

Indiana State Department of Health

Nurse Aide Curriculum

Created: July 1998 Revised: November 19, 2015

Indiana Nurse Aide Training Requirements

The Indiana Administrative Code (IAC 16.2-3.1-14CNA) requires a nurse aide working in a health facility to have successfully completed a nurse aide training program approved by the ISDH. The ISDH also serves as the State Survey Agency for the Centers for Medicare and Medicaid Services (CMS) Health Care Facility Survey and Certification Program. Federal regulations at 42 CFR § 483 require the ISDH provide oversight for nurse aide training and competency programs. This *Nurse Aide Curriculum* was developed by the ISDH as the ISDH Approved Curriculum in compliance with state and federal regulations.

In July 1998, the ISDH Division of Long Term Care created the *Nurse Aide Curriculum*. The curriculum was a product of the ISDH in conjunction with Professional Resources and input from the Indiana Health Facilities Council Advisory Sub-committee. The curriculum was based on the standards of practice for nurse aides at that time.

The care provided today at Indiana nursing homes has a higher acuity level than in the past. Nurse aides play an increasing important role in the delivery of quality health care. In 2012 the ISDH began a project to update the nurse aide curriculum to better reflect current standards of care. The curriculum was reviewed by the ISDH Division of Long Term Care, ISDH Division of Healthcare Education and Training, academic institutions, nurse aide training programs, and long term care provider associations. The updated nurse aide curriculum was completed and released in September 2013. Nurse aide training programs were to implement by January 1, 2014.

The ISDH will further update the curriculum as changes or corrections are identified. Nurse aide training programs should check the ISDH Web site periodically for any changes to the curriculum.

Indiana Nurse Aide Curriculum

The Indiana *Nurse Aide Curriculum* is organized into thirty (30) "lessons". The curriculum establishes the minimum standards for an approved program. Each lesson provides objectives, terms, content, and review questions. Each nurse aide training program is expected to include this content as part of their course.

The training entity shall utilize the lesson plans as a basis for training and may complement the lessons using a text of choice. It is the responsibility of the training entity to ensure that, if a text is utilized, any variance in the content of the text from the Indiana Nursing Assistant Scope of Practice shall be identified to prevent misinformation as to the duties of the nursing assistant.

The nurse aide lesson plans serve as a "guide" for classroom lecture. Resident care procedures should be introduced and demonstrated during lecture and then reinforced during the clinical experience.

Should a standard of practice, at any time, be revised by an applicable regulatory entity, the training entity shall be responsible to update the lesson plan accordingly without waiting for an update and/or revised curriculum to be distributed by the Indiana State Department of Health.

	Pages
Lesson 1- Introduction to the Role of the Nurse Aide I. Introduction to Long Term Care II. The Role of the Nurse Aide III. The Care Team and the Chain of Command IV. Communication and Interpersonal Skills V. Resident-Centered Care (Person-Centered Care)	1-9
Lesson 2 – Resident Rights I. Origin/Purpose II. List of Rights III. Protection of Resident Rights IV. Abuse, Neglect, and Personal Possessions/Misappropriation	10-14
Lesson 3 – Infection Control I. Introduction to Infection Control II. Hand Hygiene III. Personal Protective Equipment – PPE IV. Precautions	15-20
Lesson 4 – Infection Control, continued I. Infectious Disease/Infectious Condition II. Infection Control Practices III. Review of Personal Infection Control Practices	21-25
Lesson 5 – Medical Concerns/Emergency Procedures I. Accidents II. Falls III. Choking IV. Burns/Scalds V. Poisoning VI. Medical Emergency VII. Safety Measures/Prevention Strategies	26-31
Lesson 6 – Fire Safety and Other Resident Safety Concerns I. Fire Safety II. Side rails/Entrapment III. Resident Elopement IV. Smoking	32-36
 Lesson 7 – Basic Nursing Skills (Vital Signs, Height and Weight) I. Initial Steps II. Final Steps 	37-40

III. Vital Signs	Pages
IV. Measuring and Recording Height and Weight	
 Lesson 8 – Activities of Daily Living – (Positioning/Turning, Transfers) I. Proper Positioning and Body Alignment II. Commonly Used Positions III. Proper Transfer 	41-47
 Lesson 9 – Activities of Daily Living – (Devices Used for Transfer) I. Using Mechanical Lifts II. Transfer Resident to Stretcher/Shower Bed III. Transfer – Two Person Lift 	48-50
Lesson 10 – Activities of Daily Living – (Bathing, Shampoo, Perineal Care) I. Shower/Shampoo/Drape-Undrape/Bed Bath/Perineal Care/Back Rub/ Catheter Care/Whirlpool	51-53
Lesson 11 – Activities of Daily Living – (Oral Care, Grooming, Nail Care) I. Grooming/Personal Hygiene	54-57
Lesson 12 – Activities of Daily Living – (Dressing, Toileting) I. Dressing II. Toileting	58-62
Lesson 13 – Resident Environment I. Unoccupied Bed II. Occupied Bed III. Resident Room/Environment/Fall Prevention	63-66
 Lesson 14 – Activities of Daily Living – Nutrition/Hydration I. Promoting Proper Nutrition and Hydration II. Promoting the Use of Proper Feeding Technique/Assisting a Resident with Spec III. Caring for a Resident with a Tube Feeding and the Resident at Risk for Aspirat 	
 Lesson 15 – Skin Care/Pressure Prevention I. Understanding the Integumentary System and Basic Skin Care II. Risk Factors for Skin Breakdown III. Development IV. Prevention 	76-82
Lesson 16 – Restraints I. Physical Restraint	83-86

	Pages
Lesson 17 – Rehabilitation/Restorative Services	87-90
II. Rehabilitation	
III. Restorative Services	
IV. Devices which May be Applied per Restorative Nursing Program	
Lesson 18 – Oxygen Use	91-94
I. Oxygen Use	
Lesson 19 – Devices/Interventions – Prosthetics, Hearing Aids, Artificial,	95-98
Eye, Eyeglasses, Dentures, and Compression Stockings	
I. Purpose of a Prosthetic Device	
II. Types of Prosthetic Devices	
III. Role of CNA regarding Amputations and Prosthetic Care	
IV. Role of CNA regarding Hearing Aids	
V. Role of CNA regarding Artificial Eye and Eyeglasses	
VI. Role of CNA regarding Dentures	
VII. Role of CNA regarding Elastic/Compression Stockings	
Lesson 20 – Special Care Needs Intravenous Fluids, Non-Pharmacologic	99-102
Pain Interventions	
V. Purpose of IV or PICC	
II. Role of CNA in caring for IV/PICC	
VI. Infection Control	
IV. Pain Factors	
VII. Role of CNA related to Pain	
Lesson 21 – Cognitive Impairment/Dementia/Alzheimer's	103-113
I. Conditions	
II. Behaviors, Causes and Interventions	
III. Methods/Therapies to Reduce Behaviors	
IV. Tips to Remember when Dealing with Cognitively Impaired Residents	
V. Communication Strategies	
VI. Techniques to Handle Difficult Behaviors VII. Behavior Interventions	
	114 100
Lesson 22 – Mental Health, Depression and Social Needs	114-120
I. Causes of Mental Illness	
II. Response to Behaviors III. Use of Defense Mechanisms	
IV. Types of Mental Illness	
V. Behaviors Associated with Mental Disorders – Actions and Interventions	
V. Benaviors Associated with Mental Disorders – Actions and interventions VI. Treatment for Mental Illness	
, i. Housinont for montal minoss	

VII. Special ConsiderationsVIII. Mental Illness and Intellectual Disability Mental Retardation

Lesson 23 – Common Diseases and Disorders – Nervous, Circulatory &	Pages: 121-127
Musculo-Skeletal Systems	121-127
Nervous System	
I. Nervous System	
II. Conditions that Affect Nervous System	
III. Normal Nervous System Changes with Age	
IV. Role of the CNA	
Circulatory System	
I. Circulatory System	
II. Conditions that Affect the Circulatory System	
III. Normal Circulatory Changes with Age	
IV. Role of the CNA	
Musculo-Skeletal System	
I. Musculo-Skeletal System	
II. Conditions that Affect the Musculo-Skeletal System	
III. Importance of Exercise and Range of Motion (ROM)	
IV. Normal Musculo-Skeletal Changes with Age	
V. Role of CNA	
Lesson 24 – Common Diseases and Disorders – Respiratory and Urinary Respiratory System	128-131
I. Respiratory System	
II. Common Conditions of the Respiratory System	
III. Normal Changes with Age	
IV. Role of CNA	
Urinary System	
I. Urinary System	
II. Common Conditions of the Urinary System	
III. Normal Changes with Age	
IV. Role of the CNA	
Learner 25 Commun Discourse and Discoulants Contacting to the description	120 125
Lesson 25 – Common Diseases and Disorders – Gastrointestinal, Endocrine	132-135
Gastrointestinal Systems I. Gastrointestinal System	
II. Common Conditions of the Gastrointestinal System	
III. Normal Changes with Age	
IV. Role of the CNA	
Endocrine System	
I. Endocrine System	
II. Common Conditions that Affect the Endocrine System	
III. Normal Changes with Age	
IV. Role of the CNA	

	Pages
 Lesson 26 – Common Diseases and Disorders – Reproductive, Immune/ Lymphatic Systems I. Common Conditions of the Reproductive System II. Normal Changes with Age III. Role of the CNA IV. Common Conditions of the Immune and Lymphatic Systems V. Normal Changes with Age VI. Role of the CNA 	136-138
 Lesson 27 – Admission/Transfer/Discharge I. Admitting a New Resident to the Facility II. Assisting to Transfer a Resident to a Hospital (i.e., Care Transition) III. Assisting a Resident to Discharge Home or to Another Facility 	139-141
Lesson 28 – End of Life I. Advance Directives II. Role of Hospice III. Care of the Dying Resident IV. Signs/Symptoms of Impending Death V. Post Mortem Care VI. Disposition of Personal Belongings	142-145
 Lesson 29 – Daily Responsibilities I. Day to Day Time Management/Resident Care II. Interdisciplinary Care Plan Meetings 	146-148
Lesson 30 – Protecting Your Profession I. Reducing Stress/Burnout II. Abuse/Neglect/Misappropriation III. Nurse Aide Testing/Certification	149-153
APPENDIX AResident Care Procedures1. Initial Steps2. Final Steps3. Hand washing/Hand rub*4. Gloves*5. Gown*6. Mask*7. Falling or Fainting*8. Choking*9. Seizures*	154

10. Fire*

11. Fire Extinguisher*

12. Oral Temperature (Electronic)

- 13. Axillary Temperature
- 14. Pulse and Respiration
- 15. Blood Pressure
- 16. Height
- 17. Weight
- 18. Assist Resident to Move to Head of Bed
- 19. Supine Position
- 20. Lateral Position
- 21. Fowler's Position
- 22. Semi-Fowler's Position
- 23. Sit on Edge of Bed
- 24. Using a Gait Belt to Assist with Ambulation
- 25. Transfer to Chair
- 26. Transfer to Wheelchair
- 27. Walking
- 28. Assist with Walker
- 29. Assist with Cane
- 30. Transfer to Stretcher/Shower Bed*
- 31. Transfer: Two Person Lift*
- 32. Shower/Shampoo
- 33. Bed Bath/Perineal Care
- 34. Back Rub
- 35. Bed Shampoo*
- 36. Oral Care
- 37. Oral Care for Unconscious
- 38. Denture Care
- 39. Electric Razor
- 40. Safety Razor
- 41. Comb/Brush Hair
- 42. Fingernail Care
- 43. Foot Care
- 44. Change Gown
- 45. Dressing a Dependent Resident
- 46. Assist to Bathroom
- 47. Bedside Commode*
- 48. Bedpan/Fracture Pan
- 49. Urinal
- 50. Empty Urinary Drainage Bag*
- 51. Urine Specimen Collection*
- 52. Stool Specimen Collection*
- 53. Application of Incontinent Brief
- 54. Unoccupied Bed*
- 55. Occupied Bed

56. Thickened Liquids*

- 57. Passing Fresh Ice Water
- 58. Feeding
- 59. Assist to Eat
- 60. Inspecting Skin
- 61. Float Heels
- 62. Bed Cradle*
- 63. Passive Range of Motion
- 64. Splint Application*
- 65. Abdominal Binder*
- 66. Abduction Pillow*
- 67. Knee Immobilizer*
- 68. Palm Cones
- 69. Nasal Cannula Care
- 70. Assisting with Hearing Aids
- 71. Elastic/Compression Stocking Application
- 72. Post Mortem Care*

* May be simulated in lab if clinical experience is not available

*** Please note – bolded steps in the RCP's indicate Critical Steps

Updated: January 15, 2014

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 demonstrate 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:

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 maybe 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.

Call Light – means to communicate to staff a need for assistance. The call light should be available to the resident at all times.

Certified Nursing Assistant (CNA) – an individual who has completed a state approved course and has successfully completed certification testing. A CNA provides direct care.

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.

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 – a system of behaviors people learn from the people by which they are surrounded.

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.

Dietitian – plans menus, special diets and monitors nutritional needs of the resident.

Displacement – transferring a strong negative feeling to something or someone else.

Health Insurance Portability and Accountability Act (HIPAA) – law that requires health information to be kept secure (protected) and private.

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 **Independent** – able to carry out activities of daily living without staff assistance

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 education and has completed an exam for licensure.

Long Term Care (LTC) – care for persons who require 24 hour care and assistance.

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

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.

Ombudsman – resident advocate who investigates complaints and assists to achieve agreement between parties, often defending the rights of residents.

Optometrist – provides eye care for the residents.

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.

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. Examples of professional interactions with the resident include, but are not limited to:

- Keeping a positive attitude doing the assigned tasks you are trained to perform
- Keeping information about the resident confidential

- Being polite not discussing your personal problems with a resident or with a co-worker in front of a resident.
- Not using profanity, even if a resident uses profanity
- Listening to the resident
- Calling the resident by Mr., Mrs., Ms., or by the name he/she prefers
- Always explaining the care you will be providing before beginning to provide the care
- Presenting a positive image through personal hygiene, appearance and state of mind

Projection – seeing feelings in others that are really one's own.

Qualified Medication Aide (QMA) – 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 QMA

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 completed the examination for licensure.

Regression – going back to an old immature behavior.

Repression – blocking painful thoughts or feelings from the mind.

Respiratory Therapist – provides breathing treatment(s) and special equipment for respiratory conditions.

Scope of Practice – the tasks for which a nurse aide is trained, thus, allowed to do.

Nurse Aide duties include but are not limited to:

- Feeding residents
- Helping residents with toileting and elimination needs
- Assisting residents to move safely around the facility
- Keeping residents' living areas neat and clean
- Encouraging residents to eat and drink
- Caring for supplies and equipment
- Helping to bathe and dress residents
- Making beds
- Helping residents with oral care and other hygiene needs

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 recognizable 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 and swallowing problems

Standard 14 – "The nurse aide will perform only the tasks in the course standards and Resident Care Procedures manual, unless trained appropriately by licensed staff of the facility with policies and procedures and a system for ongoing monitoring to assure compliance with the tasks. This additional training would only apply for tasks, which are not prohibited by paragraphs 2 and 3 of this section and by current rule, which prohibits the giving of injections. The nurse aide will not perform any invasive procedures, including enemas and rectal temperatures, checking for and/or removing fecal impactions, instillation of any fluids, through any tubing, administering vaginal or rectal instillations.

The nurse aide will not administer any medications, perform treatment or apply or remove any dressings. Exception to the above would be the application of creams/ ointments to intact skin as moisture barrier cream."

Subjective Information – information that could not be or was not observed. The information is 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.

