as the resident is able to decide and express their own decisions, the resident's advance directive will not be used. This is true even under the most serious medical conditions. An advance directive will only be used when the resident is unable to communicate or when the physician decides that the resident no longer has the mental competence to make their own choices.

* Arkansas recognizes the following types of advance directives:

1. Talking directly to your physician and family.
2. Organ and tissue donation.
3. Health Care Representative.
4. Living Will Declaration or Life–Prolonging Procedures Declaration.
5. Psychiatric Advance Directive.
6. Out of Hospital Do Not Resuscitate Declaration and Order.
7. Power of Attorney.

II. Role of Hospice

A. Participation – Resident is not expected to live more than six months.

B. Licensed nurse, clergy, social service and primary caregiver services may be provided.

C. Focus is on comfort measures and pain management.

D. Preserves dignity, respect and choice.

E. Plan of care is to be coordinated between facility staff and hospice staff.

F. Offers empathy and support for the resident and the family.

III. Care of the Dying Resident

A. Place resident in most comfortable position for breathing and avoiding pain. Maintain body alignment as much as possible.

B. Bathe and groom resident as desired by the resident/family to promote self-esteem, yet do not be disruptive.

C. Keep resident's environment as normal as possible, as desired by the resident.

D. Provide skin care, including back rubs/comfort measures, frequently.

E. Provide frequent oral care as needed. Keep dry/cracked lips lubricated for comfort.

F. Offer fluids frequently.

G. Keep the resident's skin/linens clean.

H. Offer resident's favorite foods.

I. Communicate with the resident, even if he is not responsive, by identifying self and explaining everything you are doing.

J. Be guided by the resident's attitude.

K. Respect each resident's idea of death and spiritual beliefs.

L. Give the resident and the family privacy, but do not isolate them.

IV. Signs/Symptoms of Impending Death

A. Circulation – slows as heart fails; extremities become cool; pulse becomes rapid and weak.

B. Respiration – irregular, rapid and shallow or slow and heavy; Cheyne Stokes.

C. Muscle tone – jaw may sag; body becomes limp; bodily functions slow and become involuntary.

D. Senses – sensory perception declines; the resident may stare yet not respond; hearing is believed to be the last sense to be lost.

V. Post Mortem Care (See CARE SKILLS #79)

A. Respect the family's religious restrictions regarding care of the body, if applicable.

B. Provide privacy and assist a roommate to leave the area until the body is prepared and removed.

C. Place the body in the supine position with one pillow under the head to prevent facial discoloration.

D. Put in dentures. Notify nurse to remove any tubes or dressings.

E. Wash the body, as necessary, and comb hair.

F. Put on a clean gown and cover perineal area with a pad.

VI. Disposition of Personal Belongings

A. Assist the family/responsible party to gather personal belongings and compare to the personal inventory record to ensure the personal belongings of the resident are accounted for and returned to the family/responsible party.

B. Send dentures, eyeglasses and prosthetic devices with the body to the mortuary.

VII. Stages of Reaction to Dying:

A. DENIAL – denying that death will occur

1. Behaviors:

a. Unrealistically cheerful.

b. Ask lots of questions.

c. Disregard medical orders.

2. Response to this behavior:

a. Listen and be accepting.

b. Do not probe.

B. ANGER – anger that this is happening to me, and anger at others because it is not happening to them

1. Behaviors:

a. Complaining.

b. Unreasonable requests.

c. Anger at family, doctor, and nursing staff.

2. Response to this behavior:

a. Listen.

b. Remain open and calm.

c. Don't try to place blame.

C. BARGAINING – trying to make an agreement for postponing death

1. Behaviors:

a. May be difficult to observe this stage.

b. Person vacillates between doubt and hope.

2. Response to this behavior:

a. Listen.

b. Do not contradict plans.

c. Promote a sense of hope.

D. DEPRESSION – reality of death is unavoidable; is a reaction to getting sicker; and is grieving for the losses they will experience

1. Behaviors:

a. Turn face away from people.

b. Not speak or speaks in expressionless voice.

c. Separating self from the world.

2. Response to behaviors:

a. Stay with the person as much as is possible.

b. Avoid cheery phrases and behavior.

c. Encourage the person to express feelings.

E. ACCEPTANCE– realizes that death is inevitable.

CARE SKILLS:

- Post Mortem Care – #79

Review Questions --- Lesson #28

1. Blue discoloration of the skin and mucous membranes is called what?

2. Hospice services are intended to provide support to the resident who is anticipated to have six months or less to live. *(True or False)*

Lesson #29 (45 minutes)

Title: Daily Responsibilities

Lesson Objectives:

I. The student will be able to explain the importance of prioritization, organization and time management when providing daily care.

II. The student will be able to describe the importance of the interdisciplinary team and the ongoing revision of the care plan based upon the resident's changing condition/needs.

Key Terms:

Abbreviation – a shortened form of a word.

Assignment sheet – a document which lists the residents assigned to a caregiver and the specifics regarding care to be provided.

Care plan – a plan developed for each resident by the interdisciplinary team to achieve certain goals.

Care team – people with different education and experience who help care for residents. It is often called the "interdisciplinary team" or "IDT".

Chronological order – the sequence in which events occur.

Content:

I. Day-to-day Time Management/Resident Care

A. Beginning of Shift Report.

B. Use of assignment sheets/communication of resident needs.

C. Ancillary duties/assignments (e.g., cleaning, stocking supplies, etc.).

D. Documentation/Flow Records.

1. Resident's name on each page.

2. All entries in ink, neat and legible.

3. Entries are accurate and in chronological order as they occurred.

4. Never document before a procedure is completed.

5. Use facility–approved abbreviations.

6. No ditto marks or copycat documentation.

7. Time and date entries; sign with name and title, unless initials are acceptable per facility policy.

8. Never document for someone else.

9. If correcting an error, draw a single line through the error, print word "error" above entry and initial and date the correction.

10. Some facilities may use military time. In this case, for the hours between 1:00 p.m.to 11:59 p.m., add 12 to the regular time. For example, to change 2:00 p.m. to military time, add 2 + 12. The time would be 1400 hours.

11. Some facilities use computers/electronic medical records. When using, make certain information seen on the screen remains private. Do not share confidential information with anyone except other caregivers on the team.

12. Be sure you are documenting on the correct resident.

E. Reporting

1. Routine reporting.

2. Immediate reporting of resident change in condition, unusual occurrence, accident, etc. Failure to do so may be neglect under the law.

F. End of Shift Report

1. Report pertinent concerns regarding resident status.

2. Communicate any duties unable to be completed on your shift.

3. Report any resident condition that will need the attention of the oncoming shift (e.g., resident is on the bedpan, etc.).

II. Interdisciplinary Care Plan Meetings

A. Revisions of the plan of care/communication to direct caregivers

1. The Care Plan Team reviews the plan at least quarterly and with any significant change in condition.

2. The care plan is reviewed and revised to reflect the current condition(s) and needs of the resident.

3. The care plan must be accessible for review by all caregivers.

4. When revisions are made to the care plan, the assignment sheet used by direct care staff should also be updated accordingly.

Review Questions – Lesson #29

1. Explain the procedure for correcting an error in documentation.

2. Describe information that should be communicated to the oncoming shift during report.

Lesson #30 (45 minutes)

Title: Protecting Your Profession

Lesson Objectives:

I. The student will be able to describe the common causes of stress/burnout in the healthcare industry.

II. The student will be able to describe abuse/neglect/misappropriation of resident property and will be able to explain his/her responsibility to respond and report any allegations of abuse/neglect/misappropriation of resident property.

III. The student will be able to explain the requirements for certification and renewal to maintain professional status.

Key Terms:

Abuse – the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse can be verbal (something said–oral, written or gestured), physical (something done to the resident–rough handling, hitting, slapping, pinching, etc.), emotional/mental (humiliation, harassment, threats of punishment or deprivation) or sexual (harassment, coercion or sexual assault). Any sexual relationship with a resident is considered to be abuse.

Burnout – a condition of feeling stressed and/or overworked to the point that the care provided to residents is negatively affected.

Catastrophic Event – are extraordinary reactions of residents to ordinary stimuli, such as the attempt to provide care.

Consensual – agreed to by the people involved; done with the consent of the people involved.

Involuntary Seclusion – a separation of a resident from other residents or from their room or confinement against the resident's will, or the will of the legal representative.

Neglect – failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness; failure to follow a prescribed order of treatment or the care plan; Negligently failing to provide necessary treatment, rehabilitation, care, food clothing, shelter, supervision , or medical services; Negligently failing to report health problems or changes in health problems or changes in health condition of a resident to the appropriate medical personnel, and failing to carry out a prescribed treatment plan developed or implemented by the facility.

Misappropriation – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

Stress – the state of being frightened, excited, confused, in danger, or irritated, which can result in an emotional and/or physical response.

Stressor – something that causes stress (divorce, marriage, new baby, new job, losing a job, etc.).

Content:

I. Reducing Stress/Burnout

A. Manage stress

1. Develop healthy habits of diet and exercise.
2. Get sufficient rest/sleep.
3. Drink alcohol in moderation.
4. Do not smoke.
5. Find time for relaxing activities such as taking walks, reading books, etc.

B. Signs that you are not managing stress

1. Exhibiting anger toward co–workers and/or residents.
2. Arguing with a supervisor or co–workers about assignments.
3. Complaining about responsibilities.
4. Feeling tired, even when you are well-rested.
5. Difficulty focusing on residents and job duties.

C. Develop a plan to manage stress.

1. Identify the sources of stress in your life.
2. Identify when you most often feel stress.
3. Identify what effects of stress are evident in your life.
4. Identify what can be changed to decrease the stress that you are feeling.

5. Identify the things in your life that you will have to learn to cope with due to an inability to change them.

II. Abuse/Neglect/Misappropriation

A. Responsibility to immediately protect the resident should a staff member witness abuse/neglect.

1. You must stay with the resident and call for assistance.

2. Ask a caregiver to leave the room if he/she is witnessed to be abusive to the resident

B. Know the Arkansas state law and regulation regarding reporting abuse. Failure to report is against the law in Arkansas.

1. To whom should the Nurse Aide report? His/her immediate/direct supervisor

2. How should you report?

a. Verbally – to your immediate/direct supervisor.

b. In writing – if requested by your immediate/direct supervisor.

c. Form used – be familiar with the facility form to report concerns voiced by staff, family or residents.

3. When should a Nurse Aide report?

a. Immediately!

4. The Nurse Aide Must Report When He/She…

a. Receives any "allegation", witnessed event, or reason to suspect abuse, neglect or theft.

b. Observe signs that "suggest" abuse or neglect may have happened, including a change in the resident's behavior/demeanor (e.g., a resident becomes quiet, withdrawn, or flinches as if fearful when touched), or suspicious injuries such as teeth marks, belt buckle or strap marks, old and new bruises, dislocation, burns of unusual shape and in unusual locations, scratches, etc. If the aide hears of an alleged incident from a resident or co–worker then it must be reported according to the law.

5. The nurse aide doesn't make a determination that abuse or neglect "has" or "has not" occurred and then decide whether to report. If the

resident makes an allegation (even if it doesn't seem that it can't be true) it must be reported to the direct supervisor immediately. If the nurse aide hears of an alleged incident from a resident or co–worker, it must be reported to the direct supervisor immediately.

6. NA Investigation

a. Conducted by the administrator or the designated representative according to state regulations using the investigative packet provided the Arkansas Office of Long Term Care.

b. May result in revocation of certification.

III. Nurse Aide Testing/Certification

A. To Maintain Certification

1. The CNA must renew certification with the AR CNA Registry according to the current regulations.

2. To be eligible for renewal, the CNA must work at least one 8-hour shift as a CNA for pay during their certification period.

3. The CNA must not have a verified complaint against them on the registry. If a complaint of abuse or misappropriation of resident's property/funds is found to be valid, the CNA will lose certification in all 50 states permanently.

4. The CNA must not be disqualified to work based on DPSQA Criminal Record Check guidelines.

5. The nurse aide must exhibit professional behavior.

a. Be responsible, calling the facility if unable to work the scheduled shift.

b. Be on time for your scheduled shift.

c. Arrive to work clean and neatly dressed and groomed.

d. Maintain a positive attitude.

e. Follow facility policies and procedures.

f. Document and report carefully and correctly.

g. Always ask questions, if uncertain.

h. Report anything that keeps you from completing your duties/assignment.

i. Offer suggestions for improving the living and working environment.

IV. Certification Renewal

A. The CNA must renew certification with the AR CNA Registry every other year.

1. Renewals can be processed online by the CNA, or by submitting the renewal application to the AR Registry through the mail.

2. Renewals can be submitted and processed up to 60 days prior to the expiration of the certificate.

3. CNAs who do not renew within the 24-month grace period, or those who do not work during their certification period, are required to take the State competency exam in order to have their certification reinstated.

V. Course Review

A. Brief overview of each lesson.

B. Review of CARE SKILLS.

Review Questions – Lesson #30

1. Name common signs of stress and burnout in the healthcare industry.

2. What is the minimum work requirement for a CNA to maintain certification?

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Appendix A
Supplemental Materials

ZONES/AREAS OF POTENTIAL BED ENTRAPMENT

The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below.

