NATAP

NURSE ASSISTANT
TRAINING & ASSESSMENT
PROGRAM

December 2018

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INTRODUCTION

The Nurse Assistant Training and Assessment Program (NATAP) Model Curriculum is updated/revised every 3-4 years in order to keep the strong foundation curriculum current with the community standards of practice. The original curriculum published in 1994, revised in 1998, 2004, 2010, and 2013 has provided guidance to hundreds of Nurse Assistant programs. However, health care is a constantly changing environment with new knowledge appearing in practice every day. A prime example can be found in the area of Confidentiality (HIPAA), Disaster Preparedness, the use of electronic medical records, patients' rights, special needs of persons with developmental and mental disorders, and prevention of abuse. In recent years, there has also been a move to lessen the "institutional" feel of long term care facilities and more emphasis has been given to promoting independence and dignity of residents. The revised curriculum has also expanded the Recommended Teaching Strategies and Assignments, Clinical Demonstration/Method of Evaluation and Updated Terminology, references and sample test questions. The intent of the most recent revision was to include new terminology and new procedures that reflect the current practices, to assist instructors with more resources, and to improve the health care given to residents in long-term care facilities.

The NATAP Model Curriculum meets the requirements set forth in California Code of Regulations, Title 22, Section 71835 Certification Training and Competency Evaluation Program and Omnibus Budget Reconciliation Act, 42 Code of Federal Regulations, Sections 483.152-483.158. The curriculum also meets the requirements for 60 hours of theory and 100 hours of clinical stated in the California Health and Safety Code, Title 22, Section 1337.3(c)(2).

The purpose, philosophy and conceptual framework of the curriculum foundation have held fast over the past nineteen years. The organization of the content is arranged to verify the compliance of content with the California Department of Public Health (CDPH) guidelines. Nurse Assistant educators from across the state were convened to revise the curriculum and input was sought from experts from various fields of health care.

DESCRIPTION

The model curriculum was developed following California Department of Public Health Services (CDPH) guidelines. The theory and clinical hours listed are the minimum hours of study required to meet CDPH's approval. However, additional time is strongly encouraged to adequately cover the material. A majority of Nurse Assistants are prepared in the Regional Occupation Programs and Adult Education programs. Therefore, this approach has enabled the faculty to expand the content in a less restricted length of time.

The model curriculum is organized into seventeen (17) modules, with each module containing lesson plans. The lesson plans include performance standards which should be met at a minimum percentage, terminology, suggested learner activities, suggested teaching strategies, references, content for each standard, suggested evaluation methodology, clinical applications, manual skills (where appropriate), handouts and sample test items. Educators are encouraged to mold the curriculum to suit their program needs.

The performance standards are broad, whereas the suggested content for each standard is specific, allowing for multiple teaching and evaluation strategies. Suggestions for teaching are given, but instructors are encouraged to personalize the teaching strategies to their own style and add literacy.

It is suggested that the sample test items be used in a pre/post-test format, as quiz items, or as part of a unit final. The instructor is encouraged to expand upon these items, as they represent only a sample of the content. The level of student performance expected should be determined by the instructor to meet both curriculum goals and standards of practice, especially those related to resident safety.

In addition, students should demonstrate proficiency in all clinical tasks. Preset performance standards determine the level of performance expected to ensure that the Nurse Assistant has the skills necessary to consistently perform these tasks safely. Since multiple skills are exhibited during patient care, it is expected that ongoing observation and evaluation of resident care skills will occur throughout the clinical experience. The National Nurse Aide Assessment Program (NNAAP) manual skills check list published in the California Nurse Assistant Candidate Handbook by Pearson Vue can be used to monitor the successful completion of these skills. The steps listed in the NNAAP skills are used in the manual skills certification exam. You can download the California Nurse Assistant Candidate Handbook at http://www.asisvcs.com/publications/pdf/070500.pdf.

Instructors who evaluate students should provide feedback throughout the training. Areas that require improvement should be discussed with the student in addition to strategies or remedies for improvement. The student may or may not be able to experience each clinical application in the educational setting, but the instructor should provide the opportunity for students to either role-play or demonstrate and allow return demonstration for the application of these skills.

The model curriculum may be used for classroom and educational purposes only. It is prohibited by copyright law to reproduce any portion of this model curriculum for inclusion in products with a profit intention. Do not add any other name or change any portions of this curriculum.