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. Home Health Care

- F. Hospice Care
- G. Palliative Care
- II. The Role of the Nurse Aide
 - A. Requirements
 - 1. Limited criminal history performed
 - 2. Mantoux testing or health screen and physical examination
 - 3. Completion of an approved training program
 - B. Professionalism
 - 1. Accountability
 - 2. Confidentiality
 - 3. Health Insurance Portability and Accountability Act (HIPAA)
 - C. Scope of Practice Standard 14 Indiana Specific
 - D. Provide care according to the resident's comprehensive care plan
 - 1. Direct care needs/Use of a Nurse Aide Assignment Sheet
 - Actively listen 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
- III. The Care Team and the Chain of Command
 - A. Interdisciplinary Team often includes
 - 1. Activity Director, Certified Nursing Assistant, Licensed Practical Nurse, Medical Doctor, Social Worker, Occupational Therapist, Physical Therapist, Qualified

Medication Aide, Dietary Manager and/or Registered Dietitian, Registered Nurse, Speech Therapist, Administrator

- 2. Resident and Family Member/Responsible Party
- 3. Ombudsman, upon resident request
- B. Chain of Command
 - 1. Director of Nursing
 - 2. Licensed Nurse (charge nurse/supervisor)
 - 3. Certified Nursing Assistant/ Qualified Medication Aide
- 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
 - a. State your name before beginning a conversation
 - b. Describe persons, things and environment
 - c. Inform the resident when you are entering or leaving the room
 - d. Explain in detail what you are doing and ask the resident what they would like to do independently
 - e. Touch the resident, if appropriate
 - f. Read resident's mail or personal documents, only if asked
 - g. 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

- a. Speak slowly and distinctly
- b. Use short sentences
- c. Face the resident
- d. Use facial expressions and gestures
- e. Reduce outside distractions
- f. Use sign language and communication boards, if appropriate
- c. Be certain that the resident's hearing aid is in place and is working properly, if applicable
- d. 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
- 4. Denial refusal to acknowledge existence of something: a refusal to believe in something or admit that something exists
- 5. 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
- 6. 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
- 7. Regression reversion to earlier state: a return to an earlier or less developed condition or way of behaving
- 8. 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. Resident access to the call light place call light on resident's unaffected side.
 - 2. Staff response to the call light
- E. Promoting resident independence
 - 1. Activities of Daily Living (ADLs)
 - 2. Independence versus Dependence
- V. Resident-Centered Care (Person-Centered Care)

- A. Respecting resident choice/preference
 - 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 (include, 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

Visual Aides:

- Comprehensive Care Plan
- Nurse Aide Assignment Sheet
- Standard 14

<u>RCPS</u>:

• None

Review Questions

- 1. To whom does the CNA report?
- 2. What is the difference between an objective and subjective observation?
- 3. Give examples of resident choices which could be honored by the facility to promote person-centered care.

Lesson # 2

Title: <u>Resident Rights</u>

Lesson Objectives:

I. The student will be able to explain the importance of Resident Rights.

II. The student will be able to describe the components/areas that are Resident Rights.

III. The student will be able to demonstrate ways to protect Resident Rights.

IV. The student will be able to describe the types of abuse, neglect and misappropriation.

V. The student will be able to demonstrate how to respond to situations related to abuse, neglect or 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 <u>verbal</u> (something said-oral, written or gestured), <u>physical</u> (something done to the resident-rough handling/treatment, hitting, slapping, pinching, etc.), <u>emotional/mental</u> (humiliation, harassment, threats of punishment or deprivation) or <u>sexual</u> (harassment, coercion or sexual assault). <u>Any sexual relationship</u> with a resident is considered to be abuse.

Confidentiality – maintaining information as private.

Consensual – agreed to by the people involved; dome with the consent of the people involved. **HIPAA** – Health Insurance Portability and Accountability Act; 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, 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 – intentional use or theft of property or funds of another person for one's own use.

Neglect – failure to provide help or care when needed.

OBRA (**Omnibus Budget Reconciliation Act**) – 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.

Resident 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. Resident Rights
 - A. Origin Omnibus Budget Reconciliation Act (OBRA) —Passed in 1987 due to reports of poor care and abuse in nursing homes
 - B. Purpose
 - a. Inform a resident how he/she is to be treated
 - b. 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. Self-administer medication, if the interdisciplinary care planning team determines it is safe;
- 15. Refuse a transfer from a distinct part, within the institution;
- 16. Be free from any physical or chemical restraints; and
- 17. Be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.
- D. Protection of Resident Rights:
 - 1. Never abuse know your limits
 - 2. Types of abuse (explained in detail later)
 - 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 of resident's is considered abuse
- G. Resident Care
 - 1. Involve resident in care
 - 2. Explain procedures
 - 3. Respect refusal in care
 - 4. Report refusal in care

Note Introduce RCPs – "Initial Steps" and "Final Steps" to reinforce acknowledgement of Resident Rights observed when providing care.*

- H. Report and Document
 - 1. Be honest & truthful
 - 2. Notify supervisor immediately of abuse, neglect and/or misappropriation

- 3. Notify nurse about care questions
- 4. Report changes in condition
- II. Abuse, Neglect, and Personal Possessions/Misappropriation
 - A. Types of Abuse
 - 1. Physical
 - 2. Sexual
 - 3. Mental
 - 4. Verbal
 - 5. Financial
 - B. Neglect/Negligence
 - C. Involuntary Seclusion
 - D. Misappropriation
 - 1. Personal property
 - 2. Gifts
 - 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
 - 2. Neglect
 - a. Conditions pressure ulcers, dehydration, weight loss
 - b. Observations unclean, soiled bedding or clothing, unanswered call lights, wrong clothes, no glasses/hearing aids, uneaten food/snacks, no water available
 - c. Misappropriation
 - a. Conditions-anger, sadness, fear
 - b. Observations-missing items, comments from resident or family
 - F. Reporting
 - 1. Know facility policy

2. Report per your facility policy

Visual Aides:

• Resident Rights (poster and/or copy)

RCPS:

Introduce the students to:

- Initial Steps
- Final Steps

Review Questions

- 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

Title: <u>Infection Control</u>

Lesson Objectives:

I. The student will be able to explain the importance of Infection Control.

II. The student will be able to demonstrate the chain of infection.

III. The student will be able to describe the importance of hand hygiene.

IV. The student will be able to describe the importance of personal protective equipment.

V. The student will be able to explain both Standard and Transmission Based Precautions.

Key Terms:

Airborne Precautions – used for diseases that are transmitted through the air after expelled.

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

Center for Disease Control and Prevention (CDC) – federal governmental agency that issues guidelines relative to protection and manners to improve health.

Chain of Infection – an illustration to describe how a disease is transmitted from one person (or source) to another

Contact Precautions – used when there is risk for transmitting or contracting a microorganism from touching an infected object or person.

Direct Contact - touching an infected person, or his/her secretions.

Disinfection – chemicals used to decrease the spread of pathogens by destroying them.

Droplet Precautions – used when the disease causing microorganism does not stay airborne and only travels a short distance after being expelled

Hand Hygiene – hand washing 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

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 tiny living things that are always present in the environment, however are not visible to the naked eye.

Isolation – measure taken to isolate the potentially harmful microorganism and prevent spread to other residents.

Localized Infection – an infection contained to a specific body part; thus, the infection is localized.

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)

Pathogen – harmful microorganism; the causative agent.

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.

Standard Precautions – treating all blood, body fluids, non-intact skin and mucous membranes as if they are infected.

Sterilization – 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.

Content:

- I. Introduction to Infection Control
 - A. Definition of Infection Control prevent and control the spread of infection
 - B. Role of Centers for Disease Control and Prevention (CDC)
 - 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
 - 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
 - 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
 - D. Types of infections
 - 1. Systemic an infection that is in the bloodstream and is spread throughout the body, causing symptoms
 - 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
 - b. Reporting
 - c. Surveillance
 - d. Compliance
- II. Hand Hygiene
 - A. Hand washing when hands are visibly soiled

- B. Alcohol based hand rub
- 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 Hand washing moments
- E. Important factors related to Hand Hygiene
 - 1. Visibly soiled with blood or body fluids
 - 2. Exposure to potential pathogens
 - a. Spores C-Diff requires hand washing
- F. Other factors related to Hand Hygiene
 - 1. Finger nails long fingernails harbor organisms
 - 2. Jewelry
 - 3. Intact skin
- G. Procedure for hand washing (See RCP)
 - 1. Demonstrate proper hand washing
 - 2. Explain rationale for each step
- III. Personal Protective Equipment PPE
 - A. Purpose of PPE
 - B. Types of PPE
 - 1. Gloves
 - 2. Gown
 - 3. Mask
 - C. Procedure for PPE
 - 1. Demonstrate RCP:
 - a. Gloves
 - b. Gown

- c. Mask
- IV. Precautions
 - A. Standard Precautions
 - 1. Hand Hygiene
 - 2. Personal Protective Equipment
 - 3. Disposal of contaminated equipment/supplies
 - **B.** Transmission Based Precautions
 - 1. Airborne Precautions
 - 2. Droplet Precautions
 - 3. Contact Precautions

Visual Aides:

Utilize resources, charts, diagrams, etc., found at the ISDH Healthcare Associated Infections Resource Center <u>http://www.in.gov/isdh/24769.htm</u>

- WHO 5 Moments of Hand Hygiene
- WHO Hand Hygiene Checklist ("How to Hand wash")
- Chain of Infection Diagram

RCPS:

- Hand washing
- Gloves
- Gown
- Mask

Review Questions

- 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.

Lesson # 4 Title: <u>Infection Control, continued</u>

Lesson Objectives:

- I. The student will be able to describe conditions that are associated to infections.
- II. The student will be able to demonstrate proper hand washing technique and proper use of personal protective equipment.
- III. The student will be able to describe the importance of a clean environment.
- IV. The student will be able to verbalize rationale related to following proper technique related to hand washing and use of personal protective equipment.

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.

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).

Disposable - a product designed for short-term use with most products only intended for single use.

Disinfect – to decrease spread of pathogens and disease by destroying pathogens.

Hepatitis – inflammation of the liver caused by infection.

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.

Jaundice – a yellow/gold tint to the skin and eyes often seen in liver disease such as hepatitis or liver cancer.

Methicillin Resistant Staphylococcus Aureus (**MRSA**) – an antibiotic resistant infection often acquired in hospitals and other facilities; spread by direct physical contact.

Occupational Safety and Health Administration (OSHA) – federal governmental agency that protects workers from hazards on the job

Pediculosis – an infestation of lice.

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

Tuberculosis (TB) – 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. Infectious Disease/Infectious Condition
 - A. Acquired Immune Deficiency Syndrome (AIDS)
 - 1. Defintion
 - Transmission blood or body fluids; usually through contact with blood or sexual contact
 - 3. Prevention- Standard Precautions
 - B. Clostridium Difficile (C-Diff)
 - 1. Definition
 - 2. Transmission- spores which may survive up to six months on inanimate objects
 - 3. Prevention-Contact Precautions; requires caregiver to wash hands; not use alcoholbased hand rubs
 - C. Hepatitis
 - 1. Definition
 - 2. Transmission-fecal/oral; contaminated blood or needles; sexual intercourse
 - 3. Prevention-Standard Precautions
 - D. Influenza
 - 1. Definition

- 2. Transmission- direct or indirect contact; may also be airborne
- 3. Prevention-Standard Precautions; may require Droplet Precautions
- E. Methicillin Resistant Staphylococcus Aureus (MRSA)
 - 1. Definition
 - a. infectious-with symptoms
 - b. colonized-without symptoms
 - 2. Transmission-direct or indirect contact
 - 3. Prevention-Standard Precautions (colonized); Contact Precautions (infectious) dependent upon location; Droplet Precautions for a respiratory infection
 - F. Pediculosis
 - 1. Definition
 - 2. Transmission-direct or indirect contact; common use of combs/brushes, hats, linens
 - 3. Prevention-Contact Precautions
 - 4. Treatment- medications, environmental concerns.
 - G. Scabies
 - 1. Definition
 - 2. Transmission-direct or indirect contact; common use of linens
 - 3. Prevention-Contact Precautions
 - 4. Treatment- medications, environmental concerns.
 - H. Tuberculosis
 - 1. Definition
 - 2. 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
 - 3. Prevention-Airborne Precautions; relocation to an appropriate environment
 - I. Vancomycin Resistant Enterococcus (VRE)
 - 1. Definition
 - 2. Transmission-direct or indirect contact
 - 3. Prevention-Standard Precautions; may require Contact Precautions dependent upon location

- 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. Review of Personal Infection Control Practices
 - A. Hand washing/Hand Hygiene
 - B. Personal Protective Equipment
 - 1. Gloves
 - 2. Gown
 - 3. Mask

Visual Aides:

- PPE (gloves, gown, mask)
- Sharps container
- Bio-hazardous symbol
- Bio-hazardous bag/containers

RCPS:

Review

- Hand washing/Hand rub
- Gloves
- Gown
- Mask

Review Questions:

- 1. Describe direct contact which could spread infection.
- 2. Describe indirect contact which could spread infection.
- 3. If a resident has Clostridium Difficile, is an alcohol-based hand rub effective?

Lesson # 5

Title: <u>Medical Concerns/Emergency Procedures</u> 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 – confused relative 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
- 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
 - Gainting 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. (See RCP) Falling or Fainting
- 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 that 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. (See RCP) Choking

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 that 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

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
 - 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
 - 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
 - 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

Visual Aides:

• Material Safety Data Sheet

<u>RCPS</u>:

- Falling or Fainting
- Choking
- Seizures

Review Questions

- 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?

Title: <u>Fire Safety and Other Resident Safety Concerns</u> 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 those residents at risk of elopement and interventions to be implemented for those residents identified as at risk of elopement.
- IV. The student will be able to explain the smoking policy, safety concerns and interventions to promote safe smoking, as possible, and as applicable.

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 resident 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
- 7. A supervisor or charge nurse will give directions during an emergency
- B. Guidelines in case of fire (See RCP)
 - 1. Remove residents from area of immediate danger
 - 2. Activate the fire alarm
 - 3. Contain the fire, if possible (close doors)
 - 4. Extinguish, if possible
- C. Use of the fire extinguisher (See RCP)
 - 1. **P**ull the pin
 - 2. Aim at the base of the fire
 - 3. Squeeze the handle
 - 4. Sweep back and forth at the base of the fire
- D. Types of fire extinguishers
 - 1. 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
- 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 cut-off/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

Visual Aides:

- Sample evacuation plan
- Fire extinguisher
- FDA illustrations of zones of potential bedrail entrapment
- Electronic bracelet (if available)
- Smoking apron (if available)
- Fire blanket (if available)

<u>RCPS</u>:

- Fire
- Fire Extinguisher

Review Questions

- 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.

Title: <u>Basic Nursing Skills (Vital Signs, Height and Weight)</u> 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 (bottom number) – the phase when the heart relaxes; the pressure in the arteries between heartbeats

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.

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 (top number) – 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

Content:

- I. Initial Steps- These are consistent steps to be taken prior to executing any procedure with a resident. (See RCP)
 - 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 RCP)
 - A. Includes ensuring the resident is comfortable and safe
 - B. Includes removing supplies and equipment from the residents 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
 - <u>Temperature</u> (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 RCP)
 - b. Axillary (placed in the armpit)- normal range 96.6- 98.6 F (See RCP)
 - c. Aural/tympanic (placed in ear)- normal range 98.6- 100.6 F (See RCP)
 - <u>Pulse-rate</u> is the measurement of the number of heart beats per minute Normal range 60 – 100 (See RCP)

- 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, brachial
 - ii. When taking the pulse rate note the rate, rhythm and force. (See RCP)
- c. <u>Respirations/Respiratory Rate</u>-the measurement of the number of times a person inhales per minute (**See RCP**)
 - i. Affected by age, sex, emotional stress, medication, lung disease, heat and cold, heart disease, and physical activity
 - When taking respirations, note rate (number of respirations per minutenormal rate is 12-20 per minute); rhythm (the regularity or irregularity of breathing); and character (the type of breathing, such as shallow, deep or labored)
 - iii. When taking respirations, count respirations after finishing taking the pulse, without taking your fingers off the wrist or the stethoscope from the chest so that the resident is unaware you are checking the respirations
 - iv. If resident is agitated or sleeping, place hand on resident's chest and feel chest rise and fall during breathing
- <u>Blood Pressure</u> A measurement of the force the blood exerts against the walls of the arteries. Abnormally high blood pressure is called hypertension. Abnormally low blood pressure is called hypotension. Normal range for Systolic blood pressure is <u>100-139</u>; Normal range for Diastolic blood pressure is <u>60-89</u> (See RCP)
 - i. Caution: If resident has a history of mastectomy or has a dialysis access, the blood pressure is not to be taken in the affected side/extremity

E. Height (See RCP)

- a. Residents who are able to stand should utilize a standing balance scale
- b. Residents who are unable to stand should be measured while lying flat in bed.
- c. Residents who are unable to lay flat in bed should be measured using a tape measure.
- F. Weight- Have resident wear the same type of clothing each time he/she is weighed. If daily weights are ordered, attempt to weigh at approximately the same time each day.