Zone 1: Within the Rail

Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support

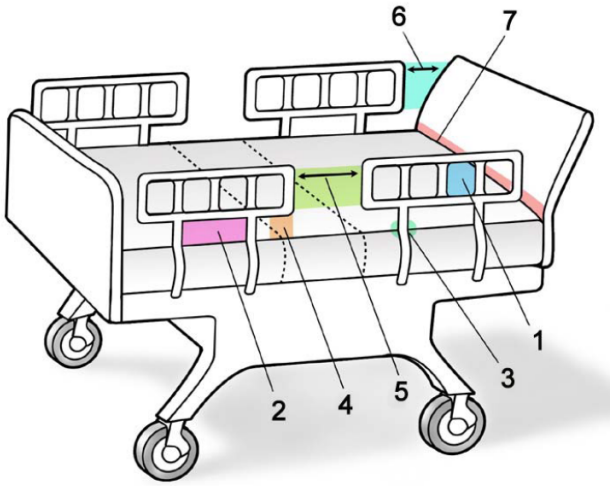
Zone 3: Between the Rail and the Mattress

Zone 4: Under the Rail, at the Ends of the Rail

Zone 5: Between Split Bed Rails

Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board

Zone 7: Between the Head or Foot Board and the Mattress End



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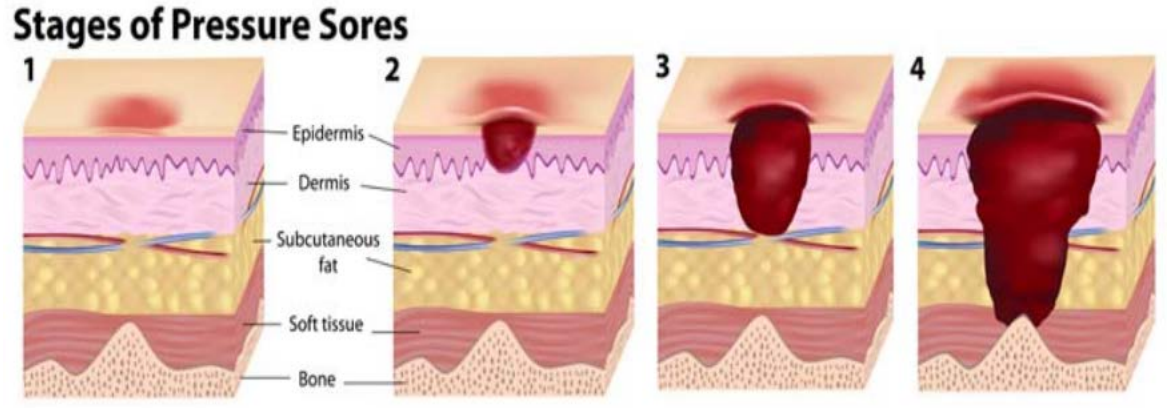
https://www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm072729.pdf



Stage 1:
The skin is not broken. Redness that is not relieved within 15-30 minutes of pressure being removed. Skin can be warmer than in other areas.

Stage 2:
Top layer of skin is broken. Blister or shallow sore can be seen. Second layer of skin can be affected. Affected area is usually painful.

Stage 3:
Wound is deeper and may extend into the subcutaneous layer.

Stage 4:
Wound extends to muscle or bone, causing severe damage to the affected areas.

https://mangarhealth.com/us/news/prevention-pressure-ulcers

COMMON MEDICAL ABBREVIATIONS

Time Abbreviations

a.m.	-morning	stat	-immediately
p.m.	-afternoon or evening	noc	-night
a.c.	-before meals	P.R.N.	-whenever necessary
p.c.	-after meals	q.d.	-every day
B.I.D.	-twice a day	q.h.	-every hour
T.I.D.	-three times a day	q.o.d.	-every other day
Q.I.D.	-four times a day	q3h	-every three hours
H.S.	-bedtime (hour of sleep)	q4h	-every four hours

Resident Orders

amt	-amount	NPO	-Nothing by mouth (sometimes NBM)
ax	-axilla		
BM	-bowel movement	P.T.	-physical therapy
BRP	-bathroom privileges	R	-rectal or right
c	-with	ROM	-range of motion
s	-without	spec.	-specimen
ad lib	-as desired	DC	-discontinued
ht	-height	w/c	-wheelchair
wt	-weight	TPR	-temperature, pulse, respiration
I&O	-Intake and Output		
ADL	-activities of daily living	BP	-blood pressure
V.S.	-vital signs (TPR & BP)		

Diagnostic Terms

MI	-Myocardial Infarction (heart attack) or Mental Illness	GI	-gastro intestinal
		GU	-genito-urinary
CVA	-cerebrovascular accident or stroke	CHF	-congestive heart failure
H.O.H.	-hard of hearing	Ca	-cancer
S.O.B.	-short of breath	CV	-cardiovascular
fx	-fracture		

Appendix B
Answers to Review Questions

Lesson #1

1. The licensed nurse.

2. An objective observation is factually seen, heard, felt or smelled by the person reporting; a subjective observation is what one "thinks" or "heard" happened from someone else.

3. Time to get dressed in the morning; whether to shower or bathe in a tub; what time to go to bed in the evening.

Lesson #2

1. Examine survey results, voice grievances, self–administer medications.

2. The caregiver must immediately report signs/symptoms of abuse, neglect or misappropriation.

3. Verbal, physical, emotional/ mental, sexual, neglect, involuntary seclusion, misappropriation.

4. Leaving a resident in bed soiled. Leaving the call light or water out of resident reach.

5. Using a resident's personal telephone to make calls. Taking a resident's money or personal belongings.

6. Report it immediately. Follow your facility's policies and procedures for reporting abuse.

Lesson #3

1. Causative Agent, Reservoir, Portal of Exit, Mode of Transmission, Portal of Entry, Susceptible Host.

2. Handwashing.

3. Before resident/patient contact, before aseptic task, after exposure to blood/body fluids, after resident/patient contact, after contact with resident/patient surroundings.

4. Proper usage will provide a barrier between the caregiver and the pathogen, thus, preventing the spread of infection.

5. Touching an infected person and then proceeding to touch another person without washing one's hands.

6. Touching a contaminated object and then proceeding to touch a person without washing one's hands.

7. No.

Lesson #4

1. Remove residents from area of immediate danger; Activate the fire alarm; Contain the fire, if possible (close doors); Extinguish, if possible.

2. Pull the pin; Aim at the base of the fire; Squeeze the handle; Sweep back and forth at the base of the fire.

3. Stop, drop and roll to smother the flames.

Lesson #5

1. Clutching throat (hands around throat).

2. Material Safety Data Sheet.

3. Call/notify nurse; stay with resident; position resident on side; move furniture away from resident; place padding under head; loosen clothing; check for injury; note duration and areas involved; do NOT place anything in mouth; do NOT restrain resident.

Lesson #6

1. True.

2. True.

3. Water.

4. Nectar thick, honey thick, and pudding thick.

Lesson #7

1. True.

2. True.

Lesson #8

1. False.

2. True.

3. True.

Lesson #9

1. True.

2. False.

Lesson #10

1. Cold/clammy skin, double or blurry vision, shaking/trembling, hunger, tingling or numbness of skin.

2. True.

Lesson #11

1. True.

2. True.

Lesson #12

1. Female: Separate labia; wash urethral area first; wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use a different part of washcloth for each stroke.

   Male: Pull back foreskin if male is uncircumcised. Wash and rinse the tip of the penis using circular motion beginning with urethra. Continue washing down the penis to the scrotum and inner thighs.

   Rationale/Importance: Prevents the spread of infection by washing pathogens away from the urethra and not toward the urethra where pathogens could enter.

Lesson #13

1. Irritation, raised areas, coated or swollen tongue, sores, complaint of mouth pain, white spots, loose/chipped or decayed teeth.

2. Due to poor circulation, even a small sore on the foot can become a large wound.

Lesson #14

1. A clean catch mid–stream requires that genitalia be cleansed prior to collecting the urine specimen.

2. True.

Lesson #15

1. The resident's shoulders are directly above their hips; their head and neck are straight; their arms and legs are in a natural position.

2. Supine, Lateral, Fowler's and Semi–Fowler's.

3. Semi–Fowler's.

4. Less.

5. False.

Lesson #16

1. False.

Lesson #17

1. Dry mouth, weight loss, foul smelling urine, dark urine, cracked lips and sunken eyes.

2. True.

Lesson #18

1. True.

2. True.

3. True.

Lesson #19

1. False.

2. On the side she will be facing – her left.

Lesson #20

1. 60 – 100 beats per minute.

2. The average BP range for adults is systolic blood pressure: 90–139; Normal range for Diastolic blood pressure is 60–89. However, baseline ranges vary from person to person.

3. Place your hand on the resident's chest and feel the chest rise and fall during breathing.

Lesson #21

1. True.

2. At least once every hour and more frequently if the resident's condition requires.

3. At least every two hours, or more often if necessary except when the resident is asleep.

Lesson #22

1. Active range of motion exercises are done by the resident himself; Passive range of motion exercises are done by caregivers providing support and moving the resident's joints through the range of motion when the resident cannot move on their own.

2. Contractures.

3. Restorative Services.

Lesson #23

1. Redness, warmth, tenderness, open area.

2. True.

3. True.

Lesson #24

1. Change in vital signs – B/P, pulse, respiration, nausea, vomiting, sweating, tearful or frowning, sighing, moaning or groaning, breathing heavy or shortness of breath, restless or having difficulty moving, holding or rubbing a body part, tightening jaw or grinding teeth.

2. Medication administration, such as antibiotics, nutrition administration, hydration, blood products, solutions are administered by gravity or through a portable pump.

3. Fear of addiction to pain medication, feeling caregivers are too busy to deal with pain, fear pain medication will cause other problems, i.e., drowsiness, sleepiness, constipation.

Lesson #25

1. A delusion – a fixed, false belief.

2. An elopement.

3. Validation Therapy.

4. Sundowning.

Lesson #26

1. Immediately.

2. Remain calm, step out of the way, remove other residents, never strike back or respond verbally, leave the resident alone to calm down (if safe) and report the behaviors to the nurse immediately.

Lesson #27

1. Prepare the room for the resident's arrival; introduce self to resident and family/responsible party and explain role; explain surroundings to resident, including use of call light to summon help, if needed; create a trusting

relationship; be available to family; become a resource and support for the family; refer family members requesting information about a resident to the nurse.

2. Personal inventory record.

Lesson #28

1. Cyanosis.

2. True.

Lesson #29

1. Draw a single line through the error, print word “error” above entry and initial and date the correction.

2. Report any resident condition that will need the attention of the oncoming shift (e.g., resident is on the bedpan, etc.)

Lesson #30

1. Exhibiting anger toward co–workers and/or residents; arguing with a supervisor or co-workers about assignments; complaining about responsibilities; feeling tired, even when you are well rested; difficulty focusing on residents and job duties.

2. The CNA must work at least one 8-hour shift as a CNA for pay during their certification period

Appendix C

Care Skills

1. Initial Steps
2. Final Steps
3. Handwashing/Hand rub
4. Gloves
5. Gown (PPE)
6. Mask
7. Fire
8. Fire Extinguisher
9. Falling or Fainting
10. Choking
11. Seizures
12. Unoccupied Bed
13. Thickened Liquids
14. Measure and Record Fluid Intake/Urinary Output
15. Passing Fresh Ice Water
16. Serving Meal Tray
17. Nasal Cannula Care
18. Shower/Shampoo
19. Bed Bath/Catheter Care/Perineal Care
20. Back Rub
21. Shampoo Hair in Bed
22. Whirlpool
23. Oral Care
24. Oral Care for the Unconscious Resident
25. Denture Care
26. Shaving with an Electric Razor
27. Shaving with a Safety Razor
28. Comb/Brush Hair
29. Fingernail Care
30. Foot Care
31. Change a Resident's Gown
32. Dressing a Dependent Resident
33. Assist to Bathroom

34. Bedside Commode
35. Bedpan/Fracture Bedpan
36. Urinal
37. Empty Urinary Drainage Bag
38. Urine Specimen Collection
39. Stool Specimen Collection
40. Application of Incontinent Brief
41. Assist Resident to Move to Head of Bed
42. Supine Position
43. Lateral Position & Side to Side
44. Fowler's Position
45. Semi-Fowler's Position
46. Use of Wheelchair/Geriatric Chair
47. Transfer to Chair
48. Sit on Edge of Bed
49. Using a Gait Belt to Assist with Ambulation
50. Walking
51. Assist with Walker
52. Assist with Cane
53. Using a Portable Mechanical Resident Lift
54. Transfer to Stretcher/Shower Bed
55. Transfer: Two Person Lift
56. Occupied Bed
57. Inspecting Skin
58. Float Heels
59. Bed Cradle
60. Feeding
61. Oral Temperature (Electronic)
62. Axillary Temperature
63. Pulse and Respiration
64. Practical Use of the Pulse Oximeter
65. Blood Pressure
66. Height

67. Weight
68. Application of Physical Restraints
69. Passive Range of Motion
70. Splint Application
71. Abdominal Binder
72. Abduction Pillow
73. Knee Immobilizer
74. Palm Cones
75. Assisting with Hearing Aids
76. Elastic/Compression Stocking Application or Ted Hose
77. Admission of a Resident
78. Transfer/Discharge of the Resident
79. Postmortem Care

CARE SKILLS #1: INITIAL STEPS (Lesson #2)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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's 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.

