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Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Provider Services & Quality Assurance

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Statutory Authority for Promulgating Rules Arkansas Code Annotated § 20-10-701 et seq., 20-77-107 and 25-10-129

Rule Title: Long Term Care Nursing Assistant Training Program

Intended Effective Date (Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other 8/1/2019 (Must be more than 10 days after filing date.)

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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Thomas Herndon	thomas.herndon@dhs.arkansas.gov	7/19/2019
Contact Person	E-mail Address	Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

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Division of Provider Services & Quality Assurance Director
Title

7/19/2019
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

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:
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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) – <u>requires</u> 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 <u>before</u> 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.

<u>Content – Endocrine System</u>:

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?

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?

Works Cited

Alzheimer's Association. (c2018). *Wandering*. Retrieved from https://www.alz.org/help-support/caregiving/stages-behaviors/wandering.

Alzheimer's Association. (c2018). *Stages and behaviors*. Retrieved from https://www.alz.org/help-support/caregiving/stages-behaviors.

Alzheimer's Foundation of America. (c2018). *About Dementia*. Retrieved from https://alzfdn.org/about-dementia/.

Arkansas State Board of Nursing. (2018). *Nurse practice act of the state of Arkansas*. Little Rock, AR: ARSBN. Retrieved from https://www.arsbn.org/Websites/arsbn/images/NURSEPRACTICEACT_2018.February2018.pdf.

Frank Broyles and the University of Arkansas Board of Trustees. (2006). *Coach broyles' playbook for alzheimer's caregivers: A practical tips guide*. Fayetteville, AR: Broyles Foundation.

Centers for Medicare & Medicaid Services. (2017). *Guidance to surveyors for long term care facilities*. State Operations Manual, Appendix PP. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B. (2018). Alzheimer's Association Dementia Care Practice Recommendations. *The Gerontologist, 58*(S1), S1–S9. doi: 10.1093/geront/gnx182

Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B. (2018). The Fundamentals of Person-Centered Care for Individuals With Dementia. *The Gerontologist, 58*(S1), S10–S19. doi: 10.1093/geront/gnx122

Kandelman, N. (2017). Risk factors for burnout among caregivers working in nursing homes. *Journal of Clinical Nursing, 27*(1-2), e147-e153. doi: 10.1111/jocn.13891

Mangar Health. (2016, October 20). *The prevention of pressure ulcers*. Retrieved from https://mangarhealth.com/us/news/prevention-pressure-ulcers.

Manthorpe, J., & Samsi, K. (2016). Person-centered dementia care: current perspectives. *Clinical Interventions in Aging, 11*, 1733–1740. doi: 10.2147/CIA.S104618

Power, A. (2010). *Dementia Beyond Drugs: Changing the Culture of Care*. Baltimore, MD: Health Professions Press.

Power, A. (2014). *Dementia Beyond Disease: Enhancing Well-Being*. Baltimore, MD: Health Professions Press.

Sorrentino, S. A. & Gorek, B. (2014). *Mosby's Essentials for Nursing Assistants* (5th ed.). St. Louis, MO: Elsevier, Inc.

United States Health and Human Services, Food and Drug Administration, Center for Devices and Radiological Health. (2006). *Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment*. Rockville, MD: Division of Dockets Management, Food and Drug Administration. Retrieved from https://www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm072729.pdf.

University of Arkansas for Medical Sciences, Donald W. Reynolds Department of Geriatrics. (2005). *Dementia Care Manual*. Little Rock, AR: UAMS.

University of Arkansas for Medical Sciences, Department of Psychiatry. (2001). *Behavioral Interventions Pocket Reference*. Little Rock, AR: UAMS.

Woodhead, E. L., Northrop, L., & Edelstein, B. (2016). Stress, social support, and burnout among long-term care nursing staff. *Journal of Applied Gerontology, 35*(1), 84-105. doi: 10.1177/0733464814542465.

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

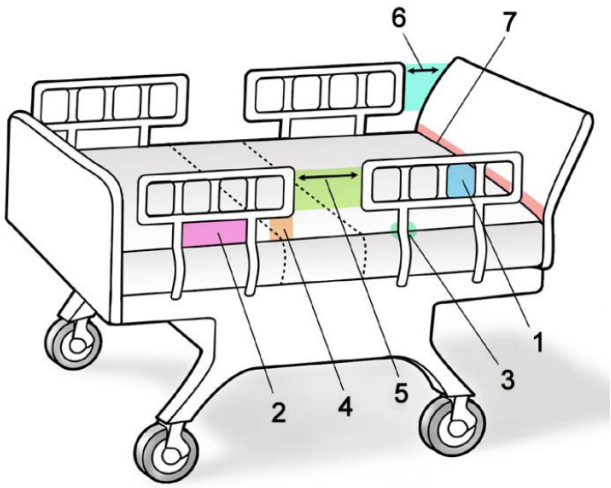
Zone 3: Between the Rail and the Mattress

Zone 4: Under the Rail, at the Ends of the Rail

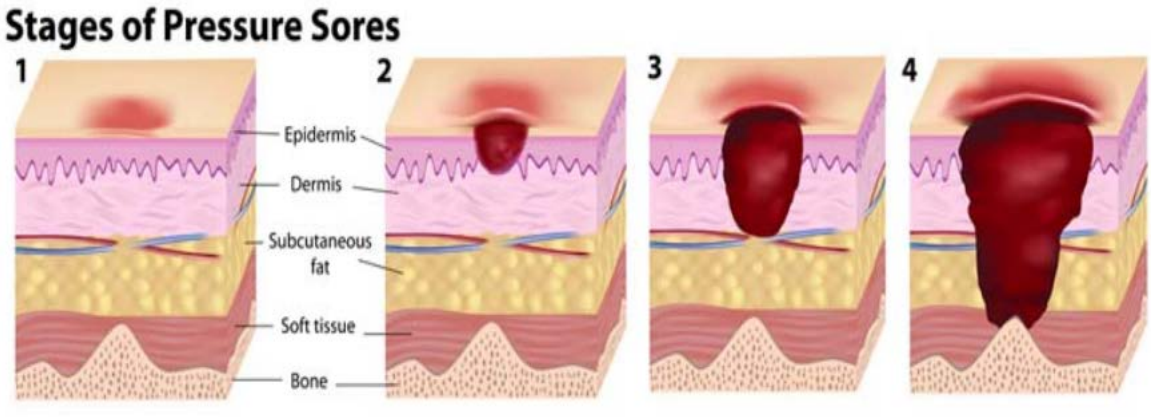
Zone 5: Between Split Bed Rails

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



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)