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. Follow the manufacturer's guidelines for use of the scale (**See RCP**)

Visual Aides:

- Watch with second-hand
- Oral Thermometer/probe covers
- Tympanic Thermometer/probe covers
- Stethoscope
- Sphygmomanometer
- Scale (standing and wheelchair, if available)
- Measuring tape
- Sample record/document to record vital signs

<u>RCPS</u>:

- Review Initial/Final Steps
- Oral Temperature
- Axillary Temperature
- Pulse and Respiration
- Blood Pressure
- Height
- Weight

Review Questions

- 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?

Title: <u>Activities of Daily Living (Positioning/Turning, Transfers)</u>

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.

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 re-positioning
 - 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. Promotes
 - i. Physical comfort
 - ii. Relieves strain
 - iii. Promotes blood flow
 - iv. Efficient body function
 - v. Prevention of 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 re-positioning
 - 5. Review care plan
 - a. Know what position 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
- II. Commonly used positions
 - A. Supine Position (see RCP) Flat
 - 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 RCP) Resident placed on left or right side
 - 1. Reposition to side
 - 2. Logrolling
 - 3. Reduces pressure on one side
 - C. Fowler's Position (see RCP)
 - 1. Head of bed elevated 45 to 60 degrees
 - a. Promotes breathing
 - b. Caution: this position adds pressure to coccyx
 - 2. Procedures which may require Fowler's position
 - a. Grooming
 - b. Oral care
 - c. Eating
 - D. Semi-Fowler's Position (see RCP)
 - 1. Head of bed elevated 30 to 45 degrees
 - a. Promotes breathing
 - b. Less pressure to coccyx
- III. Proper transfer
 - A. Planning and safety

- 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
- B. From bed to chair (See RCP)
 - 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 leg rests, if wheelchair
 - 4. Sit on side of bed/dangle (see RCP)
 - A. For approximately 10-15 seconds
 - i. Feet flat on floor
 - ii. Regain balance
- 4. Prevent self injury by using proper body mechanics
 - A. Place feet 18" or 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
 - C. Using transfer/gait belt (see RCP)
 - 1. Secure belt around resident's waist and over their clothes
 - 2. Most used when resident has fragile bones or recent fractures
 - 3. May not be used when resident has had abdominal surgery or has difficulty breathing
 - 4. Check for proper fit; not too tight; should not slide
 - 5. Use proper body mechanics
 - D. Ambulation/walking (See RCP)
 - 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 RCP)
 - 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 RCP)
 - 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
- F. Role of the Nurse Aide
 - 1. Provide for privacy and encourage the resident to help as much as possible to promote independence
 - 2. Use proper body mechanics
 - 3. Check the resident's care plan and/or assignment sheet before moving the resident

- 4. Be patient and give the resident time to adjust to changes in position
- 5. Be aware of resident's limbs when transferring
- 6. Check condition of assistive devices
- 7. Report any misuse of (or refusal of) device to nurse
- 8. Observe resident for signs of discomfort or fatigue
- 9. When assisting resident to walk with cane, stand on weaker side

Visual Aides:

- Illustrations of the four commonly used positions
- Transfer/Gait Belt
- Illustrations of proper body mechanics

RCPs:

- Assist to Move to Head of Bed
- Supine Position
- Lateral Position
- Fowler's Position
- Semi-Fowler's Position
- Sit on Edge of Bed
- Using a Gait Belt to Assist with Ambulation
- Assist to Chair
- Transfer to Wheelchair
- Walking
- Assist with Walker
- Assist with Cane

Review Questions:

- 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 a chair, the chair should be placed on the resident's right side? True or False?

Title: <u>Activities of Daily Living (Devices Used for Transfer)</u>

Lesson Objectives:

- I. To introduce the use of a mechanical lift to the student.
- 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 wheel chair or to walk; a means of transporting the severely ill or an immobile resident.

Content:

I. Using mechanical lifts

- A. Common names and types
 - a. Sling
 - b. Sit to Stand
- B. Manufacturer's instructions normally requires at least two caregivers
- C. Facility policy
- D. Transferring general principles (but may vary with type of lift)
 - 1. Position sling
 - 2. Base open and under bed
 - 3. Place over head bar
 - 4. Attach the sling
 - 5. Resident's arms across chest. Stabilize resident's head and neck.
 - 6. Raise sling/resident
 - 7. Co-worker support resident's legs
 - 8. Lower sling/resident to chair or stretcher

- 9. Position for comfort and place sling in a manner to protect the resident's dignity.
- E. 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
- II. Transfer resident to stretcher/shower bed
 - A. From bed to stretcher (see RCP)
 - 1. Need at least two co-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 RCP) 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 wheel chair brakes
 - 3. Be aware of catheter or tubing the resident may have
 - 4. Use proper body mechanics

Visual Aides:

- Textbook illustrations
- Demonstration
- Manufacturer's instructions for mechanical lift
- Videos online

RCPs:

- Transfer to Stretcher/Shower Bed
- Transfer: Two Person/Lift

Review Questions:

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 wheel chair. You have the lift ready to assist in the transfer and Cindy, another CNA, is coming to help with the transfer. After five minutes have passed and Cindy has not arrived, it would be acceptable for you to transfer Mrs. Smith by yourself.

True or False

Title: <u>Activities of Daily Living (Bathing, Shampoo, Perineal Care)</u>

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 a person does every day to care for self; including 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. Shower

Points to Remember:

- 1. Bathing is an opportunity to observe the resident's skin. Should a concern, such as a new bruise, blister, rash or open area be noted, the nurse should be notified
- 2. The resident's face, hands, underarms, and perineal area should be washed at least daily
- 3. The elderly may bathe only twice a week, in that older skin produces less perspiration and oil and frequent bathing could cause excessive dryness
- 4. 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.
- 5. 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.

- A. Shower/Shampoo (see RCP)
- B. Bed Bath/Perineal Care/Back Rub (see RCP)
- C. Catheter care (see RCP)
- D. Perineal Care (see RCP)
- E. Back Rub (see RCP)
- F. Bed Shampoo (See RCP)
- G. Whirlpool (Type of whirlpool, trolley, etc., may alter actions. Always refer to facility policy and/or manufacturer's instructions)
 - a. Whirlpool Fill tub with water before bringing resident to bathing area
 - b. Help resident remove clothing, drape resident with bath blanket
 - c. Transport resident to tub room via wheelchair, Geri-chair, or lift bath trolley
 - d. Have resident check water temperature for comfort
 - e. If not already on trolley, assist resident into lift bath trolley, secure straps and lower lift bath trolley and resident into bath. Turn system on

f.Let resident wash as much as possible, starting with face

- g. You may shower the resident by using the shower handle to gently spray over the resident's body. Stay with resident during procedure
- h. Turn system off after completion of bath and return shower handle to hook, if used
- i.Raise trolley out of tub; give resident towel and assist to pat dry and assist resident to dry areas of resident that had been touching the trolley

j.Assist resident out of trolley

- k. Help resident dress, comb hair and return to room
- 1. Drain and sanitize tub per manufacturer's instructions

NOTE* Following assisting a resident to toilet, it may be necessary for the nursing assistant to perform perineal care. If doing so, the nursing assistant must 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. With resident's feet spread apart and standing firmly, the nursing assistant must use the same aforementioned principles (i.e., wiping from front to back, using a different part of the washcloth for each stroke, and changing the washcloth as necessary). The resident's perineum should be rinsed and patted dry prior to raising the undergarment or applying a brief.

Visual Aides:

- Linens
- Basin
- Shower Chair
- Shower Bed (if available)
- Whirlpool (if available)
- Trough or basin used to wash the hair of a bedfast resident

<u>RCPS</u>:

- Shower/Shampoo
- Bed Bath/Perineal Care/Back Rub
- Bed Shampoo

Review Questions

1. Explain the procedure to cleanse the perineal area (both male and female) and rationale of importance.

Title: <u>Activities of Daily Living (Oral Care, Grooming, Nail Care)</u>

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
 - 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 includes cleaning the teeth, gums, inside of mouth and dentures and must be performed at least daily according to state rule, but recommended to occur more often
 - 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 water in a labeled denture cup when not in use
- 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, complaint of mouth pain, white spots, loose/chipped or decayed teeth
- B. Oral Care (see RCP)
- C. Oral Care for Unconscious (see RCP)
- D. Denture Care (see RCP
 - 1. Always follow manufacturer's instructions for cleaning dentures
- E. Shaving/Electric Razor (see RCP)
 - 1. Points to Remember:
 - a. Be certain that the resident wants you to shave him or assist him to shave before you begin
 - b. Wear gloves when shaving a resident
- F. Safety Razor (see RCP)
- G. Combing/Brushing Hair (see RCP)
 - 1. Always use hair care products that the resident prefers for his/her type of hair
- H. Fingernail Care (see RCP)
 - 1. Nail care is provided when assigned or if nails appear dirty or have jagged edges

 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

I. Foot Care (see RCP)

- 1. Support the foot and ankle throughout the procedure
- 2. Poor circulation occurs in the resident with diabetes. Even a small sore on the foot can become a large wound
- 3. Careful foot care, including regular daily inspection is important
- 4. During foot care, the feet should be checked for irritation or sores and reported to the nurse, if observed
- 5. A nurse aide should never trim or clip any resident's toenails, but especially not the diabetic's toenails. Only a nurse or physician should do so

Visual Aides:

- Toothbrush
- Lemon Glycerin Swabs
- Denture Cup
- Dentures (if available)
- Emesis Basin
- Nail Clippers
- Safety Razor
- Electric Razor (if available)
- Bath Basin

<u>RCPS</u>:

- Oral Care
- Oral Care for Unconscious
- Denture Care
- Electric Razor

- Safety Razor
- Comb/Brush Hair
- Fingernail Care
- Foot Care

Review Questions

- 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.

Title: Activities of Daily Living (Dressing, Toileting)

Lesson Objectives:

- I. The student will be able to demonstrate competence in assisting the independent resident or dressing the dependent 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 on 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

- A. Residents have their own style and preferences
- 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
- G. Change Gown (see RCP)
- H. Dressing a Dependent Resident (see RCP)

II. Toileting

- A. Assist to Bathroom (see RCP)
- B. Bedside Commode (see RCP)

NOTE *Ensure bedside commode is in good repair and has intact rubber stops to prevent commode from moving with resident weight, potentially causing a fall.

- C. Bedpan/Fracture Pan (see RCP)
 - 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 the 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
- D. Urinal (see RCP)
- E. 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 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
- F. Emptying urinary drainage bag/leg bag (see RCP)
- G. Catheter Care (see RCP)
 - 1. If a resident has a catheter, care is normally provided on each shift
- H. Urine Specimen Collection (see RCP)
 - 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.

- I. Stool Specimen Collection (see RCP)
 - 1. Ask the resident to inform you when he or she can have a bowel movement.
 - 2. Be ready to collect the specimen
- J. Application of Incontinent Brief
 - 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

Visual Aides:

- Gown
- Clothing (shirt, slacks, etc.)
- Bedside Commode (if available)
- Bedpan/Fracture Pan
- Urinal
- Catheter/Drainage Bag/Leg Bag
- Urine Graduated container/Cylinder
- Urine Hat
- Urine Specimen Cup
- Stool Specimen Cup
- Incontinent Brief
- Incontinent Pad

<u>RCPS</u>:

- Change Gown
- Dressing a Dependent Resident

- Assist to Bathroom
- Bedside Commode
- Bedpan/Fracture Pan
- Urinal
- Empty Urinary Drainage Bag
- Urine Specimen Collection
- Stool Specimen Collection
- Application of Incontinent Brief

Review Questions

- 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?
Title: <u>Resident Environment</u>

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 demonstrate competence in making an occupied bed.
- IV. 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 of falls.

Key Terms:

Call Light – means to call for assistance, when needed.

Closed Bed – a bed completely made with the bedspread and blankets in place.

Draw sheet – turning sheet that is placed under residents who are unable to assist with turning, lifting or moving up in bed.

Hoarding – excessive collecting and maintaining of items in the resident's environment.

Occupied Bed – bed made while a resident is in the bed.

Open Bed – folding the linen down to the foot of bed.

Reality Orientation – using calendars, clocks, signs and lists to assist/cue residents with cognitive impairment.

Unoccupied Bed – a bed made while no resident is in the bed.

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 resident's 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
- 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 the resident's environment, unless the resident's fluids are restricted by the physician, in an effort to encourage hydration
- J. The resident's 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 RCP)
- III. Occupied Bed (see RCP)
- IV. Resident Room/Environment/Fall Prevention
 - A. Each room may have slightly different equipment. Standard room contents include: bed, bedside stand, over bed table, chair, call light and privacy curtain
 - B. Always ensure the call light is within the resident's reach and answered immediately
 - C. Clean the over bed table after use and place within resident's 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 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 shoelaces are tied
 - 4. Monitor to ensure residents wear clothing that is of proper length (e.g., not too tight, not too loose, or not too long)
 - 5. Keep frequently used items within reach of resident
 - 6. If ordered, ensure any devices or alarms are in place and functional as per plan of care
 - 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 for reality orientation 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.

Visual Aides:

- Resident Bed
- Linens

<u>RCPS</u>:

- Unoccupied Bed
- Occupied Bed

Review Questions

- 1. List items that could be used to promote reality orientation.
- 2. The call light should always be placed within the resident's reach. True or False?

<u>Title: Activities of Daily Living (Nutrition/Hydration)</u>

Lesson Objectives:

- I. The student will be able to explain the importance of proper nutrition/hydration.
- II. The student will be able to demonstrate competence in proper feeding techniques and provision of assistance for the resident with special needs.
- III. 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.

Calories – the fuel or energy value of food.

Carbohydrates – the main source of energy for all body functions.

Dehydration – excessive loss of fluid from the body.

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 and dietary (i.e., fluids with meals).

Gastrostomy Tube (**G-Tube**) – tube placed through the abdomen directly into the stomach and used to provide nourishment.

Hydration – fluids consumed.

Jejunostomy (**J-Tube**) – tube placed into the second part of the small intestines and used to provide nourishment.

Minerals – compounds found in the diet or dietary supplements; builds body tissue, regulates body fluids, promotes bone & tooth formation, affects nerve and muscle function.

Nasogastric Tube – tube placed through the nose to the stomach and used to provide nourishment. **NPO** – nothing by mouth.

Nutrients – substances found in food which provide nourishment.

Nutrition – nourishment; the process by which the body takes in food to maintain health.

PEG (percutaneous endoscopic gastrostomy) – tube placed endoscopically, directly into the stomach and used to provide nourishment. Often called a "G-tube".

Proteins – complex compounds found in all living matter; promote growth and repair of tissue.

Vitamins – organic compounds obtained from one's diet or dietary supplements; helps the body function.

Water – H2O (one molecule of oxygen and two molecules of hydrogen); most essential nutrient for life.