CARE SKILLS #2: FINAL STEPS (Lesson #2)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.

CARE SKILLS #3: HANDWASHING/HAND RUB (Lesson #3)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
Wash hands when visibly soiled or prior to giving care.	1. Handwashing is the single most effective barrier to transmission of bacteria.
1. Turn on faucet.	
2. Adjust water to acceptable temperature.	3. Hot water opens pores which may cause irritation.
3. Angle arms down holding hands lower than elbows. Wet hands and wrists.	4. 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 for at least 20 seconds, covering all surfaces of the hands, fingers and wrists.	
5. Use friction to distribute soap and create lather cleansing front and back of hands, between fingers, around cuticles, under nails, and on wrists.	5. Lather and friction will loosen pathogens to be rinsed away.
6. Rinse hands with water down from wrists to fingertips.	6. Soap left on the skin may cause irritation and rashes.
7. Dry thoroughly with single use towels.	
8. Use towel to turn off faucet and discard towel.	8. Prevents contamination of clean hands.
How to Use Hand Rub:	
9. Apply a quarter size amount of the product in a cupped hand.	9. Refer to label for estimated amount of product to be placed in palm.
10. Rub hands together to distribute product on front and back of hands, between fingers, around cuticles, under nails, and on wrists.	10. Thorough application will reach all surfaces of concern.
11. Allows hands to dry. Waterless hand rubs must be rubbed for at least 10 seconds or until dry to be effective.	11. The product must be dry to be effective.

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

CARE SKILLS #5: GOWN [Personal Protective Equipment] (Lesson #3)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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. If gloves are required, put them on last.	
7. Perform procedure.	
8. Remove gloves.	
9. Remove goggles and/or face shield.	
10. Untie or break the waist ties.	
11. Untie or break the neck ties.	
12. Pull the sleeve off by grasping each shoulder at the neckline and turn the sleeves inside out as you remove them from your arms.	12. Not touching the outside surface of the gown with your bare hands prevents contamination. The back of the gown should not be soiled.
13. Fold gown with clean side out and place in laundry or discard if disposable.	13. Gowns are for one use only. They must be either discarded or laundered after each use.
14. Wash your hands.	

CARE SKILLS #6: MASK (Lesson #3)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.	3. Your mouth should be completely covered.
4. If the mask has a metal strip in the upper edge, form it to your nose.	4. 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.	6. 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.	7. 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.	9. Hands may be contaminated if you touch an area other than the ties. Masks must be discarded after each use.
10. Wash your hands.	

CARE SKILLS #7: FIRE (Lesson #4)	
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.

CARE SKILLS #8: FIRE EXTINGUISHER (Lesson #4)	
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.

CARE SKILLS #9: FALLING OR FAINTING (Lesson #5)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.	

CARE SKILLS #10: CHOKING (Lesson #5)	
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.	

*** Note:** Discuss and demonstrate administering abdominal thrust for an unconscious resident or for someone who is lying down.

CARE SKILLS #11: SEIZURES (Lesson #5)	
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.

CARE SKILLS #12: UNOCCUPIED BED (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Collect clean linen in order of use.	2. Organizing linen allows procedure to be completed faster.
3. Carry linen away from your uniform.	3. If linen touches your uniform, it becomes contaminated.
4. Place linen on clean surface (bedside stand, over bed table or back of chair).	4. Prevents contamination of linen.
5. Place bed in flat position.	5. Allows you to make a neat, wrinkle free bed.
6. Loosen soiled linen. Roll linen from head to foot of bed and place in barrel at door of room or in bag or pillow case and place at foot of bed or chair.	6. Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination.
7. Fanfold bottom sheet to center of bed and fit corners.	
8. Fanfold top sheet to center of bed.	
9. Fanfold blanket over top sheet.	
10. Tuck top linen under foot of mattress and miter corner.	10. Mitering prevents resident's feet from being restricted by or tangled in linen when getting in or out of bed.
11. Move to other side of bed.	11. Completing one side of bed at a time allows procedure to be completed faster and reduces strain on the caregiver.
12. Fit corners of bottom sheet, unfold top linen, tuck it under foot of mattress, and miter corner.	
13. Fold top of sheet over blanket to make cuff.	
14. With one hand, grasp the clean pillow case at the closed end, turning it inside out over your wrist.	

15. Using the same hand that has the pillow case over it, grasp one narrow edge of the pillow and pull the pillow case over it with your free hand.	
16. Place the pillow at head of bed with open edge away from the door.	16. Creates a neater, more uniform look to rooms and beds.
17. For open bed: make toe pleat and fanfold top linen to foot of bed with top edge closest to center of bed.	17. Top edge of top linen must be closest to head of bed so resident can easily reach covers.
18. For closed bed: pull bedspread over pillow and tuck bedspread under lower edge of pillow.	18. Toe pleat automatically reduces pressure of top linen on feet when resident returns to bed.
19. Removed soiled linens.	19. Prevents contamination.
20. Do final steps.	

CARE SKILLS #13: THICKENED LIQUIDS (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Obtain thickener and measuring spoon.	2. Measuring spoon is required to ensure proper amount of thickener is utilized to obtain ordered thickness. Follow your facility policy for thickening liquids.
3. Thicken liquids to desired consistency following manufacturer's instructions.	3. Physician will specify thickness. Various brands of thickener require different amounts of product to be added.
4. Offer thickened fluid to resident. Encourage resident to consume thickened fluids.	4. Decreases risk of resident becoming dehydrated.
5. Ensure the water pitcher has been removed from the bedside unless facility policy states otherwise.	5. Resident may attempt to drink liquids that have not been thickened which will increase risk of choking.
6. Do final steps.	

CARE SKILLS #14: MEASURE & RECORD FLUID INTAKE & URINARY OUTPUT (Lessons #6 & #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves, if necessary.	2. Gloves are not generally required for measuring fluid intake, but they are required for measuring urinary output.
Fluid Intake:	
3. Note the amount of fluids in the container before serving it to the resident. If necessary, document the amount.	3. Different containers hold different amounts of fluids. Check labels to determine how much fluid each container holds.
4. Once the resident is finished with the meal/snack, note the amount of fluid remaining in the container. (If necessary, pour the remaining fluid into a graduated container and read it at eye level to measure.)	4. Measuring the remaining fluid is more accurate, but this technique is not always necessary. Reading at eye level ensures accuracy.
5. Subtract the remaining amount of fluid from the total amount that was in the container. The difference is the amount of fluid consumed by the resident. Document the amount according to the facility's policy.	
6. Dispose of food/drinks accordingly. (If used, be sure to rinse, sanitize, and store the graduated cylinder according to the facility's policy.)	6. Leaving unconsumed food/drinks in the room could lead to pest concerns and can also result in amounts being documented multiple times. Fluids that were measured in cylinder are now considered contaminated and should not be consumed by the resident.
7. Wash hands.	
8. Do final steps.	
Urinary output:	
1. Empty urine into a graduated cylinder.	

2. Place container on a flat, level surface. Be sure to use a protective barrier between the container and the surface, including the floor.	1. If the surface is not level, the liquid will tilt, resulting in inaccurate readings. A barrier should be used to avoid cross-contamination.
3. Measure the amount of urine inside of the container at eye level.	2. Ensures accuracy.
4. Dispose of urine accordingly. Rinse, sanitize, and store the graduated cylinder according to the facility's policy.	
5. Remove gloves.	
6. Document the amount according to the facility's policy.	
7. Do final steps.	

CARE SKILLS #15: PASSING FRESH ICE WATER (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Obtain cart, ice container, ice scoop and go to ice machine. Keep ice scoop covered.	
3. Fill container with ice using ice scoop.	
4. Replace ice scoop in proper covered container or cover it with a clean towel or plastic bag to prevent contamination.	4. Keeping the ice scoop covered maintains infection control practices.
5. Proceed to resident rooms, noting any fluid restriction(s) prior to pass and any residents who require thickened liquids.	5. Residents who require a fluid restriction or thickened liquids should not have a water pitcher placed at the bedside unless facility policy states differently.
6. Empty water from pitcher and bedside glass into the sink. If resident is on I&O's – record intake of water.	6. Emptying the pitcher of old water will allow you to fill it with ice and fresh water. Emptying the glass will allow you to fill it with fresh water.
7. Take pitcher into hall and fill it with ice. NOTE: Do not touch the pitcher with the ice scoop.	7. The ice scoop is utilized for all residents thus should not be contaminated by touching a water pitcher.
8. Replace the scoop in covered container or cover with a fresh, clean towel or plastic bag between rooms to prevent contamination.	8. Maintains infection control practices.
9. Return to resident's room and fill pitcher with water at bathroom sink, not allowing pitcher to touch faucet.	9. Ensures that resident has fresh ice water in pitcher.
10. Pour fresh water into bedside glass and leave a straw with the glass, if needed.	10. Ensures that water is available and ready for resident when he/she desires it.
11. Offer the resident a drink of fresh water if resident is present.	11. Resident may be unable to independently obtain a drink of water.
12. Repeat procedure until all residents have been provided with fresh ice water.	12. Ensures that all residents receive fresh ice water.
13. Do final steps.	

CARE SKILLS #16: SERVING MEAL TRAY (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Confirm diet card/tray. Check name, diet, utensils and condiments.	2. This will ensure that the resident is being served the diet as ordered; at the appropriate consistency.
3. Confirm any adaptive equipment is present, if indicated.	3. Provision of adaptive equipment will encourage resident participation.
4. Assist to protect the resident's clothing, if desired.	4. Use of a napkin or clothing protector (if resident desires) preserves dignity by keeping clothing clean and free of spillage.
5. Assist to open carton(s), arrange food items within reach, season foods per resident preference, etc.	5. The resident may have limited hand dexterity and/or weakness, making it difficult to open cartons/containers.
6. Contact the nurse if the resident appears to be having difficulty during meal, and you are not trained on how to feed a resident If properly trained, then offer assistance.	6. Residents may refrain from "asking" for assistance, thus, staff should be pro–active in observing the need for assistance and offer the same.
7. Offer to assist in cleansing resident's hands/face following the meal.	7. Promotes good hygiene.
8. Assist resident to room or location of choice.	
9. Do final steps. Measure and record I&O's if required.	

CARE SKILLS #17: NASAL CANNULA CARE (Lesson #8)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Adjust and lift nasal cannula tubing enough to observe the skin underneath and to clean and dry nostrils as needed. Use a soft cloth or tissue for cleaning area once each shift or as needed. Do not remove cannula from nostrils.	3. Removes any accumulation of dried drainage that may be present. Removing the cannula from the nostrils is considered stopping/discontinuing the treatment/therapy, which cannot be performed by nursing assistants.
4. Note any redness or irritation of the nares or behind the ears and notify nurse if present. Continue procedure only if instructed.	4. Provides nurse with necessary information to properly assess resident's condition and needs.
5. Readjust nasal cannula so that it fits comfortably for resident. Ensure that sides are not too tight.	5. Nasal cannula too tight can cause discomfort. Incorrect placement could result in decrease flow of oxygen to resident and/or discomfort.
6. Remove gloves.	
7. Do final steps.	

CARE SKILLS #18: SHOWER/SHAMPOO (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Clean/disinfect shower area and shower chair as per facility policy. Prep the bathing area per facility policy. Gather supplies and take them into the shower area.	2. Reduces pathogens and prevents spread of infection. Have the supplies ready when you bring the resident in the shower room to ensure resident safety.
3. Help resident remove clothing. Provide resident privacy—ensure door is shut, curtains pulled, blinds closed.	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
4. Turn on water and check temperature. Also allow resident to check water temperature for comfort, if able.	4. Resident's sense of touch may be different than yours; therefore, resident is best able to identify a comfortable water temperature.
5. Assist resident into shower via wheelchair. Lock wheels of shower chair and wheelchair. Transfer resident to shower chair. Use safety belt to secure resident stability, if indicated. Never take your eyes off the resident or turn your back to the resident while in the shower.	5. Chair may slide if resident attempts to get up. Ensure resident safety at all times. Never transport resident through the facility in shower chair. Keep eyes on resident at all times in shower room to ensure safety (i.e., prevent falls, ingestion of chemicals, etc.).
Shampoo:	
6. Give resident a washcloth to cover his/her eyes during the shampoo, if he/she desires. Place cotton balls in resident's ears if desired.	6. Prevents soap and water from entering the resident's eyes and ears.
7. Wet the resident's hair.	
8. Put a small amount of shampoo into the palm of your hand and work it into the resident's hair and scalp using your fingertips.	8. Using fingertips instead of fingernails to massage the scalp decreases the risk of scratching the resident.
9. Rinse the resident's hair thoroughly.	9. Leaving soap in the hair can cause dry scalp.
10. Use a conditioner if the resident desires you to do so. Rinse.	
Shower continued:	
11. Let resident wash as much as possible,	11. Encourages resident to be independent.

starting with face. Assist as needed to wash and rinse the entire body going from head to toe. Use a separate washcloth to cleanse the perineal area last.	
12. Turn off the water. Cover resident with bath blanket or towel.	12. Prevents resident from getting cold.
13. Remove cotton balls from the resident's ears, if utilized.	
14. Give resident towel and assist to pat dry. Ensure that hair, neck, and ears are dried. Thoroughly dry under breasts, between skinfolds, in the perineal area, and between toes.	14. Patting dry prevents skin tears and reduces chaffing. Water left in areas, especially in skin folds, can cause pathogens to grow, leading to irritation and skin breakdown.
15. Apply lotion to skin and assist resident with dressing and combing hair. Blow dry hair if necessary.	
16. Be sure that floor is dry before assisting resident out of shower chair. Apply non-slip device to floor if available. Ensure shoes are on and fit properly. Assist resident out of shower room.	16. Wet floors and transferring resident without shoes or nonskid socks on
17. Do final steps. Report skin abnormalities to the nurse.	