Please refer to the CDPH Training Review Unit website for all other information regarding Nurse Assistant Training. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/TPRU.aspx

GOAL AND OBJECTIVES

The Nurse Assistant Training and Assessment Program Model Curriculum has been developed to prepare the Nurse Assistant for certification by the State of California as an entry-level worker on a health care team in a long-term care facility. The curriculum is structured to provide theory and practical application on skills needed to function as a Certified Nurse Assistant.

In order to achieve the stated goal, the curriculum is designed to focus on the needs of learners and society at large by:

- Providing learning experiences that respond to learner interests;
- Promoting clarity and understanding of the larger world;
- Fostering development of citizenship and economic survival skills;
- Developing learners' feelings of self-understanding and personal worth;
- Implementing a curriculum that meets Omnibus Budget Reconciliation Act (OBRA), California Code of Regulations (Title 22), and Health and Safety Code Guidelines for safe and quality care in long-term care settings;
- Promoting consistency in training that responds to practice as reflected in the State Certification Exam; and
- Promoting consistency and equity between different teaching environments.

LIST OF NURSE ASSISTANT CURRICULUM MODULE TITLES

Module 1 Introduction to Nurse Assistant

Module 2 Patient/Resident Rights

Module 3 Communication/Interpersonal Skills

Module 4 Prevention and Management of Catastrophe and Unusual Occurrences

Module 5 Body Mechanics

Module 6 Medical and Surgical Asepsis

Module 7 Weights and Measures

Module 8 Patient Care Skills

Module 9 Patient Care Procedures

Module 10 Vital Signs

Module 11 Nutrition

Module 12 Emergency Procedures

Module 13 Long Term Care Patient/Resident

Module 14 Rehabilitative Nursing

Module 15 Observation and Charting

Module 16 Death and Dying

Module 17 Patient/Resident Abuse

Module 1: Introduction to Nurse Assistant
Minimum Number of Theory Hours: 2
Suggested Theory Hours: 5
Recommended Clinical Hours: 0

Statement of Purpose:
The purpose of this unit is to introduce the student to California Code of Regulations, Division 5, Title 22, which regulates health care facilities, and to introduce the roles and responsibilities of the Nurse Assistant, including requirements for Nurse Assistant certification, professionalism, ethics, and confidentiality.

Terminology:

1. Activities of Daily Living (ADL) sheet
2. California Code of Regulations
3. California Department of Public Health (CDPH)
4. Citation
5. Confidentiality
6. Dignity
7. Ethics
8. Health & Safety code
9. Health Insurance Portability and Accountability Act (HIPAA)
10. Insubordination
11. Job description
12. Long-term care facility
13. Mandated reporter
14. MediCal
15. Medicare
16. Nursing Facility
17. Omnibus Budget Reconciliation Act (OBRA)
18. Privacy
19. Professionalism
20. Scope of Practice
21. Skilled nursing facility (SNF)
22. Title 22, Division 5
23. Violation

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of the two (2) hours of class plus homework assignments, the learner will be able to:

1. Define key terminology
2. Discuss the legal implications of California Code of Regulations, Title 22, Division 5, and OBRA
3. Identify Nurse Assistant requirements as set forth in Title 22, and OBRA
4. Describe the qualities of a successful Nurse Assistant
5. Describe the role and responsibilities of the Nurse Assistant
6. Describe professionalism for the Nurse Assistant.
7. Explain the ethical behavior expected of the Nurse Assistant
8. Describe behaviors that maintain confidentiality

References:

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    1987- https://www.ncbi.nlm.nih.gov/pubmed/2671955
    1989- 1990- https://www.congress.gov/bill/101st-congress/house-bill/3299/text
    1993- https://www.congress.gov/bill/103rd-congress/house-bill/2264

Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Discuss the legal implications of California Code of Regulations Title 22, Division 5 and OBRA.** A. California Code of Regulations (CCR) Title 22, Division 5 1. California state laws enacted by legislature to establish a. Licensing and certification standards of health facilities b. Minimum standards of care for the patient/resident c. Regulations which govern the Nurse Assistant Training Program d. Nurse Assistant certification requirements – initial and renewal 2. Skilled Nursing Facilities must be licensed 3. Skilled Nursing Facilities must have policies and procedures to ensure patient's/resident's rights and safety 4. Violations of Title 22 may lead to issuance of a state citation with a fine	A. Lecture B. Discussion	A. Written test B. Class participation