Content:

- I. Promoting Proper Nutrition and Hydration
 - A.Proper nutrition
 - 1. Promotes physical health
 - 2. Helps maintain muscle
 - 3. Helps maintain skin & tissues
 - 4. Helps prevent pressure sores
 - 5. Increases energy level
 - 6. Aids in resisting illness
 - 7. <u>A</u>ids 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

C.Diet specifics

- 1. Diet cards
 - a. Specific to a resident
- 2. Basic or "general" diet
- 3. Therapeutic/special/modified diets
 - a. Soft
 - b. Bland
 - c. High/low fiber
 - d. Low fat
 - e. High/low protein
 - f. Low sodium
 - g. Modified calorie/calorie count
 - h. Liquid
 - i. High potassium
 - j. Diabetic (ADA)
 - k. NPO
- 4. Mechanically altered diets
 - a. Mechanical soft
 - b. Pureed
- 5. Thickened liquids (see RCP)
 - a. Nectar thick

b. Honey thick

c. Pudding thick

D.Monitoring meal consumption/recording food consumed

- 1. Observation
- 2. Facility policy for recording
- E. Proper hydration
 - 1. Promotes physical health
 - a. Aids digestion and elimination
 - b. Maintains normal body temperature
 - c. Helps prevent dehydration
 - 2. Force fluids/encourage fluids
 - 3. Fluid restriction
 - a. Implemented by physician order due to concerns with fluid overload
 - b. Daily amount is limited and divided between dietary (for meal service) and nursing
 - 4. Recording Intake and Output (I&O's)
 - a. Approximately 2000-2500cc daily
 - b. Determine resident's total fluid intake
 - 1. Use metric measurement (cubic centimeters = cc)
 - c. Measure output (urine and emesis)
 - 1. Graduated measuring container
 - 2. Use metric measurement (cubic centimeters =cc)
 - 5. Passing Fresh Ice Water (**see RCP**)
- F. Role of the Nurse Aide
 - 1. Encourage resident to eat as much of their meal as possible
 - 2. Note foods resident avoids or dislikes and report to the nurse
 - 3. Review diet card before serving meal to resident to confirm correct diet
 - 4. Be aware of food brought in to the resident from an outside source and potential conflict with ordered diet
 - 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 fluid restriction
- 8. Observe for and report to the nurse signs of dehydration:
 - 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, 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
- 9. 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
- 10. Measure Intake & Output accurately
- II. 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

- A. Feeding (see RCP)
- B. Assist to eat (see RCP)
- C. 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
- D. 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. If feeding the resident, ask them to open their mouth at appropriate time
 - 5. If feeding the resident, tell them what food you are giving them
- E. 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. If 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
- F. 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 AspirationA. 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.

- 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 also be called a Levine tube or 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.
- 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. <u>You must notify the nurse immediately if the</u> <u>alarm sounds</u>
- 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
- <u>Residents with feeding tubes are often NPO</u>. 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
 - 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
 - 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 <u>at risk of aspiration</u>. 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

- 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
- Know your residents and ensure residents receive snacks, meals and fluids <u>at</u> the ordered consistency

Visual Aides:

- Meal Consumption Record
- Thickener (Fluids thickened to nectar, honey and pudding thick consistency)

RCPS:

- Thickened Liquids
- Passing Fresh Ice Water
- Feeding
- Assist to Eat

Review Questions

- 1. Name two symptoms of dehydration
- 2. What is the most essential nutrient for life?
- 3. What are the three types of thickened liquid?
- 4. When a tube feeding is infusing, the head of the bed must be elevated. True or False?

Title: <u>Skin Care/Pressure Prevention</u>

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

Offload – assisting a resident to stand up to completely remove the pressure from the area.

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 pushup.

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

1) Epidermis

2) Dermis

3) Subcutaneous tissue

- b. Hair
- c. Nails
- d. Glands

1) Oil

2) Sweat

e. Nerve endings

2. Function

- a. Largest organ of the body
- b. Sense organ
 - 1) Heat/cold
 - 2) Pain
 - 3) Pressure
 - 4) 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
 - 1) Provide frequent care for residents who are incontinent
 - 2) Change linens/clothing
 - 3) Check resident at least every 2 hours for needed care and encourage to reposition
- b. Observe for:
 - 1) Rashes
 - 2) Abrasions
 - 3) Dryness
 - 4) Changes in skin color
 - a) Pale
 - b) Red
 - c) Purple/Blue
 - 5) Pressure areas
 - a) Reposition at least every 2 hours
 - b) No wrinkles in bottom sheet
 - 6) Temperature
 - a) Complaints of warmth or burning
 - 7) Bruising
 - 8) Swelling
 - 9) Blisters
 - a) Ensure resident has proper fitting shoes/slippers
 - 10) Scratching
 - 11) Broken skin
 - 12) Drainage
 - 13) Wound or ulcer
 - 14) 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
- 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

 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

 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

 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

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

 Friction happens when skin rubs another surface over and over (like a rough wheelchair seat rubbing the back of the individual's leg). 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). 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)- Higher risk due to body is fighting several problems at once
- 2. Age- Higher risk due to with age, skin becomes fragile and breaks down easily
- 3. Medical devices- Higher risk due to 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 neglect their own care
- 5. History of pressure ulcers- Higher risk due to 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
- D.Treatment can take weeks, months, or years

IV. Prevention

- A.Observe skin upon admission and during the provision of daily care
 - 1. Skin Inspection
 - 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. Remove medical devices (with the permission or under the direction of the nurse) to view the skin under the device
- 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, and the scrotum and any skinto-skin contact
- d. Note observations and report to the nurse- When a potential problem is observed, notify the nurse for assessment of the area
- 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.

E. Identify residents who have been assessed by nursing as "at risk"

1. Braden Scale- standardized risk assessment tool completed by the nurse

Visual Aides:

- ISDH Pressure Ulcer Resource Center/Education Modules <u>http://www.in.gov/isdh/24558.htm</u>
- Pressure-reducing devices (mattress, overlay, cushion, heel/elbow protectors, bed cradle, etc.)
- Braden Scale

RCPS

• Inspecting Skin

- Float Heels
- Bed Cradle

Review Questions

- 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?

Title: <u>Restraints</u>

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 of 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

Convenience – any action taken by the facility to control a resident's behavior 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;
 - 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. Application
 - 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 other emergency
 - 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
 - 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; however, 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

- 1. FDA Guidance
 - A. Entrapment Zones
 - 1) Zone 1 within the rail
 - Zone 2 under the rail, between the rail supports or next to a single rail support
 - 3) Zone 3 between the rail and the mattress
 - 4) Zone 4 under the rail at the ends of the rail
 - 5) Zone 5 between split bed rails
 - 6) Zone 6 between the end of the rail and side edge of the head or foot board
 - 7)Zone 7 between the head or foot board and end of the mattress

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 that prevent him or her from exiting the device 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

Visual Aides:

- Physical Restraints
- Self-Releasing Devices
- Restraint Record
- FDA guidance/illustrations of entrapment zones/manners of entrapment

RCPS:

• None

Review Questions

- 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?

Title: <u>Rehabilitation/Restorative Services</u>

Lesson Objectives:

I. The student will understand the role of rehabilitative services.

II. The student will understand 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 to 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 rehabilitation following 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 RCP)
 - 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 RCP)
- III. Devices which may be applied per Restorative Nursing Program
 - A. Abdominal Binder (see RCP) 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 RCP) 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 RCP) 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 RCP) 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)

Visual Aides:

- Abdominal Binder
- Abduction Pillow
- Knee Immobilizer
- Palm Cone
- Splint

<u>RCPS</u>:

- Passive Range of Motion
- Splint Application
- Abdominal Binder

- Abduction Pillow
- Leg Immobilizer
- Palm Cones

Review Questions

- 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 rehabilitation following the formal rehabilitation is called _____.

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.

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 never stop, adjust, or initiate the use of oxygen
 - C. Nasal Cannula Delivery of oxygen from a long tubing from source to cannula with prongs placed in each nostril and tubing tucked behind the ears of the resident
 - 1. Observe for irritation behind the ears, as the tubing can cause skin breakdown. Notify the nurse, if observed
 - 2. Nasal Cannula Care (see RCP)
 - D. Mask delivery of oxygen from a long tubing from the source to a mask placed on the resident's face with 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.

- 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
 - 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 settings 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 in an oxygen-enriched environment

Examples include electric razors, hairdryers, electric blankets, or electric heaters.

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
- 7. Although the nursing assistant cannot adjust the oxygen level, the nurse aide should learn how to turn oxygen off in case of fire

Visual Aides:

- Nasal Cannula
- Face Mask
- Concentrator
- Liquid Oxygen
- Portable Oxygen Tank

<u>RCPS</u>:

• Nasal Cannula Care

Review Questions

- 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?

Title: <u>Devices/Interventions - Prosthetics, Hearing Aides, Artificial Eye, Eyeglasses,</u> <u>Dentures, Compression Stockings</u>

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 (thrombo embolic 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: Prosthetic Device

- 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 regarding 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 RCP)
 - 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
 - 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)
 - A. Make certain stockings are on when resident is up, if ordered by the physician
 - B. Follow care plan directions in regard to when to be applied and removed
 - C. Elastic/Compression Stocking Application (see RCP)

Visual Aides (if available):

- Hearing aid
- Eyeglasses
- Elastic/compression stockings

RCPS:

- Assisting with Hearing Aids
- TED Hose Application

Review Questions:

- 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?
<u>Title:</u> 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: IV or PICC Care

I. Purpose of IV or PICC

- A. Medication administration, such as antibiotics
- B. Nutrition administration
- C. Hydration
- D. Blood products
- E. 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. Line found out or is removed by 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 or catching of tubing
 - C. Never disconnect IV or PICC from pump
 - D. Never lower bag below IV/PICC site
 - 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

Content: Pain Control Interventions

- I. 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
- II. 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 having been given a pain medication) to the nurse

- 2. Position the resident's body in good alignment or assist to reposition the resident at the resident's direction in regard to a 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

Visual Aides:

- Body Diagram of Circulatory System (Arteries & Veins)
- Pain Scale Example
- IV Supplies & Equipment

RCPs:

• None

Review Questions:

- 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?

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.

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.

- Expressive aphasia may be slow to speak or to formulate sentences.
- Receptive aphasia may be slow to respond to communication attempts due to delay in processing the communication and the response.

Catastrophic Reaction – overreacting to stimuli in an unreasonable way.

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 another.

Reality Orientation – using calendars, clocks, signs and lists to assist residents with cognitive impairment to remember who and where they are.

Reminiscence Therapy – used to encourage residents to talk about 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 – allows residents to believe they live in the past or imaginary circumstances. Staff let the residents believe what the resident is saying, without trying to enforce current reality.

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
 - C. Dementia a general term that refers to serious loss of mental abilities, such as thinking, remembering, 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:

- Stage 1 no impairment (normal function) the resident does not experience any memory problems
- 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
- 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 own 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
 - 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 handwringing or tissue shredding
 - i) Tend to wander or become lost
- 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, hunger etc.)
 - 1. Remove trigger(s), if known
 - 2. Maintain calm environment
 - 3. Stay calm
 - 4. Patting, stroking may reassure resident/may not
 - B. Pacing/Wandering could be 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. Re-direct 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
- 2. Provide reassurance
- 3. Do not argue
- 4. Stay calm
- 5. 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. 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. Redirect
- G. Repetitive Phrasing may be caused by habit or cognitive impairment
 - 1. Be patient and calm
 - 2. Answer question
 - 3. Do not try to silence or stop
 - 4. Redirect
- H. Violence may be caused by delusion, hallucination, acute illness, cognitive impairment, provocation by another resident, 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
- I. Disruptive actions may be caused by delusion, hallucination, acute illness,

cognitive impairment, provocation by another resident, 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, 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. Reality Orientation using calendars, clocks, or signs to help memory
 - B. Validation Therapy allowing the resident to live in the past or in imaginary circumstances; to try to convince otherwise is often upsetting
 - C. Reminiscence Therapy encouraging the resident to remember; to talk about the past
 - D. Activity Therapy using activities that the resident enjoys to prevent boredom and frustration
 - E. Music Therapy form of sensory stimulation; hearing familiar songs can cause a response in residents that do not respond to other therapies

- F. 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

VI. Techniques to Handle Difficult Behaviors

- A. Anxiety/Fear
 - 1. Stay calm, speak slow
 - 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. Redirect to another activity or discussion
 - 3. Remove hazard, if possible
 - 4. Don't take the resident's actions 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. Take your time
 - 4. Provide privacy
 - 5. Make sure resident is not afraid of tub/shower
 - 6. Have resident assist, as able
 - 7. Maintain safety; do not leave alone
 - 8. Do not argue with resident; if upset, try again at another time
- B. Dressing
 - 1. Encourage to choose what to wear
 - 2. Avoid delays, but 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
 - 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
 - Document/track bowel movements (constipation may cause increase in behaviors)
- D. Eating/Meals
 - 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

Visual Aides:

• None

<u>RCPS</u>:

• None

Review Questions

- 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 _____.

Title: Mental Health, Depression and Social Needs

Lesson Objectives:

- I. The student will be able to demonstrate appropriate response to challenging or problematic resident behavior.
- II. The student will be able to describe interventions to be used in response to specific challenging or problematic resident behavior.
- III. The student will be able to describe the difference between mental illness and intellectual disability (mental retardation).
- IV. The student will be able to demonstrate the importance of immediately reporting to the nurse any challenging or problematic behavior.

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 (Mental Retardation) – 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 – 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 effect 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
 - Symptoms sweating, dizziness, choking, dry mouth, racing heart, fatigue, shakiness, muscle aches, cold or clammy feeling, shortness of breath or difficulty breathing
 - B. Depression

- 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:
 - A. Depressed mood most of the day, nearly every day
 - B. Loss of interest or pleasure in most activities
 - C. Significant weight loss or gain
 - D. Sleeping too much or not being able to sleep nearly every day
 - E. Slowed thinking or movement that others can see
 - F. Fatigue or low energy nearly every day
 - G. Feelings of worthlessness or inappropriate guilt
 - H. Loss of concentration or indecisiveness
 - I. 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, loss of motivation

- V. Behaviors associated with mental disorders actions and interventions
 - A. Combative
 - 1. Actions hitting, kicking, spitting, pinching, pushing, pulling hair, 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
 - Actions shouting, yelling, threatening, throwing things, pacing, withdrawal, sulking
 - Interventions remain calm, do not argue, try to understand what triggered anger, empathize with resident, listen, stay a safe distance, explain what you are doing
 - C. Sexual Behaviors
 - Actions sexual advances, comments, sexual words or gestures, removing clothing, inappropriate touching of self or others, exposing body parts or masturbation
 - Interventions do not over-react, be "matter-of-fact", try to redirect, gently direct to private area, report to nurse, maintain safety of other residents
 - 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 involves sessions with mental health professionals during which the residents discuss problems or issues. The mental health professionals work

with the resident 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 selfinjury REPORT IMMEDIATELY
 - B. Changes in conditions any changes in mood, activity, eating, extreme behaviors or reactions, more upset or excitable, withdrawn, hallucinations or delusions
- VIII. Mental Illness and Intellectual Disability (Mental Retardation)
 - A. Intellectual Disability (Mental Retardation) a developmental disability that causes below –average mental functioning
 - 1. Intellectual Disability (Mental Retardation) vs. Mental Illness:
 - a) Intellectual Disability (Mental Retardation) is a permanent condition; mental illness can be temporary
 - b) Intellectual Disability (Mental Retardation) is present at birth or early childhood; mental illness can develop at any age
 - c) Intellectual Disability (Mental Retardation) affects mental ability; mental illness may or may not affect mental function
 - d) No cure for Intellectual Disability (Mental Retardation). Some mental illness can be cured or controlled with treatment, such as medication or therapy.

Visual Aides:

• None

RCPS:

• None

Review Questions:

- 1. Should a resident verbalize thoughts of suicide or an intention to cause harm to self, when should this be reported to the nurse?
- 2. Should a resident begin kicking or hitting you, what actions should you take?

Common Diseases and Disorders - Nervous, Circulatory & Musculo-Skeletal Systems

Lesson Objectives:

- I. The student will be able to describe recognize 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 joint disorder that involves inflammation of one or more joints.

Atrophy – wasting away, decreasing in size, and weakening of muscles.

Cerebral Palsy – a group of disorders that can involve brain and nervous system functions, such as movement, learning, hearing, seeing and thinking.

Cerebrovascular Accident (CVA) – stroke; blood supply is suddenly cut off to the brain.

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.

Multiple Sclerosis (MS) – a progressive disease affecting the central nervous system.