CARE SKILLS #19: BED BATH/CATHETER CARE/PERINEAL CARE (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Offer resident urinal or bedpan.	2. Reduces chance of urination during procedure which may cause discomfort and embarrassment.
3. Provide Resident privacy—including closing doors, windows and curtains.	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
4. Fill bath basin with warm water and have resident check water temperature for comfort, if able.	4. Resident's sense of touch may be different than yours; therefore, resident is best able to identify a comfortable water temperature.
5. Put on gloves.	5. Protects you from contamination by body fluids.
6. Fold washcloth and wet.	
7. Gently wash eye from inner corner to outer corner, using a different part of cloth to wash other eye. Be sure to use a different part of the cloth with each wipe throughout procedure/bed bath.	7. Helps prevent eye infection. Always wash from clean to dirty. Using separate area of cloth reduces contamination.
8. Wet washcloth and apply soap, if requested. Wash, rinse and pat dry face, neck, ears and behind ears.	8. Patting dry prevents skin tears and reduces chaffing.
9. Remove resident's gown.	
10. Place towel under far arm.	10. Prevents linen from getting wet.
11. Wash, rinse and pat dry hand, arm, shoulders and underarm.	11. Soap left on the skin may cause itching and irritation.
12. Repeat steps with other arm.	
13. Place towel over chest and abdomen. Lower bath blanket to waist.	13. Maintains resident's right to privacy.
14. Lift towel and wash, rinse and pat dry chest and abdomen.	14. Exposing only the area of the body necessary to do the procedure maintains resident's dignity and right to privacy.

15. Pull up bath blanket and remove towel.	
16. Uncover and place towel under far leg.	16. Prevents linen from getting wet.
17. Wash, rinse and pat dry leg and foot. Be sure to wash, rinse and dry well between the toes.	17. Soap left on the skin may cause itching and irritation.
18. Repeat with other leg and foot.	
19. Change bath water and gloves, wash hands and use clean gloves and towel.	19. Water is contaminated after washing feet. Clean water should be used for neck and back.
20. Assist resident to spread legs and lift knees, if possible.	20. Exposes perineal area.
21. Wet and soap folded washcloth.	21. Folding creates separate areas on cloth to reduce contamination.
Catheter Care:	
22. If resident has catheter, check for leakage, secretions or irritation. Secure tubing, then gently wipe four inches of catheter from meatus out.	22. Washes pathogens away from the meatus.
Perineal Care:	
23 Wipe from front to back and from center of perineum to thighs. If washcloth is visibly soiled, change cloths. For Females: Separate labia. Wash urethral area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke. For Males: Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning with urethra. Continue washing down the penis in a circular motion to the scrotum and inner thighs. Rinse off soap and dry. Return foreskin over the tip of the penis.	23. Prevents spread of infection. Females: Removes secretions in skin folds which may cause infection or odor. Males: Removes secretions from beneath foreskin which may cause infection and odor.

24. Change water in basin. Wash hands and change gloves. With a clean washcloth, rinse area thoroughly in the same direction as when washing.	24. Water used during washing contains soap and pathogens. Soap left on the body can cause irritation and discomfort.
25. Gently pat area dry with towel in same direction as when washing.	25. If area is left wet, pathogens can grow more quickly. Patting dry prevents skin tears and reduces chaffing.
26. Assist resident to lateral position, facing away from you.	
27. Wet and soap washcloth.	
28. Clean anal area from front to back. Rinse and pat dry thoroughly.	28. Prevents spread of infection.
29. Change bath water and gloves. Use clean washcloth and towel.	29. Water and linen are contaminated after washing anal area.
30. Wash, rinse and pat dry from neck to buttocks.	30. Always wash from clean to dirty.
31. Return to supine position.	
32. Wash hands and change gloves.	
33. Help resident put on clean gown, undergarments or clothing of choice.	
34. Do Final Steps.	
35. Report any reddened areas, abrasions or bruises to the nurse.	

CARE SKILLS #20: BACK RUB (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place lotion in warm water. Shake occasionally if necessary to ensure lotion is warm all the way through. If hands are cold, hold them under warm water.	2. Warm water will help warm the lotion and hands. May need to remain in water several minutes.

3. Assist resident with turning on side or lying on abdomen.	
4. Expose the resident's back to the top of the buttocks.	
5. Pour small amount of lotion into palm of hand. If not warm enough, rub lotion between hands. Do not pour lotion directly onto resident's skin.	5. The friction of rubbing hands together will help warm the lotion. Pouring lotion directly onto the skin is cold and uncomfortable for most individuals.
6. Use the palm of both hands to apply the lotion to the back using long firm strokes, beginning at the base of the back on both sides. (Let the resident know that the lotion may feel cool at first.) Continue strokes from the buttocks to the back of the neck and shoulders, exerting firm upward pressure.	
7. Use gentle downward pressure rubbing in small circular motions with palm of hands. Do not lift hands. Alternate method – Circle hands outward at shoulders, then use gentle pressure to rub down the outer edges of the back. Circle hands again when you reach the top of the buttocks, and firmly massage in long strokes in the center of the back until you reach the shoulders again. Circle out and back down again. Repeat.	7. Regardless of the technique used, massaging will help relieve tension and relax resident. Whichever method the resident prefers is what should be used.
8. Give special attention to all bony prominences using circular motion.	8. Helps stimulate circulation and prevent skin damage. If areas are discolored, massage around them and be sure to report areas to nurse.
9. Continue rhythmic rubbing for one (1) to three (3) minutes. Let resident know when you are almost done.	
10. Dry resident's back by patting with a towel.	10. Helps to remove excess lotion.
11. Assist resident with getting dressed.	
12. Perform final steps.	

CARE SKILLS #21: SHAMPOO HAIR IN BED (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Gently comb and brush resident's hair.	2. Reduces hair breakage, scalp pain, and irritation.
3. Place a towel around resident's neck and shoulders. Lower head of bed.	3. Decreases the chance of resident getting wet.

4. Have resident check temperature of water, if able.	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.
5. Place bed shampoo basin under resident's head according to manufacturer's instructions. If available, place protective covering such as a pad, on the bed before adding basin.	5. Pad will protect linens and mattress from getting wet. If equipment is not applied according to manufacturer's instruction, discomfort or injury could result.
6. Place wash basin or other receptacle on chair to catch water flowing from shampoo basin.	
7. Pour water carefully over resident's hair.	
8. Lather hair with shampoo using fingertips. Rinse thoroughly. Apply conditioner to resident's hair if requested. Rinse thoroughly.	8. Utilizing fingertips massages the scalp and decreases the risk of scratching resident.
9. Squeeze excess water from hair. Towel dry hair.	
10. Replace gown or pajama top if necessary.	
11. Comb and brush resident's hair. Dry hair with dryer if resident wishes.	11. Helps maintain resident's dignity and self–esteem.
12. Do final steps.	

CARE SKILLS #22: WHIRLPOOL (Lesson #12)	
STEP – Type of whirlpool, trolley, etc., may alter actions. Always refer to facility policy and/or manufacturer's instructions.	**RATIONALE**
1. If possible, fill tub with water before bringing resident to bathing area.	1. Having water ready saves time.
2. Transport resident to whirlpool.	

3. If tub is already filling, have resident check water temperature for comfort. Adjust if necessary.	3. Water should be at the resident's desirable temperature vs. the temperature that suits the staff.
4. Assist resident into lift bath trolley or into the tub per facility policy and manufacturer's instructions. Remove clothing and secure straps around resident, if applicable. Lower lift bath trolley and resident into the tub. If tub is not already filled with water, do so now, adjusting the temperature to the resident's comfort. When tub is filled, turn the system on.	4. Secure straps for resident's safety. Some tubs/whirlpools are made to be pre-filled. Others cannot be filled until the resident is inside. Some whirlpools/tubs require the use of a lift to lower resident inside tub. Others have a door, allowing resident to step inside tub. Follow manufacturer's instructions and the facility's policy on when to fill tub with water and how to get resident in/out of tub.
5. Let resident wash as much as possible, starting with face.	5. Encourages independence.
6. You may shower the resident by using the shower handle to gently spray over the resident's body. Stay with resident during procedure.	6. Leaving resident unattended can result in serious injury or death.
7. Turn system off after completion of bath and return shower handle to hook, if used. Drain water from tub.	
8. Raise trolley out of tub. Assist resident to pat dry as needed. Be sure to dry areas that are touching the trolley, skinfolds, underneath breasts, and the perineal area.	8. Leaving areas wet can cause irritation and skin breakdown.
9. Assist resident with dressing and getting out of trolley/tub. Comb hair.	
10. Help resident return to room or desired location. If necessary, leave indicator for others to know that tub has not been sanitized.	10. Tub should be cleaned between use. Leaving indicator for others ensures that tub will not be used before being cleaned.
11. Sanitize tub per manufacturer's instructions.	11. Tub should be properly cleaned after use.
12. Do final steps.	

CARE SKILLS #23: ORAL CARE FOR THE ALERT AND ORIENTED RESIDENT (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Check with nurse if the resident is on swallowing precautions.	
2. Raise head of bed so resident is sitting up.	2. Prevents fluids from running down resident's throat, causing choking.
3. Put on gloves.	3. Brushing may cause gums to bleed. Protects you from potential contamination.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Wet toothbrush and apply small amount of toothpaste.	5. Water helps distribute toothpaste.
6. First brush upper teeth and then lower teeth. Gently brush inner, outer, and chewing surfaces of teeth. Clean entire mouth, including the tongue and the gum line.	6. Brushing upper teeth minimizes production of saliva in lower part of mouth.
7. Hold emesis basin under resident's chin.	
8. Ask resident to rinse mouth with water and spit into emesis basin.	8. Removes food particles and toothpaste.
9. If requested, give resident mouthwash diluted with half water.	9. Full strength mouthwash may irritate resident's mouth.
10. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.	10. Provides nurse with necessary information to properly assess resident's condition and needs.
11. Remove towel and wipe resident's mouth.	
12. Remove gloves.	
13. Do final steps.	

CARE SKILLS #24: ORAL CARE FOR AN UNCONSCIOUS RESIDENT (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Drape towel over pillow and a towel under resident's chin.	2. Protects linen.
3. Turn resident onto unaffected side.	3. Prevents fluids from running down resident's throat, causing choking.
4. Put on gloves.	4. Protects you from contamination by bodily fluids.
5. Place an emesis basin under resident's chin.	5. Protects resident's clothing and bed linen.
6. Dip swab in cleaning solution of ½ mouthwash and ½ water and wipe teeth, gums, tongue and inside surfaces of mouth, changing swab frequently.	6. Stimulates gums and removes mucous.
7. Rinse with clean swab dipped in water.	7. Removes solution from mouth.
8. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.	8. Provides nurse with necessary information to properly assess resident's condition and needs.
9. Cover lips with thin layer of lip moisturizer.	9. Prevents lips from drying and cracking. Improves resident's comfort.
10. Remove gloves.	
11. Do final steps.	

CARE SKILLS #25: DENTURE CARE (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Prevents fluids from running down resident's throat, causing choking.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Remind resident that you are going to remove their dentures. Remove upper dentures by placing your index finger at the ridge on top of the right upper denture and gently moving them up and down to release suction. Turn lower denture slightly to lift out of mouth. If able, have resident to remove their dentures.	5. Prevents injury or discomfort to resident and reduces chance of resident biting staff. Removing upper dentures first is more comfortable for the resident and placing your finger at the ridge decreases the chance of stimulating the gag reflex. Allowing resident to remove their own dentures encourages independence.
6. Put dentures in denture cup marked with resident's name and take to sink.	
7. Line sink with towel and fill halfway with water.	7. Prevents dentures from breaking if dropped.
8. Apply denture cleaner to toothbrush.	
9. Hold dentures over sink and brush all surfaces.	9. If dropped, the dentures will fall into the sink. The towel and water in sink will prevent dentures from breaking.
10. Rinse dentures under warm water. Place in a clean cup and fill with cool water.	10. Hot water may damage dentures.
11. Clean resident's mouth with swab if necessary. Help resident rinse mouth with water or mouthwash diluted with half water, if requested.	11. Removes food particles. Full strength mouthwash may irritate resident's mouth.
12. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.	12. Provides nurse with necessary information to properly assess resident's condition and needs.