B. Omnibus Budget Reconciliation Act (OBRA) of 1987 incorporated into Federal law (42 Code of Federal Regulations (CFR) part 483 subpart B) 1. Requirement that nurse aides receive training and pass a competency exam within four months of employment in a skilled nursing facility 2. Establishes standards of patient/resident care for Medicare and Medi-Cal reimbursement 3. Authorizes the Federal Government to contract with the individual states to do Federal onsite surveys for compliance with regulations 4. Violation of Federal regulations may lead to remediation such as: a. Loss of the facility's ability to provide a Nurse Assistant training program b. Civil money penalties c. Directed in-services d. Denial of payment e. State monitoring f. Termination of facility license		
Objective 3 **Identify Nurse Assistant requirements as set forth in Title 22 and OBRA** A. Complete Nurse Assistant training course approved by the California Department of Public Health (CDPH) 1. Minimum of 60 hours of mandated theory, including 10 required hours for Alzheimer's Disease and Elder Abuse 2. Minimum of 100 hours of clinical training in a skilled nursing facility 3. Course content must comply with Title 22 and OBRA 4. Students who are employees of a skilled nursing facility must be paid an hourly wage while in training 5. Criminal screening upon enrollment in Nurse Assistant course work 6. History & Physical exam, Tuberculosis clearance 7. HS - 283B Initial application form	A. Lecture/Discussion B. Share with students how to access forms online at CA Department of Public Health Website for licensing requirements https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/CNA.aspx C. Show samples of Applications forms 1. Handout 1.3a-	A. Written test B. Application form completed C. Criminal screening completed

B. Successfully complete the state competency test 1. Includes a written and skills test 2. Three opportunities to pass 3. Competency test fee 4. Facility must pay competency test fee if the student is an employee 5. If student is hired by a skilled nursing facility within a year of passing the competency test, the facility must reimburse the competency test fee C. California has contracted with two vendors to give the state competency examination 1. Chancellor's Office, California Community Colleges, which contracts with Pearson Vue, administrators of the National Nurse Aide Assessment Program (NNAAP) Examination for the California Nurse Assistant Registry 2. American Red Cross D. Criminal clearance prior to certification E. Certification renewal requirements 1. Complete the CDPH renewal application – HS 283C form 2. Complete 48 hours of approved in-service/continuing education hours every two years with at least 12 of the 48 hours completed in each of the two years. 24 of these hours can be done online now 3. Verify at least one day of work for pay, providing nursing - related services in the past two years 4. Criminal clearance – repeat fingerprinting not required F. Competency Evaluation Approval by CDPH 1. If approved to test, candidate will receive the Certified Nurse Assistant Competency Evaluation Approval Form CDPH 932 (06/09) 2. Form must contain the state stamp and seal to be valid 3. Form lists date by which the candidate must successfully pass the evaluation 4. Form must be presented at time of testing 5. Candidate's Right thumb fingerprint will be applied to form each time candidate tests	HS283B also found in Appendix E 2. Handout 1.3b-HS283C also found in Appendix F 3. Note when copying HS283C form, copy on yellow paper D. Maintain student files for compliance with CDPH including Title 22 and OBRA E. Share other resources 1. Pearson Vue California NNAAP website www.pearsonvue.com 2. Regional Testing Center So. California www.regionaltestingcenter.org 714-895-8708 3. NNAAP Testing Center No. California 916-485-6000 4. NNAAP Testing Center Central California 805-965-0581 x 2783 5. American Red Cross 323-780-7627	

6. If candidate does not pass testing, the candidate will need to. 7. Retain the form for re-testing.		
Objective 4 **Describe qualities of a successful Nurse Assistant.** A. Dependable B. Considerate C. Pleasant D. Empathetic E. Flexible F. Honest G. Compassionate and caring H. Sensitive to others I. Respectful J. Cooperative K. Team player L. Observant M. Well groomed N. Organized O. Respectful of cultural differences	A. Lecture/Discussion B. Have students research the history of nursing and report findings regarding current Nurse Assistant duties, professionalism and behavior	A. Written test B. Demonstrates qualities when providing care to patient/resident
Objective 5 **Describe the role and responsibility of the Nurse Assistant.** A. Health care team members 1. Patient/resident 2. Family 3. Registered Nurse (RN) 4. Nurse Practitioner (NP) 5. Physician's Assistant (PA) 6. Licensed Vocational Nurse (LVN) 7. Certified Nurse Assistant (CNA) 8. Restorative Nurse Assistant (RNA) 9. Physician 10. Physical Therapist (PT) 11. Occupational Therapist (OT) 12. Speech Therapist 13. Dietician 14. Activities Director	A. Lecture/Discussion B. Role play activity: Students take on one of the team member roles and describes what the role would be for a patient/resident who has had a stroke or other debilitating disease C. Have students create a wall size organizational chart for the classroom with the lines of authority	