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
 - A. Central Nervous System (CNS) composed of the brain and spinal cord
 - 1. Brain sends, receives and interprets messages to make sense of the outside world/stimulus
 - Spinal cord nerves which transmit information from body organs and external stimuli to the brain and send information from the brain to other areas of the body
 - B. Peripheral Nervous System (PNS) nerves that extend throughout the body

II. Conditions that Affect Nervous System

- A. Dementia
 - 1. Affects thought process: memory, communication
 - 2. As the process progresses it will make it difficult to perform ADLs: e.g., eating, dressing, bathroom
- B. Alzheimer's Disease
 - 1. Set up regular schedule for bathing, toileting, exercise
 - 2. Use repetition in daily activities
- C. Parkinson's Disease
 - 1. A progressive, degenerative disease that affects the brain
 - 2. As the disease progresses, it will make it more difficult for the resident to perform ADLs. Hands often tremor and limbs and trunk become rigid
 - 3. Assist by placing food and drink close; use assistive devices

- D. Cerebrovascular Accident (CVA) or stroke
 - Symptoms: may include dizziness, blurred vision, nausea/vomiting, headache, slurred speech
 - 2. Occurs when blood supply is suddenly cut off to the brain caused by a clot or a ruptured blood vessel
 - 3. When dressing a resident, address the weaker side first to prevent unnecessary bending or stretching and when undressing address the stronger side first
 - 4. Use a gait belt when walking or transferring the resident for safety precautions and stand on the weaker side
- E. Multiple Sclerosis (MS)
 - 1. A progressive disease affecting the central nervous system
 - 2. It may be difficult to perform ADLs; be patient when assisting, as stress can increase MS effects
- F. Epilepsy
 - 1. Observe for seizure activity; report to nurse
- G. Cerebral palsy
 - 1. Muscles may become very tight; may develop contractures
 - 2. Muscle weakness or loss of movement (paralysis)
 - 3. Abnormal movements
 - May exhibit speech problems, hearing/vision problems, seizures, drooling, problems swallowing
 - 5. Resident may be totally dependent on staff for ADLs
- H. Head or spinal cord injuries
 - Dependent upon extent of injury, resident may need assistance or be totally dependent on staff for ADLs

III. Normal Nervous System Changes with Age

A. Decreased blood flow to certain areas of the brain causes decreased short-term memory. Nerve cells die causing decreased perception of sensory stimuli and less awareness of pain and injury

- B. Responses and reflexes slow
- C. Nerve ending decreased sensitivity
- D. Memory loss often short-term memory
- IV. Role of the Nurse Aide
 - A. Observe and Report
 - 1. Shaking or trembling
 - 2. Inability to speak clearly
 - 3. Inability to move one side of the body
 - 4. Changes in vision or hearing
 - 5. Difficulty swallowing
 - 6. Depression or mood changes
 - 7. Memory loss or confusion
 - 8. Behavior changes

Content - Circulatory System:

- I. Circulatory System
 - A. Heart pumps blood through the body
 - B. Blood body fluid that carries oxygen to the cells
 Blood vessels tubes (arteries, veins, capillaries) through which the blood is transported to and from the heart

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

- A. Observe and report
 - 1. Complaint of headache
 - 2. Chest pain
 - 3. Blurred vision
 - 4. Dizziness
 - 5. Nausea

Content - Musculo-Skeletal System:

- I. Musculo-Skeletal System gives the body shape and structure
 - A. Muscles-tissues that contract (shorten) and relax (lengthen) to make motion possible
 - B. Bones- provide the frame for the body. A joint is the point where two bones come together and allow movement
 - C. Ligament connect bone to bone and support joints
 - D. Tendon connect muscle to bone
 - E. Cartilage cushions joints

II. Conditions that Affect Musculo-Skeletal System

- A. Fracture
 - 1. Symptoms of fracture include: change in skin color, bruising, pain, 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
- 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 Musculo-Skeletal 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
 - 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

- B. Fall prevention
 - 1. Keep mobile
 - 2. Encourage activities and exercise
 - 3. Participate in care
 - 4. Proper positioning
 - 5. Use of assistive devices

Visual Aides:

- Musculo-Skeletal System Body Chart
- Nervous System Body Chart
- Circulatory/Cardiovascular System Body Chart

RCPs:

• Review Passive Range of Motion

Review Questions:

- 1. Should a resident complain of headache and blurred vision, the caregiver must report this 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

<u>Title: Common Diseases and Disorders - Respiratory and Urinary Systems</u> 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.

- **Incontinence** inability to control the bladder.
- Inspiration breathing in.
- **Sputum** fluid that is coughed up.

Content:

- I. Respiratory System
 - A. mouth and nose take in air
 - B. trachea tube connecting mouth and nose to lungs
 - C. lungs-move oxygen from air into blood and remove carbon dioxide (gaseous waste product)
 - 1. Two functions:
 - a) Inspiration brings oxygen into the body
 - b) Expiration eliminates carbon dioxide

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 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

- 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

- A. Kidneys filter waste products from blood and produce urine
- B. Ureters- carry urine from kidneys to bladder
- C. Urinary bladder-stores urine
- D. Urethra- carries urine from bladder out of body
- E. Two functions
 - 1. Eliminates waste products through urine
 - 2. Maintains water balance in the body
- F. Common Conditions of the Urinary System
 - 1. Urinary Tract Infection (UTI) or cystitis
 - 2. 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. More frequent urination due to bladder holds less urine
 - E. Bladder does not empty completely
- IV. Role of the Nurse Aide
 - 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/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

Visual Aides:

- Respiratory System Body Chart
- Urinary Tract Body Chart

RCPs:

• None

Review Questions:

- 1. Green, yellow or blood tinged sputum should be reported to the nurse. True or False
- 2. Should the resident complain of pain or burning with urination, this should be reported to the nurse? True or False

Title: <u>Common Diseases and Disorders – Gastrointestinal and Endocrine Systems</u>

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 – section of the colon is removed and the stool will be evacuated through a stoma and emptied into a bag adhered to the abdomen of the resident.

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
 - A. Mouth takes food in and masticates (chews) food and fluid
 - B. Esophagus tube that transports masticated (chewed) food from mouth to stomach
 - C. Stomach sac that mixes food and fluid with digestive juices
 - D. Small Intestine tube that absorbs water and digested food from waste
 - E. Large Intestine tube that absorbs water from waste
 - F. Rectum sac at end of large intestine which stores waste
 - G. Anus opening at end of rectum through which waste is expelled
 - H. Other organs which aid in digestion include gall bladder, liver, pancreas
- II. Common Conditions of the Gastrointestinal System
 - A. Gastroesophageal Reflux Disease (GERD)
 - B. Peptic Ulcer
 - C. Ulcerative Colitis
 - D. Hemorrhoids
 - E. Constipation
 - 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 loose 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
 - A. Observe and Report to the nurse

- 1. Difficulty chewing and/or swallowing
- 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 bowel movements
 - b) observation of stool for blood; notify nurse

Content - Endocrine System:

- I. Endocrine System
 - A. Glands that produce hormones and secretions to regulate body functions
- 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
 - 3. Hyperglycemia (high blood sugar)
 - a) signs/symptoms: shortness of breath, breath smells fruity, nausea/vomiting, frequent urination, thirst
 - G. Hyperthyroidism
 - 1. sign/symptoms: can't tolerate being hot
 - 2. increased heart rate, and enlarged thyroid (goiter)
 - H. Hypothyroidism
 - 1. sign/symptoms: confusion, tired
 - 2. inability to tolerate the cold
- V. 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
- VI. Role of the Nurse Aide
 - A. Identify residents in your care who are diabetic
 - B. Encourage diabetic resident to consume all meals/snacks; notify nurse if resident refuses meal/snack or consumes less than half of meal/snack
 - C. Notify nurse immediately of signs/symptoms of hypoglycemia
 - D. Notify nurse if a diabetic resident is consuming foods in conflict with ordered diet which could cause hyperglycemia

Visual Aides:

- Gastrointestinal System Body Chart
- Endocrine System Body Chart

<u>RCPS</u>:

• None

Review Questions

- 1. List signs/symptoms of hypoglycemia (low blood sugar).
- If vomitus looks like coffee grounds, the nurse must be notified immediately. True or False

Lesson #26

Title: <u>Common Diseases and Disorders - Reproductive, Immune/Lymphatic Systems</u> <u>Lesson Objectives:</u>

- 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.

Immune System – protects the body from disease.

Lymphatic System – removes excess fluids and waste products from the tissues of the body.

Perineum – the area between the anus and the scrotum (male) or vulva (female).

Reproductive Systems:

Female- ovaries – produce estrogen, progesterone and ova (eggs)

- **fallopian tubes** carry eggs from ovaries to the uterus
- **uterus** muscular sac where the eggs can develop
- **vagina** muscular canal leading out of the body
- vulva external gentialia of the female, including the labia and clitoris
- **breasts** holds mammary glands which produce nutrients for infants

Male- testes – glands that produce testosterone and sperm

- **scrotum** sac which contains the testes
- prostate gland gland which produces the fluid for sperm
- **penis** external organ through which males ejaculate and urinate

Content:

- I. Common Conditions of the Reproductive System
 - A. Breast, prostate and ovarian cancer
 - B. Vaginitis
- II. 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

III. Role of the Nurse Aide

- A. Observe and Report
 - 1. Abnormal bleeding
 - 2. Complaints of pain
- IV. 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)
- C. Result of cancer treatment/medications
- V. Normal Changes with Age
 - A. Increased risk of infection
 - B. Increased drying of tissue causes irritation
- VI. Role of the Nurse Aide
 - A. Observe and Report
 - 1. Fever
 - 2. Diarrhea

3. Increased fatigue/weakness

Visual Aides:

- Reproductive System Body Chart
- Immune/Lymphatic System Body Chart

<u>RCPS</u>:

• None

Review Questions

- 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

Lesson #27

Title: <u>Admission/Transfer/Discharge</u>

Lesson Objectives:

- I. The student will be able to describe the role of the direct caregiver to familiarize the newly admitted resident to new surroundings.
- 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 same status (e.g.,

Medicaid to Medicaid; Medicare to Medicare).

Content:

- I. Admitting a New Resident to the Facility
 - 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 use of call light to summon help, 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. Respond to the directives 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
 - A. Role of the Nurse Aide
 - Respond to the directives given by the nurse to prepare the resident for discharge
 - Assist to gather personal belongings, as requested, in preparation for transfer/discharge, using the personal inventory as reference to personal items on site

Visual Aides:

• Personal Inventory Record

<u>RCPS</u>:

• None

Review Questions

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

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

II. Indiana recognizes the following types of advance directives:

- Talking directly to your physician and family
- Organ and tissue donation
- Health Care Representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric Advance Directive
- Out of Hospital Do Not Resuscitate Declaration and Order
- Power of Attorney

III. 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

- IV. Care of the Dying Resident
 - A. Place resident in most comfortable position for breathing and avoiding pain.
 Maintain body alignment.
 - 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 drinking water/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
- V. 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
 - VI. Post Mortem Care
 - 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
- VII. 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

Visual Aides:

• None

<u>RCPS</u>:

• Post Mortem Care

Review Questions

- 1. Blue discoloration of the skin and mucous members is called _____.
- 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

Title: Daily Responsibilities

Lesson Objectives:

- I. The student will be able to explain the importance of prioritization, organization and time management while 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

- 7. Time and date entries; sign with name and title, unless initials are acceptable per facility policy.
- 8. Never document for someone else
- 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 between1:00 p.m.to 11:59 p.m., add 12 to the regular time. For example to change2:00 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.

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.

Visual Aides:

- Sample Nursing Assistant Assignment Sheet
- Sample Documentation Flow Records (BM Record, Food Consumption, ADL Record, Weight Record, etc.)

RCPS:

• None

Review Questions

- 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

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 testing, 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 <u>verbal</u> (something said-oral, written or gestured), <u>physical</u> (something done to the resident-rough handling, hitting, slapping, pinching, etc.), <u>emotional/mental</u> (humiliation, harassment, threats of punishment or deprivation) or <u>sexual</u> (harassment, coercion or sexual assault). <u>Any sexual relationship</u> 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.

Consensual – agreed to by the people involved; dome 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

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 <u>protect</u> 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 your facility's policy regarding reporting abuse
 - 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) Actually sees/witnesses an incident that you suspect is abuse or neglect
 - 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 should be reported
 - 5. The nurse aide doesn't make a determination that abuse or neglect "has" or "has not" occurred and <u>then</u> 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 ISDH when abuse has been reported
 - b) May result in revocation of certification

- III. Nurse Aide Testing/Certification
 - A. To Maintain Certification
 - 1. The CNA must be offered at least 12 hours of in-service education per year
 - 2. The CNA must work for a health care provider at least one eight hour shift every twenty-four months
 - 3. The CNA must never have a verified complaint against them on the registry. If a complaint of abuse or misappropriation of resident's property or funds is found to be valid, the CNA will lose certification in all 50 states permanently
 - 4. The CNA must be evaluated yearly for performance and offered in-service education on any weaknesses identified
 - 5. The nurse aide must remain professional
 - 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 ISDH CNA Registry on-line at the time of expiration
 - B. Proof of continued good standing on the registry must be provided to the employer

V. Course Review

- A. Brief overview of each lesson
- B. Review of RCPs

Visual Aides:

• Introduce the student to the on-line means to renew certification

RCPS:

• None

Review Questions

- 1. Name common signs of stress and burnout in the healthcare industry
- 2. What is the minimum requirement of hours worked for a healthcare provider within a 24 month period to maintain CNA certification?

Appendix A

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

Student Signature

Date

Instructor Signature

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

Student Signature

Date

Instructor Signature

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

14. Apply a quarter sized amount of the	14. May refer to label for estimated amount
product in a cupped hand and cover all	of product to be placed in palm.
	or product to be placed in paint.
surfaces.	
15. Rub hands palm to palm.	15. Thorough application will reach all
	surfaces of concern.
16. Right palm over left dorsum with	
interlaced fingers and vice versa.	
17. Palm to palm with fingers interlaced.	
18. Backs of fingers to opposing palms with	
fingers interlocked.	
19. Rotational rubbing of left thumb clasped	
in right palm and vice versa.	
20. Rotational rubbing, backwards and	
forwards with clasped fingers of right	
hand in left palm and vice versa.	
21. Allows hands to dry. Waterless hand	21. The product must be dry to be effective.
rubs must be rubbed for at least 10	
seconds or until dry to be effective.	

Student Signature

Date

Instructor Signature

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

Student Signature

Date

Instructor Signature

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

Student Signature

Date

Instructor Signature

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

Standards.

Student Signature

Date

Instructor Signature

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

Student Signature

Date

Instructor Signature

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

Student Signature

Date

Instructor Signature

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

Student Signature

Instructor Signature

Date

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

Student Signature

Date

Instructor Signature

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

Student Signature

Date

Instructor Signature

PROCEDURE #12: ORAL TEMPERATURE (ELECTRONIC)	
STEP	RATIONALE
Do not take oral temperature for a resident	
who is unconscious, uses oxygen, or who is	
confused/disoriented.	
1. Remove thermometer from storage/	
battery charger.	
2. Do initial steps.	
3. Position resident comfortably in bed or chair.	
4. Put on disposable sheath and place	4. The thermometer measures heat from
thermometer under the tongue and to	blood vessels under the tongue.
one side, press button to activate the	
thermometer.	
5. The resident should be directed to	
breathe through their nose.	
6. Instruct resident to hold thermometer	6. The lips hold the thermometer in
in mouth with lips closed. Assist as	position.
necessary.	
7. Leave thermometer in place until	
signal is heard, indicating the	
temperature has been obtained.	
8. Read the temperature reading on the	8. Record temperature immediately so you
face of the electronic device, remove	won't forget. Accuracy is necessary
the thermometer, discard the sheath,	because decisions regarding resident's care
and record the reading.	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.