13. Help resident place dentures in mouth, if requested. Moisturize the lips.	13. Restores resident's dignity and keeps lips from drying and cracking. Improves resident comfort.
14. Remove gloves.	
15. Do final steps.	

CARE SKILLS #26: SHAVING WITH AN ELECTRIC RAZOR (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Places resident in more natural position.
3. Do not use electric razor near any water source, when oxygen is in use or if resident has pacemaker.	3. Electricity near water may cause electrocution. Electricity near oxygen may cause explosion. Electricity near some pacemakers may cause an irregular heartbeat.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Put on gloves.	5. Shaving may cause bleeding. Protects you from potential contamination.
6. Apply pre–shave lotion as resident requests.	
7. Hold skin taut and shave resident's face and neck according to manufacturer's guidelines.	7. Smooth out skin. Shave beard with back and forth motion in direction of beard growth with foil (oscillating blades) shaver. Shave beard in circular motion with three head (rotary, circular blades) shaver.
8. Check for any breaks in the skin. Apply aftershave lotion as resident requests.	8. Decreases risk of pain from aftershave getting into any breaks in the skin. Improves resident's self–esteem.
9. Remove towel from resident.	9. Restores resident's dignity.
10. Remove gloves.	
11. Do final steps.	

CARE SKILLS #27: SHAVING WITH A SAFETY RAZOR (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Places resident in more natural position.
3. Fill bath basin halfway with warm water.	3. Hot water opens pores and causes irritation.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Put on gloves.	5. Shaving may cause bleeding. Protects you from potential contamination.
6. Moisten beard with washcloth and spread shaving cream over area.	6. Softens skin and hair.
7. Hold skin taut and shave beard in downward strokes on face and upward strokes on neck.	7. Maximizes hair removal by shaving in the direction of hair growth.
8. Rinse resident's face and neck with washcloth.	8. Removes soap which may cause irritation.
9. Pat dry with towel.	
10. Apply after–shave lotion, as requested.	10. May decrease skin irritation, especially with sensitive skin. Improves resident's self–esteem.
11. Remove towel.	
12. Remove gloves.	
13. Do final steps.	

CARE SKILLS #28: COMB/BRUSH HAIR (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Places resident in position to access hair.
3. Drape towel over pillow.	3. Protects resident's clothing and bed linen.
4. Remove resident's glasses and any hairpins or clips.	
5. Remove tangles by dividing hair into small sections and gently combing out from the ends of hair to scalp.	
6. Use hair products, as resident requests.	
7. Style hair as resident requests.	7. Improves resident's self–esteem.
8. Offer mirror.	
9. Do final steps.	

CARE SKILLS #29: FINGERNAIL CARE (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Check fingers and nails for color, swelling, cuts or splits. Check hands for extreme heat or cold. Report any unusual findings to nurse before continuing procedure.	2. Provides nurse with information to properly assess resident's condition and needs.
3. Raise head of bed so resident is sitting up.	3. Places resident in more natural position.
4. Fill bath basin halfway with warm water and have resident check water temperature for comfort. Add soap to water. If possible use non–rinse soap, being sure to follow manufacturer's instructions for dilution. If no–rinse solution is not available, and regular soap is used, then aide must rinse hands by using a pitcher of water, or by taking resident to sink, or by emptying and refilling basin.	4. Resident's sense of touch may be different than yours; therefore, resident is best able to identify a comfortable water temperature. Adding soap helps to clean resident's hands.
5. Soak resident's hands and pat dry.	5. Nail care is easier if nails are softened.
6. Put on gloves.	6. Nail care may cause bleeding. Protects you from potential contamination.
7. Clean under nails with orange stick.	7. Pathogens can be harbored beneath the nails.
8. Clip fingernails straight across, then file in a curve.	8. Clipping nails straight across prevents damage to skin. Filing in a curve creates smooth nails and eliminates edge which may catch on clothes or cause skin tear.
9. Remove gloves.	
10. Do final steps.	

CARE SKILLS #30: FOOT CARE (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Fill the basin halfway with warm water. Have resident check the water temperature.	2. To prevent resident from scalding or burning his/her feet.
3. Place basin on towel or bathmat.	
4. Remove resident's socks. Completely submerge resident's feet in water and soak for five to ten minutes.	4. Soaking allows for softening skin depending on thickness of calluses, etc.
5. Put on gloves.	
6. Remove one foot from water. Wash entire foot, including between the toes and around the nail beds using a soapy washcloth.	
7. Rinse entire foot, including between the toes.	7. Soap left on the skin may cause itching and irritation.
8. Dry entire foot, including between the toes. Inspect the feet and in between all toes for condition of skin, presence of corns or callouses or other foot problems.	8. Thoroughly drying skin reduces irritation and chaffing.
9. Check with the charge nurse before trimming the resident's toenails. If trimming is allowed, trim the toenails straight across to prevent the edges from becoming ingrown.	9. Facility may not allow nurse aides to trim toenails and/or fingernails. Certain residents may require licensed staff (nurses, doctors, podiatrist, etc.) to trim their toenails, especially if they are diabetic or have poor circulation.
10. Repeat steps with the other foot.	
11. Place lotion in hand, warm lotion by rubbing hands together, and then massage lotion into entire foot (top and bottom) except between toes, removing excess with a towel.	
12. Assist resident to replace socks and shoes, as desired.	
13. Do final steps.	

14. Report any cuts, sores, or other findings to the nurse.	

CARE SKILLS #31: CHANGING RESIDENT'S GOWN (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Untie and/or unbutton soiled gown as needed.	2. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
3. Raise top sheet over resident's chest.	
4. Remove resident's arms from gown, unaffected arm first.	4. Undressing unaffected arm first requires less movement.
5. Roll soiled gown from neck down and remove from beneath top sheet. Place soiled gown in dirty linen bag.	5. Rolling reduces spread of infection.
6. Slide resident's arms into clean gown, affected arm first.	6. Dressing affected side first requires less movement and reduces stress to joints.
7. Tie or button gown as needed.	
8. Remove top sheet from beneath clean gown and cover resident.	8. Maintains resident's dignity and right to privacy.
9. Do final steps.	

CARE SKILLS #32: DRESSING A DEPENDENT RESIDENT (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Check care plan to see if resident is a one person or two-person assist.	
2. Assist resident to choose clothing.	2. Allows resident as much choice as possible to improve self–esteem.
3. Move resident onto back.	
4. Provide privacy.	4. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
5. Guide feet through leg openings of underwear and pants, affected leg first. Pull garments up legs to buttocks.	5. Dressing affected side first requires less movement and reduces stress to joints.
6. Slide arm into shirt sleeve, affected side first.	6. Dressing lower and upper body together reduces number of times resident needs to be turned.
7. Turn resident onto unaffected side. Pull lower garments over buttocks and hip. Tuck shirt under resident.	
8. Turn resident onto affected side. Pull lower garments over buttocks and hip and straighten shirt.	
9. Turn resident onto back and slide arm into shirt sleeve, align and fasten garments.	
10. Do final steps.	

CARE SKILLS #33: ASSIST TO BATHROOM (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Check care plan to see if resident is a one person or two-person assist.	
2. Assist resident to put on non–skid socks/ footwear.	
3. Walk with resident into bathroom.	
4. Assist resident to lower garments and sit.	4. Allows resident to do as much as possible to help promote independence.
5. Provide resident with call light and toilet tissue if resident has been identified as safe to be provided privacy. Remain with the resident if required to do so.	5. Ensures ability to communicate need for assistance. Provides for resident's right to privacy.
6. Put on gloves.	6. Protects you from contamination by bodily fluids.
7. Assist resident to wipe area from front to back.	7. Prevents spread of pathogens toward meatus which may cause urinary tract infection.
8. Remove gloves. Wash hands.	
9. Assist resident to raise garments.	
10. Assist resident to wash hands.	10. Handwashing is the best way to prevent the spread of infection.
11. Walk with resident back to bed or chair.	
12. Do final steps.	

CARE SKILLS #34: BEDSIDE COMMODE (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Assist resident to put on non–skid socks/ footwear.	
3. Place commode next to bed on resident's unaffected side.	3. Helps stabilize commode and is the shortest distance for resident to turn.
4. Assist resident to transfer to commode by transferring the safest way the resident is able. Check care plan to see if resident is a one person or two person assist.	
5. Give resident call light and toilet tissue if resident has been identified as safe to be provided privacy and not attended by staff.	5. Ensure ability to communicate need for assistance. Provides resident's right to privacy.
6. Put on gloves.	6. Protects you from contamination by bodily fluids.
7. Assist resident to wipe from front to back.	7. Prevents spread of pathogens toward meatus which may cause urinary tract infection.
8. Assist resident to bed or chair.	
9. Remove and cover pan and take to bathroom.	9. Pan should be covered to prevent the spread of infection.
10. Prior to disposal, observe urine and/or feces for color, odor, amount & characteristics and report unusual findings to nurse.	10. Changes may be the first sign of a medical problem. By alerting the nurse, you ensure that the resident receives prompt attention.
11. Dispose of urine and/or feces, sanitize pan and return pan according to facility policy.	11. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.
12. Remove gloves. Wash hands.	
13. Assist resident to wash hands.	13. Handwashing is the best way to prevent the spread of infection.
14. Do final steps.	

CARE SKILLS #35: BEDPAN/FRACTURE BEDPAN (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Lower head of bed.	2. When bed is flat, resident can be moved without working against gravity.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Turn resident away from you.	
5. Place bedpan or fracture pan under buttocks according to manufacturer directions.	5. Equipment used incorrectly may cause discomfort and injury to resident.
6. Gently roll resident back onto pan and check for correct placement.	6. Prevents linen from being soiled.
7. Cover resident with sheet/blanket.	7. Provides for resident's privacy.
8. Raise head of bed to comfortable position for resident.	8. Increases pressure on bladder to encourage with elimination.
9. Give resident call light and toilet paper.	9. Ensures ability to communicate need for assistance.
10. Leave resident and return when called.	10. Provides for resident's privacy.
11. Lower head of bed.	11. Places resident in proper position to remove pan.
12. Press bedpan flat on bed and turn resident.	12. Prevents bedpan from spilling.
13. Wipe resident from front to back. Wash hands and change gloves.	13. Prevents spread of pathogens toward meatus which may cause urinary tract infection.
14. Provide perineal care, if necessary.	
15. Cover bedpan and take to bathroom.	15. Pan should be covered to prevent the spread of infection.
16. Check urine and/or feces for color, odor, amount and characteristics and report unusual findings to nurse.	16. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives prompt attention.

17. Dispose of urine and/or feces, sanitize pan and return pan according to facility policies.	17. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.
18. Remove gloves. Wash hands.	
19. Assist resident to wash hands.	19. Handwashing is the best way to prevent the spread of infection.
20. Do final steps.	

CARE SKILLS #36: URINAL (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed to sitting position.	2. Increases gravity on top of bladder to encourage urination.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Offer urinal to resident or place urinal between his legs and insert penis into opening. Remove gloves.	4. Allows resident to do as much as possible to help promote independence.
5. Cover resident.	5. Maintains resident's right to privacy.
6. Give resident call light and toilet paper.	6. Ensures ability to communicate need for assistance.
7. Leave resident and return when called.	7. Provides for resident's privacy.
8. Put on gloves. Remove and cover urinal.	8. Urinal should be covered to prevent the spread of infection.
9. Take urinal to bathroom, check urine for color, odor, amount and characteristics and report unusual findings to nurse.	9. Changes may be first sign of medical problems. By alerting the nurse you ensure that the resident receives prompt attention.
10. Dispose of urine, rinse urinal, sanitize and return urinal according to facility policies.	10. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.
11. Remove gloves. Wash hands.	
12. Assist resident to wash hands.	12. Handwashing is the best way to prevent the spread of infection.
13. Do final steps.	

CARE SKILLS #37: EMPTY URINARY DRAINAGE BAG (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Place paper towel on floor beneath bag and place graduated cylinder on paper towel.	3. Reduces contamination of graduate cylinder and protects floor from spillage.
4. Detach spout (if bag has one) and point the drainage tube into center of graduated cylinder without letting tube touch sides.	4. Prevents contamination of tubing.
5. Unclamp spout and drain urine.	
6. Clamp spout. Clean using alcohol wipe.	6. Removes contaminates from spout.
7. Replace spout in holder.	
8. Check urine for color, odor, amount and characteristics and report unusual findings to nurse.	8. Changes may be first signs of medical problem. By alerting the nurse you ensure that the resident receives prompt attention.
9. Measure and accurately record amount of urine.	9. 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.
10. Dispose of urine, rinse, sanitize and return graduated cylinder according to facility policies.	10. Facilities have different methods of disposal and sanitation. Follow facility policy and procedures.
11. Remove gloves.	
12. Do final steps.	

CARE SKILLS #38: URINE SPECIMEN COLLECTION (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Prepare label for specimen with appropriate information and place it on specimen container, not the lid.	2. Label contains resident's identifying information which is essential for the laboratory. Label should be placed on the specimen container in the event the lid is misplaced or thrown away.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Assist resident to bathroom or commode, or offer bedpan or urinal.	
5. Provide perineal care to the resident.	5. To ensure area is clean and free of possible contamination of the specimen.
6. Ask resident to void into the urine hat placed on the toilet, or to urinate in the bedpan. Ask the resident not to put toilet paper with the sample.	6. A clean collection device is necessary for accurate lab evaluation. Toilet paper will contaminate the urine and produce an inaccurate result.
7. After urination, assist the resident as necessary with perineal care and to wash the resident's hands. Change your gloves and wash your hands.	
8. Take bedpan, urinal, and commode pail to bathroom and pour urine in to the specimen container. The container should be at least half full.	
9. Cover the urine container with its lid. Do not touch the inside of the container. Wipe off the outside with a paper towel.	9. Touching the inside can contaminate the specimen, causing inaccurate results.
10. Place the specimen container in the bag supplied by the lab for transport.	
11. Discard excess urine in bedpan or urinal; clean and disinfect equipment as per facility policy.	
12. Do final steps.	

CARE SKILLS #39: STOOL SPECIMEN COLLECTION (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Prepare label for specimen with appropriate information and place it on specimen container, not the lid.	2. Label contains resident's identifying information which is essential for the laboratory. Label should be placed on the specimen container in the event the lid is misplaced or thrown away.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. When the resident is ready to move bowels, ask him/her not to urinate at the same time. Ask the resident not to put toilet paper in with the sample.	4. A clean collection device is necessary for accurate lab evaluation. Urine contaminated stool will produce an inaccurate result.
5. Provide the resident with a bedpan, assisting if needed.	
6. After the bowel movement, assist as needed with perineal care.	
7. Remove gloves, wash hands and put on clean gloves.	
8. Using two tongue blades, take about two tablespoons of stool and put in the container. Try to collect material from different areas of the stool.	8. In order to ensure adequate amount of stool for test ordered. Obtaining material from different areas ensures that all possible contents will be identified.
9. Cover the container with lid. Label as directed per facility policy and procedure and place in the plastic bag supplied by the lab for transport. Dispose of remaining stool; clean and disinfect equipment as per facility policy. Notify nurse of collection.	
10. Do final steps.	

CARE SKILLS #40: APPLICATION OF INCONTINENT BRIEF (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	
3. Provide the resident privacy.	
4. Unfasten and remove brief resident is currently wearing and place in small plastic trash bag for disposal in soiled utility bag.	4. Residents should have soiled briefs removed promptly to decrease risk of skin breakdown.
5. Provide perineal care as indicated.	5. Prevents infection, odor, and skin breakdown; improves resident's comfort.
6. Wash hands and change gloves.	
7. Place back of brief under resident's hips, plastic side of disposable brief away from resident's skin.	7. Plastic may cause irritation of the resident's skin.
8. Bring front of brief between resident's legs and up to his/her waist.	
9. Fasten each side of brief and adjust fit.	9. Adjusting brief to a snug fit will prevent leakage.
10. Apply resident's clothing.	
11. Do final steps.	

CARE SKILLS #41: ASSIST RESIDENT TO MOVE TO HEAD OF BED (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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, two 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.	

CARE SKILLS #42: SUPINE POSITION (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.	

CARE SKILLS #43: LATERAL POSITION & SIDE TO SIDE (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.	
Moving a Resident in Bed from Side to Side:	
1. Do initial steps. Ask another CNA to assist you if needed.	
2. Put the side rail in the up position on the far side of the bed.	
3. Loosen the top sheets but do not expose the resident.	
4. Place your feet in a good position – one in close to the bed – one back. Slide both of your arms under the resident's back to his far shoulder and then slide the resident's shoulders toward you by rocking your weight to your back foot. If a second aide is present, use the draw sheet to move the resident in bed.	
5. Keep your knees bent and your back straight as you slide the resident.	

6. Slide both your arms as far as you can under the resident's buttocks and slide his/her buttocks toward you in the same way. Use a draw sheet whenever possible for helpless residents.	
7. Place both your arms under the resident's feet and slide them toward you.	
8. Place pillows under resident accordingly to ensure spine is in proper alignment.	
9. Do final steps.	

CARE SKILLS #44: FOWLER'S POSITION (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.	

CARE SKILLS #45: SEMI–FOWLER'S POSITION (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.	

CARE SKILLS #46: USE OF WHEELCHAIR/GERIATRIC CHAIR (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Be sure you know how to properly operate chair before transferring resident into it. Reading manufacturer's instructions may be necessary.	2. Not all wheelchairs are made alike. Electronic vs manual chairs differ in use. Improper use can result in damage to chair and injury to resident and staff.
3. Inspect the chair to ensure that it is clean and works properly. Most wheelchairs can be opened by pressing down on the bars on either side of the seat. To fold, lift the center edges of the seat.	3. Decreases spread of pathogens and likelihood of injury.
4. Engage and disengage the wheel lock by moving the braking device towards and away from the wheel.	4. Locking wheels helps to ensure chair will not move during transfers.
5. To move the footrests, press or pull the release lever and swing it out towards the side of the wheelchair. To remove the footrest, lift it off when it is at the side of the chair. To replace it, put the footrest back onto the pins at the side of the wheelchair. Swing footrest back to the front of the chair to lock it into place.	5. Leaving footrest in front of chair can cause injury and/or falls for the aide and/or the resident during transfers.
6. Remove armrests by releasing lock and pulling armrest straight up. Not all armrests are detachable from chair.	6. Removing armrests can help prevent injury during transfer.
7. To adjust footrest up or down, activate the release mechanism before pulling or pushing the footrest into desired position. Always support the leg/foot when moving footrest.	7. Decreases injury and adds comfort for resident.
8. Follow manufacturer's instructions on how to properly recline and engage locks for geri-chair.	8. Process varies depending on brand of chair.
9. Do final steps.	

CARE SKILLS #47: TRANSFER TO CHAIR/WHEELCHAIR (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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. (Refer to Using a Gait Belt to Assist with Ambulation for instructions on applying gait belt.)	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 or shoulders.	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 to shoulder's width 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. Remove gait belt.	11. Shoulders and hips should be in straight line to reduce stress on spine and joints.
12. Place feet on footrests and reattach armrest if necessary.	
13. Unlock wheels and transport resident to desired location, as needed.	
14. Do final steps.	

CARE SKILLS #48: SIT ON EDGE OF BED (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.	

CARE SKILLS #49: USING A GAIT BELT TO ASSIST WITH AMBULATION (LESSON #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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. Ensure a female resident's breasts are not under the belt.
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.	

CARE SKILLS #50: WALKING (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.
3. Assist resident to stand on count of three.	3. Allows you and resident to work together.
4. Allow resident to gain balance, check for dizziness.	4. Change in position may cause dizziness due to a drop in blood pressure.
5. Stand to side and slightly behind resident.	5. Allows clear path for the resident and puts you in a position to assist resident if needed.
6. Walk at resident's pace.	6. Reduces risk of resident falling.
7. Do final steps.	

CARE SKILLS #51: ASSIST WITH WALKER (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Assist resident to sit on edge of bed.	2. Allows resident to adjust to position change.
3. Place walker in front of resident as close to the bed as possible.	
4. Have resident grasp both arms of walker.	4. Helps steady resident.
5. Brace leg of walker with your foot and place your hand on top of walker.	5. Prevents walker from moving.
6. Assist resident to stand on count of three. Check for balance and dizziness.	6. Allows you and resident to work together.
7. Stand to side and slightly behind resident.	7. Puts you in a position to assist resident if needed.
8. Have resident move walker ahead 6 to 10 inches, then step up to walker moving the weak or injured leg forward to the middle of the walker while pushing down on the handles of the walker, and then bringing the unaffected leg forward even with the weak/injured leg. Continue sequence until desired destination is reached.	8. Resident may fall forward if he steps too far into walker.
9. Do final steps.	

CARE SKILLS #52: ASSIST WITH CANE (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Check the cane for presence of rubber tip(s).	2. Presence of intact rubber tips decreases the risk of falls by improving traction and preventing slipping.
3. Assist resident to sit on edge of bed.	3. Allows resident to adjust to position change.
4. Assist resident to stand on count of three.	4. Allows you and resident to work together.
5. Allow resident to gain balance. Check for dizziness.	5. Change in position may cause dizziness due to a drop in blood pressure.
6. Have resident place cane approximately 4 inches to the side of his/her stronger/ unaffected foot. The height of the cane should be level with resident's hip.	
7. Stand to the affected side and slightly behind resident.	7. Allows clear path for the resident and puts you in a position to assist resident if needed.
8. Have resident move cane forward about 4–6 inches, step forward with weak (affected) leg to a position even with the cane. Then have resident move strong leg forward and beyond the weak leg and cane. Repeat the sequence.	8. Reduces risk of resident falls.
9. Do final steps.	

CARE SKILLS #53: USING A PORTABLE MECHANICAL RESIDENT LIFT (Lesson #16)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Never use a lift that you have not been properly trained to use. Facility should ensure that each aide is properly trained over facility policy and manufacturer's instructions for use.	1. Misuse could result in serious injury to resident. Different manufacturers provide different instructions for equipment. Aide must know how to properly work the equipment they are responsible for using.
2. Never use a lift alone. There should always be two aides present to transfer resident with lift.	2. One aide should guide the lift, while the other aide guides the resident and ensures resident is not injured during transfer.
3. Before transferring resident, ensure that battery for lift is charged. Also check other equipment (i.e., lift pad, sling, straps, etc.) to ensure it works properly and is not in need of repair.	3. If battery is not charged, lift could shut down during transfer. Fraying, holes, tears, etc. on lift pad could result in resident falling.
4. Do initial steps.	
5. Follow manufacturer's instructions and facility's policy on transfers using the lift.	
6. Be sure all locks and straps are fastened securely. Lock brakes on lift once it is in position. Brakes on wheelchair should be locked before transferring resident.	6. Brakes should be locked to ensure equipment does not move during transfer, which could result in serious injury to resident and/or staff.
7. Reassure and talk to resident during transfer.	7. Helps calm anxiety and fear of falling.
8. After transfer is complete, ensure resident is comfortable. Remove sling/lift pad if indicated.	
9. Perform final steps.	

CARE SKILLS #54: TRANSFER: TO STRETCHER/SHOWER BED (Lesson #16)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Loosen sheet directly under resident and roll edges close to resident.	2. This sheet will be utilized to slide resident from bed to stretcher.
3. Place stretcher/shower bed at bedside. NOTE: Make certain wheels are locked. After locking wheels, ensure bed and stretcher/shower bed are at the same height. Then lower side rails.	3. Wheels must be locked to prevent stretcher from moving.
4. Staff should be present at the bedside as well as on the opposite side of the stretcher/shower bed. (Requires a minimum of two staff members, except when use of additional staff is specified in care plan and/or facility policy.)	4. To prevent resident from falling/rolling off the bed or stretcher.
5. Grasp sheet on each side of resident. On the count of three, slide resident laterally onto stretcher/shower bed.	5. Counting to three enables staff members to work together to distribute weight evenly and prevent injury to resident and/or staff.
6. Center and align resident. Place pillow under his/her head, cover with a blanket, and raise the rails of stretcher/shower bed.	6. Place resident in proper position and alignment. Pillow provides comfort; blanket maintains dignity, provides privacy, and keeps resident warm; raising the rails prevents resident injury.
7. Do final steps.	

CARE SKILLS #55: TRANSFER - TWO PERSON LIFT (Lesson #16) ***ONLY TO BE USED IN AN EMERGENCY***	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place chair at bedside. Brace it firmly against side of bed. Lock wheels of wheelchair or Geri chair.	2. Helps stabilize chair and is the shortest distance for staff to turn. Wheel locks prevent chair from moving.
3. Assist resident to sit on edge of bed. Ensure there is staff on each side of the resident.	3. Allows resident to adjust to position change.
4. Reach around resident's back and grasp other assistant's forearm above wrist. Have resident place arms around your shoulders (not your neck) or on your upper arms.	4. Having resident place arms on your shoulders or upper arms reduces the chance of injury to your neck.
5. Each NA should reach under resident's knees and grasp other assistant's forearm above wrist.	5. Grasping your partner's forearm provides for support and prevents resident from slipping out of your grasp.
6. On the count of three lift resident.	6. Allows you to work together and allows weight to be distributed evenly to prevent injury to resident or staff.
7. Pivot and lower resident into chair.	
8. Align resident in chair.	8. Shoulders and hips should be in a straight line to reduce stress on spine and joints.
9. Do final steps.	

CARE SKILLS #56: OCCUPIED BED (Lesson #17)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Collect clean linen in order of use.	2. Organizing linen allows procedure to be completed faster.
3. Carry linen away from your uniform.	3. If linen touches your uniform, it becomes contaminated.
4. Place linen on clean surface (bedside stand, over bed table or back of chair).	4. Prevents contamination of linen.
5. Lower head of bed and adjust bed to a safe working level, usually waist high. Lock bed wheels.	5. When bed is flat, resident can be moved without working against gravity.
6. Drape the resident.	
7. The caregiver will make the bed one side at a time. The caregiver will raise the side rail on far side of bed (if rail not in use, ensure there is a second caregiver on the opposite side of the bed to ensure that the resident does not roll over the side of bed). Assist resident to turn onto side, moving away from you toward raised side rail (or second caregiver).	
8. Loosen bottom soiled linen on the side of bed on which you are working. Put on gloves.	
9. Roll bottom soiled linen toward resident and tuck it snuggly against the resident's back. Change gloves to avoid cross–contamination after working with soiled/dirty linens.	9. Rolling puts dirtiest surface of linen inward, lessening contamination. The closer the linen is rolled to resident, the easier it is to remove from the other side.
10. Place clean bottom linen on unoccupied side of bed and roll remaining clean linen under resident in the center of the bed.	
11. Smooth bottom sheet out and ensure there are no wrinkles. Roll all extra material toward resident and tuck it under the resident's body.	