Student Signature

Date

Instructor Signature
PROCEDURE #13: AXILLARY TEMPERATURE	
STEP	RATIONALE
Often taken when inappropriate to take an	
oral temperature; particularly if resident is	
confused or combative	
1. Remove thermometer from storage/ battery charger.	
2. Do initial steps.	
3. Position resident comfortably in bed or chair.	
4. Put on disposable sheath, remove	4. Places thermometer against blood
resident's arm from sleeve of gown,	vessels to get reading.
wipe armpit and ensure it is dry. Hold	
thermometer in place with end in	
center of armpit and fold resident's	
arm over chest.	
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	7. Record temperature immediately so you
face of the electronic device, remove	won't forget. Accuracy is necessary
the thermometer, discard the sheath,	because decisions regarding resident's care
and record the reading.	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.

Student Signature

Date

Instructor Signature

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

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

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

Student Signature

Date

Instructor Signature

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

Student Signature

Date

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

Student Signature

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

Student Signature

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Date

PROCEDURE #19: SUPINE POSITION	
STEP	RATIONALE
1. Do initial steps.	
2. Lower head of bed.	2. When bed is flat, resident can be moved without working against gravity.
3. Move resident to head of bed if necessary.	3. Places resident in proper position in bed.
4. Position resident flat on back with legs slightly apart.	4. Prevents friction in thigh area.
5. Align resident's shoulder and hips.	5. Reduces stress to spine.
6. Use supportive padding and/or float	6. Maintains position, prevents friction and
heels, if necessary.	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.	

Student Signature

Date

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

Student Signature

Date

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

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Date

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

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Date

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

Student Signature

Date

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

Student Signature

Date

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

Student Signature

Date

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PROCEDURE #26: TRANSFER TO WHEELCHAIR	
STEP	RATIONALE
1. Do initial steps.	
2. Place wheelchair on resident's	2. Unaffected side supports weight. Helps
unaffected side. Brace firmly against	stabilize chair and is shortest distance for
side of bed with wheels locked and	the resident to turn. Wheel locks prevent
foot rests out of way.	chair from moving.
3. Assist resident to sit on edge of bed.	3. Allows resident to adjust to position
Encourage resident to sit for a few	change.
seconds to become steady. Check for	
dizziness.	
4. Stand in front of resident and apply	4. Gait belts reduce strain on your back and
gait belt around the resident's	provides for security for the resident.
abdomen	
5. Grasp the gait belt securely on both	5. Provides security for the resident and
sides of the resident	enables them to turn.
6. Ask resident to place his hands on	6. You may be injured if resident grabs
your upper arms.	around your neck.
7. On the count of three, help resident	7. Allows you and resident to work
into standing position by	together. Minimizes strain on your back.
straightening your knees. Stand toe to	
toe with resident	
8. Allow resident to gain balance, check	8. Change of position may cause dizziness
for dizziness.	due to drop in blood pressure.
9. Move your feet to shoulder width	9. Improves your base of support and
apart and slowly turn resident.	allows space for resident to turn.
10. Lower resident into wheelchair by	10. Minimizes strain on your back.
bending your knees and leaning	
forward.	
11. Align resident's body and position	11. Shoulders and hips should be in straight
foot rests. Remove gait belt.	line to reduce stress on spine and joints.
12. Unlock wheels. Transport resident	12. Provides for safety.
forward through open doorway after	
checking for traffic.	
13. Transport resident up to closed door,	13. Prevents door from closing on resident.
open door and back wheelchair	
through doorway.	
14. Take resident to destination and lock	14. Prevents wheelchair from rolling if
wheelchair.	resident attempts to get up.

15. Do final steps.	
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Student Signature

Date

Instructor Signature

PROCEDURE #27: WALKING	
STEP	RATIONALE
1. Do initial steps.	
2. Assist resident to sit on edge of bed.	2. Allows resident to adjust to position
Encourage resident to sit for a few	change.
seconds to become steady. Check for	
dizziness.	
3. Assist resident to stand on count of	3. Allows you and resident to work
three.	together.
4. Allow resident to gain balance, check	4. Change in position may cause dizziness
for dizziness.	due to a drop in blood pressure.
5. Stand to side and slightly behind	5. Allows clear path for the resident and
resident.	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.	

Student Signature

Date

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PROCEDURE #28: ASSIST WITH WALKER	
STEP	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	4. Helps steady resident.
walker.	
5. Brace leg of walker with your foot and	5. Prevents walker from moving.
place your hand on top of walker.	
6. Assist resident to stand on count of	6. Allows you and resident to work
three, check for balance and dizziness.	together.
7. Stand to side and slightly behind	7. Puts you in a position to assist resident if
resident.	needed.
8. Have resident move walker ahead 6 to	8. Resident may fall forward if he steps too
10 inches, then step up to walker	far into 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.	
9. Do final steps.	

Student Signature

Date

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PROCEDURE #29: ASSIST WITH CANE	
STEP	RATIONALE
1. Do initial steps.	
2. Check the cane for presence of rubber	2. Presence of intact rubber tips decrease
tip(s).	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	4. Allows you and resident to work
three.	together.
5. Allow resident to gain balance. Check	5. Change in position may cause dizziness
for dizziness.	due to a drop in blood pressure.
6. Have resident place cane	
approximately 4 inches to the side of	
his/her stronger/ <u>unaffected foot</u> . The	
height of the cane should be level with	
resident's hip.	
7. Stand to the affected side and slightly	7. Allows clear path for the resident and
behind resident.	puts you in a position to assist resident if
	needed.
8. Have resident move cane forward	8. Reduces risk of resident falls.
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.	
9. Do final steps.	

Student Signature

Date

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PROCEDURE #30: TRANSFER: TO STRETCHER/SHOWER BED	
STEP	RATIONALE
1. Do initial steps.	
2. Loosen sheet directly under resident	2. This sheet will be utilized to slide
and roll edges close to resident.	resident from bed to stretcher.
3. Place stretcher/shower bed at bedside.	3. Wheels must be locked to prevent
NOTE: Make certain wheels are	stretcher from moving.
locked. After locking wheels, ensure	
bed and stretcher/shower bed are at	
the same height. Then lower side rails.	
4. Staff should be present at the bedside	4. To prevent resident from falling/rolling
as well as on the opposite side of the	off of bed or stretcher.
stretcher/shower bed. (Requires a	
minimum of two staff members;	
however the number of staff required	
will be depended upon the size of the	
resident).	
5. Staff should grasp sheet on each side	5. Counting to three enables staff members
of resident. On the count of three,	to work together to distribute weight
slide resident laterally onto	evenly and prevent injury to resident and/or
stretcher/shower bed.	staff.
6. Center and align resident. Place	6. Places resident in proper position and
pillow under his/her head and cover	alignment. Pillow provides comfort;
with a blanket and raise the rails of	blanket maintains dignity, provides
stretcher/ shower bed.	privacy, and keeps resident warm; raising
	the rails prevents resident injury.
7. Do final steps.	

Student Signature

Date

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PROCEDURE #31: TRANSFER: TWO PERSON LIFT *ONLY TO BE USED IN	
AN EMERGENCY	
STEP	RATIONALE
1. Do initial steps.	
2. Place chair at bedside. Brace it firmly	2. Helps stabilize chair and is the shortest
against side of bed. Lock wheels of	distance for staff to turn. Wheel locks
wheelchair or Geri chair.	prevent chair from moving.
3. Assist resident to sit on edge of bed.	3. Allows resident to adjust to position
Ensure there is staff on each sides of	change.
the resident.	
4. Reach around resident's back and	4. Having resident place arms on your
grasp other assistant's forearm above	shoulders or upper arms reduces the chance
wrist. Have resident place arms	of injury to your neck.
around your shoulders (not your	
neck) or on your upper arms.	
5. Each NA should reach under	5. Grasping your partner's forearm
resident's knees and grasp other	provides for support and prevents resident
assistant's forearm above wrist.	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.	

Student Signature

Date

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PROCEDURE #32: SHOWER/SHAMPOO	
STEP	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	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
 4. Turn on water and have resident check water temperature for comfort, if able. 5. Assist resident into shower via wheelchair. Lock wheels of shower chair and 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 	 4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature. 5. Chair may slide if resident attempts to get up. Ensure resident safety at all times. Never transport resident in shower chair.
shower 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. 7. Wet the resident's hair. 	6. Prevents soap and water from entering into resident's eyes and ears.
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. Utilizing fingertips massages the scalp and decreases the risk of scratching the resident.
 9. Rinse the resident's hair thoroughly. 10. Use a conditioner if the resident desires you to do so. 	9. Leaving soap in the hair can cause dry scalp.

11. Encourages resident to be independent
15. Patting dry prevents skin tears and
reduces chaffing.
19. Combing hair in shower room allows
resident to maintain dignity when returning
to room.

Student Signature

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Date

PROCEDURE #33: BED BATH/PERINEAL CARE	
STEP	RATIONALE
1. Do initial steps.	
2. Offer resident urinal or bedpan.	2. Reduces chance of urination during procedure which may cause discomfort and
3. Provide Resident privacy	embarrassment. 3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
4. Fill bath basin with warm water and	4. Resident's sense of touch may be
have resident check water	different than yours; therefore, resident is
temperature for comfort, if able.	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	7. Helps prevent eye infection. Always
outer corner, using a different part of	wash from clean to dirty. Using separate
cloth to wash other eye.	area of cloth reduces contamination.
8. Wet washcloth and apply soap, if	8. Patting dry prevents skin tears and
requested. Wash, rinse and pat dry	reduces chaffing.
face, neck, ears and behind ears.	
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.	17. Soap left on the skin may cause itching

Be sure to wash, rinse and dry well	and irritation.
between the toes.	
18. Repeat with other leg and foot.	
19. Change bath water and gloves, wash	19. Water is contaminated after washing
hands and use clean gloves and towel.	feet. Clean water should be used for neck
	and back.
20. Assist resident to spread legs and lift	20. Exposes perineal area.
knees, if possible.	
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	22. Washes pathogens away from the
leakage, secretions or irritation. Gently	meatus.
wipe four inches of catheter from meatus	
out.	
Perineal Care:	
23. Wipe from front to back and from	23. Prevents spread of infection.
center of perineum to thighs. If	-
washcloth is visibly soiled, change	Females: Removes secretions in skin
cloths.	folds which may cause infection or
	odor.
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:	
A. Pull back foreskin if male is	
uncircumcised. Wash and rinse	
the tip of penis using circular	Males: Removes secretions from beneath
motion beginning with urethra.	foreskin which may cause infection and
B. Continue washing down the penis	odor.
to the scrotum and inner thighs.	
3	1

Rinse off soap and dry. Return	
foreskin over the tip of the penis.	
24. Change water in basin. Wash hands	24. Water used during washing contains
and change gloves. With a clean	soap and pathogens. Soap left on the body
washcloth, rinse area thoroughly in	can cause irritation and discomfort.
the same direction as when washing.	
25. Gently pat area dry with towel in	25. If area is left wet, pathogens can grow
same direction as when washing.	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.	28. Prevents spread of infection.
Rinse and pat dry thoroughly.	
29. Change bath water and gloves. Use	29. Water and linen are contaminated after
clean washcloth and towel.	washing anal area.
30. Wash, rinse and pat dry from neck to	30. Always wash from clean to dirty.
buttocks.	
31. Return to supine position.	
32. Wash hands and change gloves	
33. Help resident put on clean gown.	
34. Do Final Steps	
35. Report any reddened areas, abrasions or bruises to the nurse.	

Student Signature

Date

Instructor Signature

PROCEDURE #34 : BACK RUB	
STEP	RATIONALE
1. Do initial steps.	
2. Place resident in lateral position with	
neck/back toward you.	
3. Expose back and shoulders.	
4. Rub lotion between your hands.	4.Warms lotion and increases resident's
	comfort.
5. Make long, firm strokes along spine	5. Long upward strokes releases muscle
from buttocks to shoulders. Make	tension. Circular strokes increase
circular strokes down on shoulders,	
upper arms and back to buttocks.	circulation in muscle area.
6. Repeat for at least 3-5 minutes.	
7. Gently pat off excess lotion with towel.	7. Provides for resident's comfort.
Cover and position as resident requests.	
8.Do final steps.	

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PROCEDURE #35: BED SHAMPOO	
STEP	RATIONALE
1. Do initial steps.	
2. Gently comb and brush resident's hair.	2. Reduces hair breakage, scalp pain, and irritation.
3. Provide the resident privacy.	3. Maintains resident's dignity and right to privacy by not exposing body.
4. Remove resident's gown or pajama top. Place a towel around resident's neck and shoulders. Lower head of bed.	4. Decreases the chance of resident getting wet.
5. Have resident check temperature of water to be used for comfort, if able.	5. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature
6. Place bed shampoo basin under resident's head according to manufacturer's instructions.	6. If equipment is not applied according to manufacturer's instruction, discomfort or injury could result.
7. Place wash basin on chair to catch water flowing from shampoo basin.	
8. Pour water carefully over resident's hair.	
9. Lather hair with shampoo using fingertips. Rinse thoroughly. Apply conditioner to resident's hair if requested. Rinse thoroughly.	9. Utilizing fingertips massages the scalp and decreases the risk of scratching resident.
10. Squeeze excess water from hair. Towel dry hair.	
11. Replace gown or pajama top.	
12. Comb and brush resident's hair. Dry hair with dryer if resident wishes.	12. Helps maintain resident's dignity and self-esteem.
13. Do final steps.	

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PROCEDURE #36: ORAL CARE FOR THE ALERT AND ORIENTED	
RESI	DENT
STEP	RATIONALE
1. Do initial steps. Check with nurse if the	
resident is on swallowing precautions.	
2. Raise head of bed so resident is sitting	2. Prevents fluids from running down
up.	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 put on apply small	5. Water helps distribute toothpaste.
amount of toothpaste.	
6. First brush upper teeth and then	6. Brushing upper teeth minimizes
lower teeth.	production of saliva in lower part of mouth.
7. Hold emesis basin under resident's chin.	
8. Ask resident to rinse mouth with	8. Removes food particles and toothpaste.
water and spit into emesis basin.	
9. If requested, give resident mouthwash	9. Full strength mouthwash may irritate
diluted with half water.	resident's mouth.
10. Check teeth, mouth, tongue and lips	10. Provides nurse with necessary
for odor, cracking, sores, bleeding and	information to properly assess resident's
discoloration. Check for loose teeth.	condition and needs.
Report unusual findings to nurse.	
11. Remove towel and wipe resident's	
mouth.	
12. Remove gloves.	
13. Do final steps.	
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PROCEDURE #37: ORAL CARE FOR AN UNCONSCIOUS RESIDENT	
STEP	RATIONALE
1. Do initial steps.	
2. Drape towel over pillow and a towel	2. Protects linen.
under resident's chin.	
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	5. Protects resident's clothing and bed
chin.	linen.
6. Dip swab in cleaning solution of 1/2	7. Stimulates gums and removes mucous.
mouthwash and ½ water and wipe	
teeth, gums, tongue and inside	
surfaces of mouth, changing swab	
frequently.	
7. Rinse with clean swab dipped in	8. Removes solution from mouth.
water.	
8. Check teeth, mouth, tongue and lips	9. Provides nurse with necessary
for odor, cracking, sores, bleeding and	information to properly assess resident's
discoloration. Check for loose teeth.	condition and needs.
Report unusual findings to nurse.	
9. Cover lips with thin layer of lip	10. Prevents lips from drying and cracking.
moisturizer.	Improves resident's comfort.
10. Remove gloves.	
11. Do final steps.	

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Date

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PROCEDURE #38: DENTURE CARE	
STEP	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	5. Prevents injury or discomfort to resident.
remove their dentures. Remove upper	And reduces chances of bite for staff.
dentures by placing your index finger	Removing upper dentures first is more
at the ridge on top of the right upper	comfortable for the resident and placing
denture and gently moving them up	your finger at the ridge decreases the
and down to release suction. Turn	chance of stimulating the gag reflex.
lower denture slightly to lift out of	
mouth.	
6. Put dentures in denture cup marked with	
resident's name and take to sink.	
7. Line sink with towel and fill halfway	7. Prevents dentures from breaking if
with water.	dropped.
8. Apply denture cleaner to toothbrush	
9. Hold dentures over sink and brush all surfaces.	
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	11. Removes food particles. Full strength
with water or mouthwash diluted with half water, if requested.	mouthwash may irritate resident's
	mouth.
12. Check teeth, mouth, tongue and lips	12. Provides nurse with necessary
for odor, cracking, sores, bleeding and discoloration. Check for loose teeth.	information to properly assess
Report unusual findings to nurse.	resident's condition and needs.
13. Help resident place dentures in mouth, if	13. Restores resident's dignity and keeps
requested. Moisturize the lips	lips from drying and cracking. Improves

	resident comfort.
14. Remove gloves.	
15. Do final steps.	