12. Raise the side rail nearest you (or remain in place if a second caregiver is being utilized) and assist the resident to turn onto clean bottom sheet. Inform resident that he/she may feel hump due to the covers being rolled up. Move to opposite side of bed, as resident will now be facing away from you.	
13. While resident is lying on side, loosen soiled linen and roll linen from head to foot of bed, avoiding contact with your skin or clothing.	13. Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination.
14. Place soiled linen in barrel or bag at foot of bed or in chair. Change gloves to prevent possible cross contamination.	
15. Pull clean bottom linen as was done on the opposite side.	
16. Assist resident to roll onto back, keeping resident covered and comfortable.	
17. Unfold the top sheet placing it over the resident. Request the resident to hold the clean top sheet, slip the bath blanket or previous sheet out from underneath the clean sheet.	17. Maintains resident's dignity and right to privacy by not exposing body.
18. Assist resident with blanket over the top sheet and tuck the bottom edges of the top sheet and blanket under the bottom of the mattress. Miter the corners and loosen the top linens over the resident's feet.	18. Mitering prevents resident's feet from being restricted by or tangled in linen when getting in or out of bed. Prevents pressure on feet which can cause pressure sores.
19. Remove pillow and remove the soiled pillow case by turning it inside out.	
20. With one hand, grasp the clean pillow case at the closed end, turning it inside out over your wrist.	
21. Using the same hand that has the pillow case over it, grasp one narrow edge of the pillow and pull the pillow case over it with your free hand.	21. Prevents contamination.
22. Place the pillow under resident's head with open edge away from the door.	22. Creates a neater, more uniform look to rooms and beds.

23. Assist resident to comfortable position and return the bed to the appropriate position.	
24. Remove soiled linens from room – carrying away from uniform.	
25. Do final steps.	

CARE SKILLS #57: INSPECTING SKIN (Lesson #18)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Provide the resident privacy.	2. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
3. Check bony areas including ears, shoulder blades, elbows, coccyx, hips, knees, ankles and heels for redness and warmth.	3. Redness and warmth indicates that the skin is under pressure and position should be changed more frequently.
4. Check friction areas including under breasts and arms, between buttocks, groin, thighs, skin folds, contracted areas, and around any tubing for redness, irritation, moisture and odor.	4. Pressure, rubbing and perspiration will cause skin to break down.
5. Remove drape from resident, if one was used, and assist resident with getting comfortable and changing position if necessary.	
6. Report any unusual findings to the nurse immediately.	6. Provides nurse with necessary information to properly assess resident's condition and needs.
7. Do final steps.	

CARE SKILLS #58: FLOAT HEELS (Lesson #18)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Lift resident's lower extremity.	
3. Inspect the skin, especially the heels.	3. To identify any potential skin problems/breakdown.
4. Place a full pillow under calves, leaving heels in the air and free from pressure. (Do not use rolled pillows or blankets.)	4. Placing the pillow directly under the heels can increase pressure on heels.
5. Do final steps.	

CARE SKILLS #59: BED CRADLE (Lesson #18)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place bed cradle on bed according to manufacturer's instructions.	2. If equipment is not applied according to manufacturer's instructions, discomfort or injury could result.
3. Cover bed cradle with top sheet and bedspread/blanket.	3. Keeps the top linens from applying pressure/weight to toes, feet and lower legs.
4. Do final steps.	

CARE SKILLS #60: FEEDING (Lesson #19)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Assist resident with toileting if needed, change brief if soiled.	
2. Confirm diet card/tray. Check name, diet, utensils and condiments.	2. This will ensure that the resident is being served the diet as ordered; at the appropriate consistency.
3. Explain procedure.	
4. Have resident wash hands, help the resident if needed.	4. Provides good hygiene in preparation for meal consumption.
5. Sit on unaffected side eye level with resident and facing them.	5. Encourages interaction with the resident and placement of spoon at an appropriate angle.
6. Resident's head should be elevated at least 45 degrees, if in bed.	6. Places resident at an angle to promote swallowing and reduce risk of choking.
7. Protect the resident's clothing with a clothing protector or per facility policy and procedures.	7. Use of a napkin or clothing protector (if resident desires) preserves dignity by keeping clothing clean and free of spillage.
8. Offer different foods; ask resident's preference.	8. Involving the resident encourages consumption.
9. Food should be in bite sized pieces or with the spoon half full. Food should be fed to the unaffected side of the mouth.	9. Reduces risk of choking.
10. Allow time for resident to chew and empty mouth between bites. Notify nurse immediately should choking occur.	10. Reduces risk of choking.
11. Frequently offer beverage.	11. Encourages swallowing.
12. Make conversation with the resident; atmosphere should be pleasant.	12. Enhances meal experience, thus encourages consumption.
13. Cleanse the resident's hands/face as needed during the meal and after.	13. Promotes good hygiene.
14. Do final steps. If required, measure and record I&O's and percentage of food eaten.	

CARE SKILLS #61: ORAL TEMPERATURE [ELECTRONIC] (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.

CARE SKILLS #62: AXILLARY TEMPERATURE (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**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.

CARE SKILLS #63: PULSE AND RESPIRATION (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Place resident's hand on comfortable surface.	
2. Feel for pulse above wrist on thumb side with tips of first three fingers.	2. Because of artery in your thumb, pulse would not be accurate if you use your thumb.
3. Count beats for 60 seconds, noting rate, rhythm and force.	3. Ensures accurate count. Rate is number of beats. Rhythm is regularity of beats. Force is strength of beats.
4. Continue position as if feeling for pulse. Count each rise and fall of chest as one respiration.	4. Resident could alter breathing pattern if aware that respirations are being taken.
5. Count respirations for 60 seconds noting rate, regularity and sound.	5. Ensure accurate count. Rate is number of breaths. Regularity is pattern of breathing. Sound is type of auditory breaths heard.
6. Record pulse and respiration rates.	6. 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.
7. Report unusual findings to nurse.	7. Provides nurse with information to assess resident's condition and needs.
8. Do final steps.	

CARE SKILLS #64: PRACTICAL USE OF THE PULSE OXIMETER (Lesson #20)	
STEP – Initial Steps: Turn the pulse oximeter on: it will go through internal calibration and checks.	**RATIONALE**
1. Select the appropriate probe with particular attention to correct sizing and where it will go (usually finger, toe or ear).	1. If used on a finger or toe, make sure the area is clean. Remove any nail varnish.
2. Connect the probe to the pulse oximeter.	
3. Position the probe carefully; make sure it fits easily without being too loose or too tight.	3. If possible, avoid the arm being used for blood pressure monitoring as cuff inflation will interrupt the pulse oximeter signal.
4. Allow several seconds for the pulse oximeter to detect the pulse and calculate the oxygen saturation.	
5. Look for the displayed pulse indicator that shows that the machine has detected a pulse. Without a pulse signal, any readings are meaningless.	
6. Once the unit has detected a good pulse, the oxygen saturation and pulse rate will be displayed.	
7. Like all machines, oximeters may occasionally give a false reading – if in doubt, rely on your clinical judgment, rather than the machine.	7. The function of the oximeter probe can be checked by placing it on your own finger. Aide is to record pulse ox % (as in other vital signs).
9. Adjust the volume of the audible pulse beep to a comfortable level for your theatre – ever use on silent.	9. Always make sure the alarms are on.
10. Record measurements as displayed on monitor, per facility policy, and report to charge nurse accordingly.	10. Further treatment may be needed, depending on values that are reported. If the numbers are not documented, then the skill cannot be considered performed.

CARE SKILLS #65: BLOOD PRESSURE (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Clean earpieces and diaphragm of stethoscope with antiseptic wipe.	1. Reduces pathogens; prevents spread of infection.
2. Uncover resident's arm to shoulder.	
3. Rest resident's arm, level with heart, palm upward on comfortable surface.	3. A false low reading is possible, if arm is above heart level.
4. Wrap proper sized sphygmomanometer cuff around upper unaffected arm approximately 1–2 inches above elbow.	4. 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.
5. Put earpieces of stethoscope in ears.	5. Earpieces should fit into ears snugly to make hearing easier.
6. Place diaphragm of stethoscope over brachial artery at elbow.	
7. 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 30 mm/hg past the point of occlusion.	7. Inflating cuff too high is painful and may damage small blood vessels.
8. Slowly open valve on bulb.	8. Releasing valve slowly allows you to hear beats accurately.
9. Watch gauge and listen for sound of pulse.	
10. Note gauge reading at first pulse sound.	10. First sound is systolic pressure.
11. Note gauge reading when pulse sound disappears or changes.	11. Last sound is diastolic pressure.
12. Completely deflate and remove cuff.	12. 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.

13. Accurately record systolic and diastolic readings.	13. 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.
14. Do final steps.	
15. Report unusual readings to nurse.	15. Provides nurse with information to properly assess resident's condition.

CARE SKILLS #66: HEIGHT (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Using standing balance scale: 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.	1. Measurements are written on the rod in inches.
2. When a resident is unable to stand: 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.	2. Places resident in proper position and alignment; allows you to measure resident accurately.
3. If the resident is unable to lay flat due to contractures: 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.	3. Allows you to obtain an accurate measurement for the resident who cannot fully extend body.
4. Accurately record resident's height. Assist resident off the scale.	4. 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.
5. Do final steps.	

CARE SKILLS #67: WEIGHT (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Balance scale.	1. Scale must be balanced on zero for weight to be accurate.
2. 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.	2. 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.
3. 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.	3. When arm drops, weight is too high. When pointer is suspended, weight is accurate. Total gives accurate weight.
4. Subtract weight of wheelchair from total weight, if applicable.	
5. Accurately record resident's weight.	5. Record weight immediately so you won't forget. Weight changes are an indicator of resident's 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.
6. Do final steps.	
7. Report unusual reading to nurse.	7. Provides nurse with information to assess resident's condition and needs.

CARE SKILLS #68: APPLICATION OF PHYSICAL RESTRAINTS (Lesson #21)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Check with the nurse before gathering supplies. Verify the type of restraint that was ordered for the resident. The NA should ensure that he/she was properly trained by the facility on how to use the restraint per the manufacturer's instructions and facility's policy.	1. NA/CNA can only use/apply restraints when instructed to do so by the charge nurse. Ensures that the correct restraint will be used, as ordered by the physician. NA/CNA should not apply a restraint that he/she has not received training for. Although restraints appear the same, manufacturers can provide different instructions/guidance for use and application. Improper application can result in serious harm and/or death for the resident.
2. Do initial steps.	
3. Follow manufacturer's instructions and facility's policy on applying the restraint.	3. Same as previously stated.
4. If resident is in bed, be sure to tie restraint to the part of the bed that moves with the resident. Never tie restraints to side rails or the fixed part of the bed frame (that does not move with the resident when repositioning).	4. Tying restraints to the fixed portion of the frame or to side rails will cause the restraint to tighten as the bed is moved for positioning. This can cause discomfort, pain, and problems with circulation and lead to more serious concerns.
5. Make sure that the restraint is not too tight. Check pulse in the affected areas to ensure circulation is not occluded (cut off). Make sure that breasts and skin are not caught in the restraint.	5. Occlusion can lead to serious consequences for the resident, including nerve damage, loss of use, etc.
6. Place call light in easy reach.	
7. Check resident and restraint every 15 minutes, or more frequently if necessary or instructed.	7. Constant monitoring helps to ensure that the resident is not in distress or experiencing discomfort due to the restraint.
8. Release the restraint at least every two hours or more frequently as needed or instructed. Assist the resident with toileting, ambulating, changing position, and other ADLs as needed.	
9. Document according to facility policy.	
10. Perform initial/final steps as needed when checking on the resident.	

CARE SKILLS #69: PASSIVE RANGE OF MOTION (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Position resident in good body alignment.	2. Reduces stress to joints.
3. Observe joints. If swelling, redness or warmth is present, or if resident complains of pain, notify nurse. Continue procedure only if instructed.	3. Indicates inflammation in joint which can be worsened if procedure is continued.
4. Support limb above and below joint.	
5. Begin range of motion at shoulders and include the shoulders, elbows, wrists, thumbs, fingers, hips, knees, ankles and toes.	5. Allows you to control joint movement and minimize resident's discomfort.
6. Slowly move joint in all directions it normally moves.	6. Rapid movement may cause injury.
7. Repeat movement per facility policy or care plan.	7. Ensures benefit from procedure.
8. Encourage resident to participate as much as possible.	8. Promotes resident's independence and self–esteem.
9. Stop procedure at any sign of pain and report to nurse immediately.	9. Pain is a warning sign for injury.
10. Do final steps.	