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PROCEDURE #39: ELECTRIC RAZOR	
STEP	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	3. Electricity near water may cause
water source, when oxygen is in use or	electrocution. Electricity near oxygen may
if resident has pacemaker.	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	7. Smoothes out skin. Shave beard with
face and neck according to	back and forth motion in direction of beard
manufacturer's guidelines.	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	8. Decreases risk of pain from aftershave
after-shave lotion as resident requests.	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.	

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Date

Instructor Signature
PROCEDURE #40: SAFETY RAZOR	
STEP	RATIONALE
1. Do initial steps.	
2. Raise head of bed so resident is sitting	2. Places resident in more natural position.
up.	
3. Fill bath basin halfway with warm	3. Hot water opens pores and causes
water.	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	6. Softens skin and hair.
spread shaving cream over area.	
7. Hold skin taut and shave beard in	7. Maximizes hair removal by shaving in
downward strokes on face and	the direction of hair growth.
upward strokes on neck.	
8. Rinse resident's face and neck with	8. Removes soap which may cause
washcloth.	irritation.
9. Pat dry with towel.	
10. Apply after-shave lotion, as requested.	10. Improves resident's self-esteem.
11. Remove towel.	
12. Remove gloves.	
13. Do final steps.	

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Date

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PROCEDURE #41: COMB/BRUSH HAIR	
STEP	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.	

Student Signature

Date

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PROCEDURE #42: FINGERNAIL CARE	
STEP	RATIONALE
1. Do initial steps.	
2. Check fingers and nails for color,	2. Provides nurse with information to
swelling, cuts or splits. Check hands	properly assess resident's condition and
for extreme heat or cold. Report any	needs.
unusual findings to nurse before	
continuing procedure.	
3. Raise head of bed so resident is sitting	3. Places resident in more natural position.
up.	
4. Fill bath basin halfway with warm	4. Resident's sense of touch may be
water and have resident check water	different than yours, therefore, resident is
temperature for comfort.	best able to identify a comfortable water
	temperature.
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	8. Clipping nails straight across prevents
file in a curve.	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.	

Student Signature

Date

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PROCEDURE #43: FOOT CARE (BASIN)	
STEP	RATIONALE
1. Do initial steps.	
2. Fill the basin halfway with warm	2. To prevent resident from scalding or
water. Have resident check the water	burning his/her feet.
temperature	
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.	
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	7. Soap left on the skin may cause itching
the toes.	and irritation.
8. Dry entire foot, including between the	8. Thoroughly drying skin reduces
toes.	irritation and chaffing.
9. Repeat steps with the other foot.	
10. 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.	
11. Assist resident to replace socks.	
12. Do final steps.	
13. Report any cuts, sores, or other	
findings to the nurse	

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PROCEDURE #44: CHANGING RESIDENT'S GOWN	
STEP	RATIONALE
1. Do initial steps.	
2. Untie soiled gown.	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,	4. Undressing unaffected arm first requires
unaffected arm first.	less movement.
5. Roll soiled gown from neck down and	5. Rolling reduces spread of infection.
remove from beneath top sheet. Place	
soiled gown in dirty linen bag.	
6. Slide resident's arms into clean gown,	6. Dressing affected side first requires less
affected arm first.	movement and reduces stress to joints.
7. Tie gown.	
8. Remove top sheet from beneath clean	8. Maintains resident's dignity and right to
gown and cover resident.	privacy.
9. Do final steps.	

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Date

Instructor Signature

PROCEDURE #45: DRESSING A DEPENDENT RESIDENT	
STEP	RATIONALE
1. Do initial steps.	
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	5. Dressing affected side first requires less
underwear and pants, affected leg	movement and reduces stress to joints.
first. Pull garments up legs to buttocks.	
6. Slide arm into shirt sleeve, affected	6. Dressing lower and upper body together
side first.	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.	

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Date

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PROCEDURE #46: ASSIST TO BATHROOM	
STEP	RATIONALE
1. Do initial steps.	
2. Assist resident to put on non-skid	
socks/ footwear.	
3. Walk with resident into bathroom.	
4. Assist resident to lower garments and	4. Allows resident to do as much as
sit.	possible to help promote independence.
5. Provide resident with call light and	5. Ensures ability to communicate need for
toilet tissue if resident has been	assistance; Provides for resident's right to
identified as safe to be provided	privacy.
privacy and not mandated to remain	
attended by staff.	
6. Put on gloves.	6. Protects you from contamination by
	bodily fluids.
7. Assist resident to wipe area from	7. Prevents spread of pathogens toward
front to back.	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. Hand washing is the best way to
	prevent the spread of infection.
11. Walk with resident back to bed or chair.	
12. Do final steps.	

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Date

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PROCEDURE #47: BEDSIDE COMMODE	
STEP	RATIONALE
1. Do initial steps.	
2. Assist resident to put on non-skid socks/ footwear.	
3. Place commode next to bed on	3. Helps stabilize commode and is the
resident's unaffected side.	shortest distance for resident to turn.
4. Assist resident to transfer to commode	
by transferring the safest way the resident is able.	
5. Give resident call light and toilet	5. Ensure ability to communicate need for
tissue if resident has been identified as	assistance. Provides resident's right to
safe to be provided privacy and not	privacy.
attended by staff.	
6. Put on gloves.	6. Protects you from contamination by bodily fluids.
7. Assist resident to wipe from front to	7. Prevents spread of pathogens toward
back.	meatus which may cause urinary tract
	infection.
8. Wash hands and change gloves	8. Infection control
9. Assist resident to bed or chair.	
10. Remove and cover pan and take to	9. Pan should be covered to prevent the
bathroom.	spread of infection.
11. Prior to disposal, observe urine	10. Changes may be the first sign of a
and/or feces for color, odor, amount	medical problem. By alerting the nurse,
& characteristics and report unusual	you ensure that the resident receives
findings to nurse.	prompt attention.
12. Dispose of urine and/or feces, sanitize	11. Facilities have different methods of
pan and return pan according to	disposal and sanitation. You need to carry
facility policy.	out the policies of your facility.
13. Remove gloves. Wash hands	
14. Assist resident to wash hands.	13. Hand washing is the best way to
	prevent the spread of infection.
15. Do final steps.	

Student Signature

Date

Instructor Signature

PROCEDURE #48: BEDPAN/FRACTURE PAN	
STEP	RATIONALE
1. Do initial steps.	
2. Lower head of bed.	2. When bed is flat, resident can be moved
	without working against gravity.
3. Put on gloves.	3. Protects you from contamination by
	bodily fluids.
4. Turn resident away from you.	
5. Place bedpan or fracture pan under	5. Equipment used incorrectly may cause
buttocks according to manufacturer	discomfort and injury to resident.
directions.	
6. Gently roll resident back onto pan	6. Prevents linen from being soiled.
and check for correct placement.	
7. Cover resident with sheet/blanket.	7. Provides for resident's privacy.
8. Raise head of bed to comfortable	8. Increases pressure on bladder to
position for resident.	encourage with elimination.
9. Give resident call light and toilet	9. Ensures ability to communicate need for
paper.	assistance.
10. Leave resident and return when	10. Provides for resident's privacy.
called.	
11. Lower head of bed.	11. Places resident in proper position to
	remove pan.
12. Press bedpan flat on bed and turn	12. Prevents bedpan from spilling.
resident.	
13. Wipe resident from front to back.	13. Prevents spread of pathogens toward
Wash hands and change gloves.	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,	16. Changes may be first sign of medical
odor, amount and characteristics and	problem. By alerting the nurse you ensure
report unusual findings to nurse.	that the resident receives prompt attention.
17. Dispose of urine and/or feces, sanitize	17. Facilities have different methods of
pan and return pan according to	disposal and sanitation. You need to carry
facility policies.	out the policies of your facility.
18. Remove gloves. Wash hands	

19. Assist resident to wash hands.	19. Hand washing is the best way to
	prevent the spread of infection.
20. Do final steps.	

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PROCEDURE #49: URINAL	
STEP	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	4. Allows resident to do as much as
urinal between his legs and insert	possible to help promote independence.
penis into opening.	
5. Cover resident.	5. Maintains resident's right to privacy.
6. Give resident call light and toilet	6. Ensures ability to communicate need for
paper.	assistance.
7. Leave resident and return when	7. Provides for resident's privacy.
called.	
8. Remove and cover urinal.	8. Urinal should be covered to prevent the
	spread of infection.
9. Take urinal to bathroom, check urine	9. Changes may be first sign of medical
for color, odor, amount and	problems. By alerting the nurse you ensure
characteristics and report unusual	that the resident receives prompt attention.
findings to nurse.	
10. Dispose of urine, rinse urinal, sanitize	10. Facilities have different methods of
and return urinal according to facility	disposal and sanitation. You need to carry
policies.	out the policies of your facility.
11. Remove gloves. Wash hands	
21. Assist resident to wash hands.	12. Hand washing is the best way to
	prevent the spread of infection.
22. Do final steps.	

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PROCEDURE #50: EMPTY URINARY DRAINAGE BAG	
STEP	RATIONALE
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Place paper towel on floor beneath	3. Reduces contamination of graduate
bag and place graduated cylinder on paper towel.	cylinder and protects floor from spillage.
4. Detach spout (if bag has one) and	4. Prevents contamination of tubing.
point the drainage tube into center of	
graduated cylinder without letting	
tube touch sides.	
5. Unclamp spout and drain urine.	
6. Clamp spout.	
7. Replace spout in holder.	
8. Check urine for color, odor, amount	8. Changes may be first signs of medical
and characteristics and report	problem. By alerting the nurse you ensure
unusual findings to nurse.	that the resident receives prompt attention.
9. Measure and accurately record	9. Accuracy is necessary because decisions
amount of urine.	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	10. Facilities have different methods of
return graduated cylinder according	disposal and sanitation. Follow facility
to facility policies.	policy and procedures.
11. Remove gloves.	-
23. Do final steps.	
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Student Signature

Date

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PROCEDURE #51: URINE SPECIMEN COLLECTION	
STEP	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 peri-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. 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. 	6. A clean collection device is necessary for accurate lab evaluation. Toilet paper will contaminate the urine and produce an inaccurate result.
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. 	
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. 	

Student Signature

Date

Instructor Signature

PROCEDURE #52: STOOL SPECIMEN COLLECTION	
STEP	RATIONALE
1. Do initial steps.	
2. Prepare label for specimen with	2. Label contains resident's identifying
appropriate information and place it	information which is essential for the
on specimen container, not the lid.	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	4. A clean collection device is necessary
bowels, ask him/her not to urinate at	for accurate lab evaluation. Urine
the same time. Ask the resident not to	contaminated stool will produce an
put toilet paper with the sample.	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	8. In order to ensure adequate amount of
two tablespoons of stool and put in the	stool for test ordered. Obtaining material
container. Try to collect material	from different areas ensures that all
from different areas of the stool.	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.	

Student Signature

Date

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PROCEDURE #53: APPLICATION OF INCONTINENT BRIEF	
STEP	RATIONALE
1. Do initial steps.	
2. Put on gloves.	
3. Provide the resident privacy.	3. Privacy
4. Unfasten and remove brief resident is	4. Residents should have soiled briefs
currently wearing and place in small	removed promptly to decrease risk of skin
plastic trash bag for disposal in soiled	breakdown.
utility bag.	
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	7. Plastic may cause irritation of the
hips, plastic side of disposable brief	resident's skin.
away from 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	9. Adjusting brief to a snug fit will prevent
fit.	leakage.
10. Apply resident's clothing	
11. Do final steps.	

Student Signature

Date

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STEPRATIONALE1. Do initial steps2. Collect clean linen in order of use.2. Organizing linen allows procedure to be completed faster.3. Carry linen away from your uniform3. 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 contaminated.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 or room or in bag and place at foot of bed or chair.6. Always work from cleanest (head of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination.7. Fanfold bottom 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.11. Completing one side of bed at a time allows procedure to be completed faster and reduces strain on the caregiver.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	PROCEDURE #54: UNOCCUPIED BED	
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 or room or in bag and place at foot of bed or chair. 6. Always work from cleanest (head of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination. 7. Fanfold bottom sheet to center of bed. 9. Fanfold top sheet to center of bed. 9. Fanfold bolanket over top sheet. 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. 11. Completing one side of bed at a time allows procedure to be completed faster 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	STEP	RATIONALE
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case at the closed end, turning it	_	
inside out over your arm.		

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.	
17. <u>For open bed</u> : make toe pleat and	17. Top edge of top linen must be closest to
fanfold top linen to foot of bed with	head of bed so resident can easily reach
top edge closest to center of bed.	covers.
18. <u>For closed bed</u> : pull bedspread over	18. Toe pleat automatically reduces
pillow and tuck bedspread under	pressure of top linen on feet when resident
lower edge of pillow. Make toe pleat.	returns to bed.
19. Removed soiled linens.	19. Prevents contamination.
20. Do final steps.	

Student Signature

Date

Instructor Signature

STEP 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 contaminated. 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). 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 solied linen on unoccupied side of bed and roll remaining clean linen under resident in the center of the bed. 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.	PROCEDURE #55: OCCUPIED BED	
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remaining clean linen under resident in the center of the bed.	10. Place clean bottom linen on	
remaining clean linen under resident in the center of the bed.	unoccupied side of bed and roll	
in the center of the bed.	-	
11. Smooth bottom sheet out and ensure		
	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. Move to opposite side of bed,	
as resident will now be facing away	
from you.	
13. While resident is lying on side, loosen	13. Always work from cleanest (head of
soiled linen and roll linen from head	bed) to dirtiest (foot of bed) to prevent
to foot of bed, avoiding contact with	spread of infection. Rolling dirtiest surface
your skin or clothing.	of linen inward, lessening contamination.
14. Place soiled linen in barrel or bag at	
foot of bed or in chair.	
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	17. Maintains resident's dignity and right
the resident. Request the resident to	to privacy by not exposing body.
hold the clean top sheet. While	
slipping the bath blanket or previous	
sheet out from underneath the clean	
sheet.	
18. Assist resident with blanket over the	18. Mitering prevents resident's feet from
top sheet and tuck the bottom edges of	being restricted by or tangled in linen when
the top sheet and blanket under the	getting in or out of bed. Prevents pressure
bottom of the mattress. Miter the	on feet which can cause pressure sores.
corners and loosen the top linens over	
the resident's feet.	
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 arm.	
21. Using the same hand that has the pillow	21. Prevents contamination.

	case over it, grasp one narrow edge of	
	the pillow and pull the pillow case over	
	it with your free hand.	
22.	Place the pillow under resident's head	
	with open edge away from the door.	
23.	Assist resident to comfortable position	
	and return the bed to the appropriate	
	position.	
24.	Removed soiled linens from room –	
	carrying away from uniform.	
25.	Do final steps.	
1		

Student Signature

Date

Instructor Signature

PROCEDURE #56: THICKENED LIQUIDS	
STEP	RATIONALE
1. Do initial steps.	
2. Obtain thickener and measuring	2. Measuring spoon is required to ensure
spoon.	proper amount of thickener is utilized to
	obtain ordered thickness.
3. Thicken liquids to desired consistency	3. Physician will specify thickness.
following manufacturer's instructions.	Various brands of thickener require
	different amounts of product to be added.
4. Offer thickened fluid to resident.	4. Decreases risk of resident becoming
Encourage resident to consume	dehydrated.
thickened fluids.	
5. Ensure the water pitcher has been	5. Resident may attempt to drink liquids
removed from the bedside unless	that have not been thickened which will
facility policy states otherwise.	increase risk of choking.
6. Do final steps.	

Student Signature

Date

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PROCEDURE #57: PASSING FRESH ICE WATER		
STEP	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	4. Keeping the ice scoop covered maintains	
container, or cover it with a clean	infection control practices.	
towel or plastic bag to prevent		
contamination.		
5. Proceed to resident rooms, noting any	5. Residents who require a fluid restriction	
fluid restriction(s) prior to pass and	or thickened liquids should not have a	
any residents who require thickened	water pitcher placed at the bedside unless	
liquids.	facility policy states differently.	
6. Empty water from pitcher and	6. Emptying the pitcher of old water will	
bedside glass into the sink. If resident	allow you to fill it with ice and fresh water.	
is on I&O's – record intake of water.	Emptying the glass will allow you to fill it	
	with fresh water.	
7. Take pitcher into hall and fill it with	7. The ice scoop is utilized for all residents	
ice. NOTE: Do not touch the pitcher	thus should not be contaminated by	
with the ice scoop.	touching a water pitcher.	
8. Replace the scoop in covered	8. Maintains infection control practices.	
container, clean towel or plastic bag		
between rooms to prevent		
contamination.		
9. Return to resident's room and fill	9. Ensures that resident has fresh ice water	
pitcher with water at bathroom sink,	in pitcher.	
not allowing pitcher to touch faucet.		
10. Pour fresh water into bedside glass	10. Ensures that water is available and	
and leave a straw with the glass, if	ready for resident when he/she desires it.	
needed.		
11. Offer the resident a drink of fresh	11. Resident may be unable to	
water if resident is present.	independently obtain a drink of water.	
12. Repeat procedure until all residents	12. Ensures that all residents receive fresh	
have been provided with fresh ice	ice water.	
water.		
13. Do final steps.		

Student Signature

Date

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PROCEDURE #58: FEEDING	
STEP	RATIONALE
1. Do initial steps.	
2. Confirm diet card/tray. Check name,	2. This will ensure that the resident is being
diet, utensils and condiments.	served the diet as ordered; at the
	appropriate consistency.
3. Explain procedure.	
4. Have resident wash hands, help the	4. Provides good hygiene in preparation for
resident if needed.	meal consumption.
5. Sit on unaffected side eye level with	5. Encourages interaction with the resident
resident and facing them.	and placement of spoon at an appropriate
	angle.
6. Resident's head should be elevated at	6. Places resident at an angle to promote
least 45 degrees, if in bed.	swallowing and reduce risk of choking.
7. Protect the resident's clothing with a	7. Use of a napkin or clothing protector (if
clothing protector or per facility	resident desires) preserves dignity by
policy and procedures.	keeping clothing clean and free of spillage.
8. Offer different foods; ask resident's	8. Involving the resident encourages
preference.	consumption.
9. Food should be in bite sized pieces or	9. Reduces risk of choking.
with the spoon half full. Food should	
be fed to the unaffected side of the	
mouth.	
10. Allow time for resident to chew and	10. Reduces risk of choking.
empty mouth between bites. Notify	
nurse immediately should choking	
occur.	
11. Frequently offer beverage. If	11. Encourages swallowing.
required, measure I&O's and	
percentage of food eaten.	
12. Make conversation with the resident;	12. Enhances meal experience, thus
atmosphere should be pleasant.	encourages consumption.
13. Cleanse the resident's hands/face as	13. Promotes good hygiene.
needed during the meal and after.	
14. Do final steps.	

Student Signature

Date

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PROCEDURE #59: ASSIST TO EAT	
STEP	RATIONALE
1. Do initial steps.	
2. Confirm diet card/tray. Check name,	2. This will ensure that the resident is being
diet, utensils and condiments.	served the diet as ordered; at the
	appropriate consistency.
3. Confirm any adaptive equipment is	3. Provision of adaptive equipment will
present, if indicated.	encourage resident participation.
4. Assist to protect the resident's	4. Use of a napkin or clothing protector (if
clothing, if desired.	resident desires) preserves dignity by
	keeping clothing clean and free of spillage.
5. Assist to open carton(s), arrange food	5. The resident may have limited hand
items within reach, season foods per	dexterity and/or weakness, making it
resident preference, etc.	difficult to open cartons/containers.
6. Offer assistance if resident appears to	6. Residents may refrain from "asking" for
be having difficulty during meal.	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	7. Promotes good hygiene.
hands/face following the meal.	
8. Assist resident to room or location of	
choice.	
9. Do final steps. Measure I&O's if	
required.	

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Date

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PROCEDURE #60: INSPECTING SKIN	
STEP	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,	3. Redness and warmth indicates that the
shoulder blades, elbows, coccyx, hips,	skin is under pressure and position should
knees, ankles and heels for redness	be changed more frequently.
and warmth.	
4. Check friction areas including under	4. Pressure, rubbing and perspiration will
breasts and arms, between buttocks,	cause skin to break down.
groin, thighs, skin folds, contracted	
areas, and around any tubing for	
redness, irritation, moisture and odor.	
5. Undrape resident.	
6. Report any unusual findings to the	6. Provides nurse with necessary
nurse immediately.	information to properly assess resident's
	condition and needs.
7. Do final steps.	

Student Signature

Date

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PROCEDURE #61: FLOAT HEELS	
STEP	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,	3. Placing the pillow directly under the
leaving heels in the air and free from	heels can increase pressure on heels.
pressure. (Do not use rolled pillows	
or blankets.)	
5. Do final steps.	

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Date

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PROCEDURE #62: BED CRADLE		
STEP	RATIONALE	
1. Do initial steps.		
2. Place bed cradle on bed according to	2. If equipment is not applied according to	
manufacturer's instructions.	manufacturer's instructions, discomfort or	
	injury could result.	
3. Cover bed cradle with top sheet and	3. Keeps the top linens from applying	
bedspread/blanket.	pressure/weight to toes, feet and lower	
	legs.	
4. Do final steps.		

Student Signature

Date

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PROCEDURE #63: PASSIVE RANGE OF MOTION	
STEP	RATIONALE
1. Do initial steps.	
2. Position resident in good body	2. Reduces stress to joints.
alignment.	
3. Observe joints. If swelling, redness or	3. Indicates inflammation in joint which
warmth is present, or if resident	can be worsened if procedure is continued.
complains of pain, notify nurse.	
Continue procedure only if instructed.	
4. Support limb above and below joint.	
5. Begin range of motion at shoulders	5. Allows you to control joint movement
and include the shoulders, elbows,	and minimize resident's discomfort.
wrists, thumbs, fingers, hips, knees,	
ankles and toes.	
6. Slowly move joint in all directions it	6. Rapid movement may cause injury.
normally moves.	
7. Repeat movement at least five times.	7. Ensures benefit from procedure.
8. Encourage resident to participate as	8. Promotes resident's independence and
much as possible.	self-esteem.
9. Stop procedure at any sign of pain	9. Pain is a warning sign for injury.
and report to nurse immediately.	
10. Do final steps.	

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Date

PROCEDURE #64: SPLINT APPLICATION	
STEP	RATIONALE
1. Do initial steps.	
2. Observe affected joints. If swelling,	2. Indicates inflammation in joint which
redness, or warmth is present or if	can be worsened if splint is applied.
resident complains of pain, notify	
nurse. Continue procedure only if	
instructed.	
3. Apply splint according to therapy	3. Application of splint not in accordance
recommendation and physician's	with therapy recommendation could cause
order.	injury or discomfort to resident.
4. Remove splint after designated period	4. Indicates inflammation in joint.
of time. Cleanse the skin, dry	Notifying nurse provides him/her with
thoroughly and again observe for	information to assess resident's condition
swelling, redness, warmth, complaint	and needs.
of pain or open area. Notify the nurse	
if present.	
5. Do final steps.	

Student Signature

Date

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PROCEDURE #65: ABDOMINAL BINDER	
STEP	RATIONALE
1. Do initial steps.	
2. Check the skin for redness, open	2. Allows you to identify early signs of
areas, or needed incontinence care.	skin breakdown and the need for cleansing
	prior to binder application.
3. Place binder flat on the bed and ask	3. A binder placed above the waist
resident to lie down with upper	interferes with breathing; one placed too
border at the upper waist and lower	low interferes with elimination and
border at the level of the gluteal fold.	walking.
If resident is in bed, assist him/her to	
roll side-to-side while placing binder	
underneath him/her in the same	
position.	
4. Bring the ends of binder around the	4. A snug fit provides maximum support.
resident, and overlap them.	If the binder is too loose, efficacy is
Beginning at the bottom of the binder,	impaired. If it is too tight, resident may be
secure the Velcro fastener strip so	uncomfortable.
that the binder fits snugly.	
5. Ensure that there are no wrinkles or	5. Wrinkles and creases put pressure on the
creases in the binder.	skin increasing the risk for excoriation.
6. Do final steps.	

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Date

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PROCEDURE #66: ABDUCTION PILLOW	
STEP	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	3. Securing the straps prevents the pillow
the pillow's indentations. Raise each	from slipping out of place.
leg slightly by lifting under the knee	
and ankle to bring straps under and	
around leg and then secure the straps	
to the pillow.	
4. Do final steps.	
5. Report resident intolerance or	5. Provides nurse with information to
complaint of pain upon application to	assess resident's condition and needs.
the nurse.	

Student Signature

Date

Instructor Signature
PROCEDURE #67: KNEE IMMOBILIZER	
STEP	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. 3. The caregiver will lower the leg into 	2. It is important to maintain the leg in a straight position while placing the immobilizer and to monitor for any skin problems/breakdown.
 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 	6. Constant contact with the edge of the immobilizer can place the skin at risk of
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.	breakdown. Early detection of any concern can prevent further breakdown.
 7. Report to the nurse any skin irritation, open area, or complaint of pain. 8. Do final steps. 	7. Reporting to the nurse will ensure that treatment is obtained, if needed.

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Date

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PROCEDURE #68: PALM CONES	
STEP	RATIONALE
1. Do initial steps.	
2. Cleanse and thoroughly dry resident	2. Cleansing and drying of hands prevents
hand.	odor and infection.
3. Place cone with clean cover in	
resident palm.	
4. Observe hand(s) every shift; cleanse	3. Allows you to identify early signs of
and thoroughly dry hands. Observe	skin breakdown.
for areas of redness, swelling or open	
areas and report to the nurse, if noted.	
5. Note covering of palm cone and send	4. Maintaining cleanliness enhances
to laundry when soiled, re-covering	resident's dignity.
cone with a clean covering, as needed.	
6. Do final steps.	

Student Signature

Date

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PROCEDURE #69: NASAL CANNULA CARE	
STEP	RATIONALE
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by
	bodily fluids.
3. Remove nasal cannula and clean	3. Removes any accumulation of dried
nostrils with a soft cloth or tissue once	drainage that may be present.
each shift or as needed.	
4. Note any redness or irritation of the	4. Provides nurse with necessary
nares or behind the ears and notify	information to properly assess resident's
nurse if present. Continue procedure	condition and needs.
only if instructed.	
5. Replace nasal cannula. Do not cinch	5. Nasal cannula too tight can cause
side up too tightly	discomfort.
6. Remove gloves.	
7. Do final steps.	

Student Signature

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Date

PROCEDURE #70: ASSISTING WITH HEARING AIDS	
STEP	RATIONALE
1. Do initial steps.	
2. Gently clean resident's ear with a	2. To ensure ears are clean prior to
damp washcloth. Clean hearing aid of	insertion of hearing aids, thus ensuring
wax and dirt when needed according	maximum acuity.
to manufacturer's instructions	
3. Insert hearing aid into resident's ear.	
4. Assist to adjust the volume control to	4. To ensure that aid is turned up high
a desired level.	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.	

Student Signature

Date

Instructor Signature

PROCEDURE #71: ELASTIC/COMPRESSION STOCKING APPLICATION OR	
TED HOSE	
STEP	RATIONALE
1. Do initial steps.	
2. Observe skin prior to applying the	2. Provides nurse with information to
stockings for any redness, warmth,	assess resident's condition and needs.
swelling, excessive dryness, or open	
area. Notify nurse if abnormalities	
present. Continue procedure only if	
instructed.	
3. Apply the hose before resident gets	3. Hose should be applied before veins
out of bed.	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	7. Wrinkles, creases, or twisted areas can
areas.	irritate the skin and interfere with
	circulation.
8. Remove the hose at least twice daily	8. Allows you to identify early signs of
for skin care unless otherwise	skin break down.
indicated by physician.	
9. Do final steps.	

Student Signature

Date

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PROCEDURE #72: POST MORTEM CARE	
STEP	RATIONALE
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Respect the family's religious	3. Residents/families have the right to
restrictions regarding the care of	freedom of religion.
body, if applicable.	
4. Assist roommate to leave the area	4. Reduces the roommates stress.
until body is prepared and removed, if	
applicable.	
5. Place body in supine position.	5. Prepares body for procedure.
6. Place one pillow beneath resident's	6. Prevents blood from discoloring the face
head.	by settling in it.
7. Close the eyes.	
8. Insert dentures, if this is the facility	8. It is easier to put dentures in the mouth
policy, and close the mouth.	right away and gives the face a natural
	appearance.
9. Cleanse body as necessary. Comb	9. Prepares the body for viewing by family
hair.	and friends.
10. Place a pad under the buttocks to	10. Due to total loss of muscle tone, urine
collect any drainage.	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.	

Student Signature

Date

Instructor Signature

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. Hand washing
- 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

Lesson 4

- 1. Touching an infected person and then proceeding to touch another person without washing one's hands
- 2. Touching a contaminated object and then proceeding to touch a person without washing one's hands.
- 3. No

- 1. Clutching the throat
- 2. MSDS Material Safety Data Sheet
- 3. Call for nurse and stay with resident, assist the nurse with positioning the resident on

his/her side, place padding under head and move furniture away from resident, do not restrain resident or place anything in mouth, loosen resident's clothing, especially around the neck, after the seizure stops, assist nurse to check for injury, note duration of seizures and areas involved.

Lesson 6

- 1. **R**emove residents from area of immediate danger; Activate the fire alarm; Contain the fire, if possible (close doors); Extinguish, if possible.
- 2. **P**ull the pin; **A**im at the base of the fire; **S**queeze the handle; **S**weep back and forth at the base of the fire
- 3. Stop, drop and roll to smother the flames

Lesson 7

- 1. 60 100 beats per minute
- 2. The average BP range for adults is systolic blood pressure: <u>100-139</u>; Normal range for Diastolic blood pressure is <u>60-89</u> however, it depends on the individual.
- 3. Place your hand on the resident's chest and feel the chest rise and fall during breathing

Lesson 8

- 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 9

1. False

Lesson 10

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 <u>away from</u> the urethra and not toward the urethra where pathogens could enter.

Lesson 11

- 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 12

- 1. A clean catch mid-stream requires that genitalia be cleansed prior to collecting the urine specimen.
- 2. True

Lesson 13

- 1. Calendar, clock, familiar pictures, visual cues
- 2. True

Lesson 14

- 1. Dry mouth, weight loss, foul smelling urine, dark urine, cracked lips and sunken eyes
- 2. Water
- 3. Nectar thick, honey thick, pudding thick
- 4. True

Lesson 15

- 1. True
- 2. True
- 3. True

Lesson 16

- 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 17

- 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

- 1. False
- 2. True

3. True

Lesson 19

- 1. redness, warmth, tenderness, open area
- 2. True
- 3. True

Lesson 20

- 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 21

- 1. A delusion a fixed, false belief.
- 2. An elopement
- 3. Validation Therapy
- 4. Sundowning

Lesson 22

- 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 23

- 1. True
- 2. False

- 1. True
- 2. True

Lesson 25

- 1. cold/clammy skin, double or blurry vision, shaking/trembling, hunger, tingling or numbness of skin
- 2. True

Lesson 26

- 1. True
- 2. True

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.)

- 1. Exhibiting anger toward co-workers and/or residents; arguing with a supervisor or coworkers 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 for a healthcare provider at least one eight hour shift every twentyfour months.