CARE SKILLS #70: SPLINT APPLICATION (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Observe affected joints. If swelling, redness, or warmth is present or if resident complains of pain, notify nurse. Continue procedure only if instructed.	2. Indicates inflammation in joint which can be worsened if splint is applied.
3. Apply splint according to therapy recommendation and physician's order.	3. Application of splint not in accordance with therapy recommendation could cause injury or discomfort to resident.
4. Remove splint after designated period of time. Cleanse the skin, dry thoroughly and again observe for swelling, redness, warmth, complaint of pain or open area. Notify the nurse if present.	4. Indicates inflammation in joint. Notifying nurse provides him/her with information to assess resident's condition and needs.
5. Do final steps.	

CARE SKILLS #71: ABDOMINAL BINDER (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Check the skin for redness, open areas, or needed incontinence care.	2. Allows you to identify early signs of skin breakdown and the need for cleansing prior to binder application.
3. Place binder flat on the bed and ask resident to lie down with upper border at the upper waist and lower border at the level of the gluteal fold. If resident is in bed, assist him/her to roll side–to–side while placing binder underneath him/her in the same position.	3. A binder placed above the waist interferes with breathing; one placed too low interferes with elimination and walking.
4. Bring the ends of binder around the resident, and overlap them. Beginning at the bottom of the binder, secure the Velcro fastener strip so that the binder fits snugly.	4. A snug fit provides maximum support. If the binder is too loose, efficacy is impaired. If it is too tight, resident may be uncomfortable.
5. Ensure that there are no wrinkles or creases in the binder.	5. Wrinkles and creases put pressure on the skin increasing the risk for excoriation.
6. Do final steps.	

CARE SKILLS #72: ABDUCTION PILLOW (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place the pillow between the supine resident's legs. Slide it with the narrow end pointing toward the groin until it touches the legs all along its length.	
3. Place the upper part of both legs in the pillow's indentations. Raise each leg slightly by lifting under the knee and ankle to bring straps under and around leg and then secure the straps to the pillow.	3. Securing the straps prevents the pillow from slipping out of place.
4. Do final steps.	
5. Report resident intolerance or complaint of pain upon application to the nurse.	5. Provides nurse with information to assess resident's condition and needs.

CARE SKILLS #73: KNEE IMMOBILIZER (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. With resident lying supine in bed, one caregiver will support the leg above the knee and at the ankle and lift the leg in one motion, providing enough height for a second caregiver to place the immobilizer under the affected leg. Check skin prior to applying the immobilizer.	2. It is important to maintain the leg in a straight position while placing the immobilizer and to monitor for any skin problems/breakdown.
3. The caregiver will lower the leg into the open immobilizer, keeping the leg straight.	
4. Pull both sides of the immobilizer to center of front of leg and wrap one side over the other, securing the Velcro strip holding the immobilizer in place. Make sure the Velcro stabilizer bar strips are attached to opposite sides of the immobilizer to prevent any motion of the knee medially or laterally.	
5. Bring straps around each side and secure to stabilize the immobilizer.	
6. When removing the immobilizer for bathing/care, support the leg in the same manner, keeping the leg straight at all times. Observe for any reddened areas, particularly at the upper and lower edge of the immobilizer, which is in contact with the resident's skin.	6. Constant contact with the edge of the immobilizer can place the skin at risk of breakdown. Early detection of any concern can prevent further breakdown.
7. Report to the nurse any skin irritation, open area, or complaint of pain.	7. Reporting to the nurse will ensure that treatment is obtained, if needed.
8. Do final steps.	

CARE SKILLS #74: PALM CONES (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Cleanse and thoroughly dry resident's hand.	2. Cleansing and drying of hands prevents odor and infection.
3. Place cone with clean cover in resident's palm.	
4. Observe hand(s) every shift; cleanse and thoroughly dry hands. Observe for areas of redness, swelling or open areas and report to the nurse, if noted.	4. Allows you to identify early signs of skin breakdown.
5. Note covering of palm cone and send to laundry when soiled, re–covering cone with a clean covering, as needed.	5. Maintaining cleanliness enhances resident's dignity.
6. Do final steps.	

CARE SKILLS #75: ASSISTING WITH HEARING AIDS (Lesson #23)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Gently clean resident's ear with a damp washcloth. Clean hearing aid of wax and dirt when needed according to manufacturer's instructions.	2. To ensure ears are clean prior to insertion of hearing aids, thus ensuring maximum acuity.
3. Insert hearing aid into resident's ear.	
4. Assist to adjust the volume control to a desired level.	4. To ensure that aid is turned up high enough for resident to hear, but not so high that noises will hurt resident's ear(s).
5. Do final steps.	
6. Report any abnormalities to nurse.	6. Provides nurse with necessary information to properly assess resident's condition and needs.
7. Keep hearing aid in safe place when not in use.	7. Helps reduce risk of damage to device.

CARE SKILLS #76: ELASTIC/COMPRESSION STOCKING APPLICATION OR TED HOSE (Lesson #23)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Observe skin prior to applying the stockings for any redness, warmth, swelling, excessive dryness, or open area. Notify nurse if abnormalities present. Continue procedure only if instructed.	2. Provides nurse with information to assess resident's condition and needs.
3. Apply the hose before resident gets out of bed.	3. Hose should be applied before veins become distended and edema (swelling) occurs.
4. Hold heel of stocking and gather the rest in your hand turning hose inside out to mid foot area.	
5. Support foot at the heel and slip the front of the stocking over the toes, foot and heel.	
6. Pull the stocking up until it is fully extended.	
7. Smooth away any wrinkles or twisted areas.	7. Wrinkles, creases, or twisted areas can irritate the skin and interfere with circulation.
8. Remove the hose at least twice daily for skin care unless otherwise indicated by physician.	8. Allows you to identify early signs of skin break down.
9. Do final steps.	

CARE SKILLS #77: ADMISSION OF A RESIDENT (Lesson #27)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Prepare the room for the resident by making sure that all necessary equipment and furniture are in its proper place, in good working condition and clean. Make sure bed is made with clean linen and all space is clean. Check for adequate lighting and provide ventilation. Apply resident's name label on door, etc. as needed.	2, Preparing the room in advance can help the resident feel more welcomed and at ease upon arrival, and it allows more time to focus on the resident.
3. Identify the new resident by asking his/her name and by checking the identification. Identify yourself. Greet the resident and family courteously. Call resident by proper or preferred name. Introduce yourself and state your position.	3. Greeting the resident and family and showing kindness helps ease anxiety. Identifying them by proper name shows respect and allows the resident the opportunity to establish how they prefer to be addressed.
4. Take the resident and family to the room. If semi-private room, be sure to introduce resident to roommate.	4. Resident should be introduced to other residents and employees. Helps establish bonds and ease anxiety.
5. Assist resident with getting comfortable in the room. Provide privacy and assistance as needed with transferring to bed/chair, dressing/undressing, or any other task as requested by resident and/or nurse.	
6. Place call light within reach of resident and explain how and why it is used.	6. Gets the resident familiar with how they will contact the staff if assistance is needed.
7. Care for clothing and personal articles according to facility policy. Assist with unpacking and labeling clothing. Label all personal articles and store in bedside table (or appropriate place). Be certain that resident and/or family member(s) know where to place these articles.	7. Labeling articles helps the staff to identify what items belongs to which resident. Ensures that items will be returned to appropriate person. Establishing placement of articles alleviates confusion, especially when room is being shared with another resident.

8. Follow and explain to the resident and family the facility policy for inventory and safekeeping of valuables.	8. Same rationale as above.
9. Give instructions to resident and/or family as to time and place of meals and, as appropriate, provide other orientation such as facility premises, introduction to other staff, etc.	9. Orienting resident and family to facility and staff helps them learn the daily routine, addresses questions/concerns they may have, and helps get them familiar with their new home and caregivers. Alleviates confusion regarding their new surroundings.
10. Obtain vital signs, including temperature, pulse, respiration, and blood pressure. Also obtain weight and height. Record according to facility policy. Follow guidelines for performing each skill accordingly.	10. Establishes baseline levels for nurses to compare to later.
11. Ensure resident is comfortable and has call light available. If permitted, leave fresh ice water within reach.	
12. Record/report completion of procedure. Report to charge nurse: resident's vital signs; any bruises, sores, etc. on the resident's body; any special observations made about the resident. Perform any additional final steps accordingly.	

CARE SKILLS #78: TRANSFER/DISCHARGE OF THE RESIDENT (Lesson #27)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Inform the resident of the move and let them know you are there to assist. Questions or concerns that arise should be addressed by the nurse, unless informed otherwise.	2. Some information may be different from what you were previously told. It is best for the nurse to provide updates and address any concerns/questions.
3. Collect all personal items that are to be moved with the resident and assist with packing as needed. Secure valuables per facility policy. Ensure that all items on the inventory list are there. Report to the nurse if items are missing. Take items to designated pick-up area.	3. Nurse should be aware of missing items so that attempts can be made to locate them. If possible, take belongings to designated area first to make transporting the resident easier.
4. Assist the resident with getting dressed if necessary.	
5. Before the resident leaves the unit, confirm with the nurse that all discharge procedures have been completed.	5. Helps to ensure that steps are not being missed.
6. Speak with the nurse to determine how the resident is to be transported (in his/her own bed, wheelchair, or stretcher). Transport accordingly.	
7. Allow and assist the resident to say goodbye to the staff and other residents while being transported to the designated pick-up area.	
8. Assist resident with getting into the vehicle and ensure that their belongings are also loaded.	
9. Wash hands. Document and report. Perform any additional final steps accordingly.	

CARE SKILLS #79: POSTMORTEM CARE (Lesson #28)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Respect the family's religious restrictions regarding the care of body, if applicable.	3. Residents/families have the right to freedom of religion.
4. Assist roommate to leave the area until body is prepared and removed, if applicable.	4. Reduces the roommate's stress.
5. Place body in supine position.	5. Prepares body for procedure.
6. Place one pillow beneath resident's head.	6. Prevents blood from discoloring the face by settling in it.
7. Close the eyes.	
8. Insert dentures, if this is the facility policy, and close the mouth.	8. It is easier to put dentures in the mouth right away and gives the face a natural appearance.
9. Cleanse body as necessary. Comb hair.	9. Prepares the body for viewing by family and friends.
10. Place a pad under the buttocks to collect any drainage.	10. Due to total loss of muscle tone, urine and/or stool may drain from the body even after death.
11. Put a clean hospital gown on resident and place body in a comfortable looking position to allow family and friends to view the body.	
12. Remove gloves.	
13. Do final steps.	
14. After the mortuary has removed the body, strip the bed and clean the room according to facility policy.	

Appendix D
Task Performance Record

Trainee's Name		**SS#**	
Primary Instructor's Name			
Program Name			
Program's Address		**Telephone**	

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Initial Steps			
Final Steps			
Handwashing/Hand Rub			
Gloves			
Gown (PPE)			
Mask			
Fire			
Fire Extinguisher			
Falling or Fainting			
Choking			
Seizures			
Unoccupied Bed			
Thickened Liquids			

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Measure & Record Fluid Intake/Urinary Output			
Passing Fresh Ice Water			
Serving Meal Tray			
Nasal Cannula Care			
Shower/Shampoo			
Bed Bath/Catheter Care/Perineal Care			
Back Rub			
Shampoo Hair in Bed			
Whirlpool			
Oral Care			
Oral Care for the Unconscious Resident			
Denture Care			
Shaving with an Electric Razor			
Shaving with a Safety Razor			
Comb/Brush Hair			
Fingernail Care			
Foot Care			
Change a Resident's Gown			

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Dressing a Dependent Resident			
Assist to Bathroom			
Bedside Commode			
Bedpan/Fracture Bedpan			
Urinal			
Empty Urinary Drainage Bag			
Urine Specimen Collection			
Stool Specimen Collection			
Application of Incontinent Brief			
Assist Resident to Move to Head of Bed			
Supine Position			
Lateral Position & Side to Side			
Fowler's Position			
Semi-Fowler's Position			
Use of Wheelchair/Geriatric Chair			
Transfer to Chair			
Sit on Edge of Bed			
Using a Gait Belt to Assist with Ambulation			

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Walking			
Assist with Walker			
Assist with Cane			
Using a Portable Mechanical Resident Lift			
Transfer to Stretcher/Shower Bed			
Transfer: Two Person Lift			
Occupied Bed			
Inspecting Skin			
Float Heels			
Bed Cradle			
Feeding			
Oral Temperature (Electronic)			
Axillary Temperature			
Pulse and Respiration			
Practical Use of the Pulse Oximeter			
Blood Pressure			

Height			
Weight			
TASK PERFORMANCE	**Satisfactory Performance Date**	**Supervising Instructor's Initials**	**Clinical Performance Date**
Application of Physical Restraints			
Passive Range of Motion			
Splint Application			
Abdominal Binder			
Abduction Pillow			
Knee Immobilizer			
Palm Cones			
Assisting with Hearing Aids			
Elastic/Compression Stocking Application or Ted Hose			
Admission of a Resident			
Transfer/Discharge of the Resident			
Postmortem Care			

I, as Primary Instructor, attest to the competency/skills observations shown on this Task Performance Record, whether performed by me or designated to another training instructor.

Primary Instructor's Signature Date

DMS-741 (Revised 01-19)