15. Social Worker 16. Clergy 17. Ombudsman B. Health care settings in which Nurse Assistants are employed 1. Skilled nursing facility (SNF) 2. Acute hospital 3. Intermediate Care Facility (ICF) – ICF/Developmentally Disabled Habilitative (ICF/DDH) –ICF/Developmentally Disabled Nursing (ICF/DDN) 4. Hospice 5. Assisted Living/Residential Care/Board & Care Facilities 6. Psychiatric Facilities 7. Clinics 8. Prison System Facilities 9. Alzheimer's units C. Supervision of Nurse Assistant 1. The direct supervisor of the Nurse Assistant is a licensed nurse (RN, LVN or LPN) that is functioning as the Charge Nurse 2. May also be accountable to a. Director of Staff Development (DSD) b. Director of Nursing c. Facility/Agency Administrator d. Physician (in a clinic setting) D. Nurse Assistant Scope of Practice 1. Scope of Practice— are the tasks that the Nurse Assistant is allowed to perform according to state and federal law and facility policies 2. Provide uniform, safe care 3. Provide care according to educational standards 4. Legal concept—functioning within the scope of practice protects the Nurse Assistant and the facility E. Responsibility of Nurse Assistant in patient/resident care 1. Provide a safe environment for the patient/resident a. Proper use of equipment and protective devices b. Awareness of potential hazards (such as liquid spills)	Abuse reporting form SOC341 also found in Appendix G and online at: www.cdss.ca.gov E. Have students search several job descriptions for local employing agencies, focusing on expectations and commitment required for employment	

c. Practice personal hygiene and cleanliness d. Care for patient's/resident's personal property e. Adhere to standard precautions 2. Meet the patient's/resident's physical needs a. Observe changes in patient's/resident's physical status and report as needed b. Assist with activities of daily living c. Assist with medical and rehabilitative activities (vital signs, turning, collecting specimens, ambulation, etc.) d. Maintain a clean environment e. Assist with ADLs in a timely manner f. Document care provided as required by facility policy 3. Assist the patients/residents to meet their psychosocial, emotional, spiritual and cultural needs 4. Observe changes in patient's/resident's mental status and report as needed 5. Assist with patient/resident comfort and anxiety relief 6. By protecting Patient's Rights, the Nurse Assistant will ensure that the patient/resident will: a. Be treated with dignity and respect b. Feel secure c. Be recognized as an individual d. Love and be loved e. Feel a sense of accomplishment f. Feel good about themselves g. Follow personal beliefs h. Receive nursing care that assures cultural recognition and acceptance F. Mandated Reporter 1. Nurse Assistants are legally required to report suspected or observed abuse or neglect 2. Abuse Report form SOC341 G. Responsibilities of Nurse Assistant to employer 1. Report to work on time 2. Fulfill assigned schedule reliably 3. Notify supervisor when ill in a timely manner		

4. Work as a team member 5. Perform one's job to the best of his or her ability as specified by job description 6. Conserve supplies and equipment		
Objective 6 **Describe professionalism for the Nurse Assistant.** A. Definition of professionalism. Carrying out patient/resident care in a manner that is: 1. Ethical 2. Competent 3. Knowledgeable 4. Caring 5. Committed 6. Representative of high standards B. Professional behaviors or attitudes 1. Being skilled and caring while performing care 2. Being responsible, trustworthy, truthful (e.g., reporting change of address to CDPH, keeping a record of in-service education/CEU's) 3. Attending in-service/educational activities to improve skills and knowledge 4. Showing compassion for others 5. Being a team player 6. Doing the best job possible 7. Asking for assistance when necessary 8. Being a mandated reporter 9. Understanding scope of practice for licensed personnel (RN, LVN, DON) a. Nurse Practice Act b. Delegation of duties c. Job description of permitted nursing skills for nurse assistant 10. Maintaining current Nurse Assistant certification 11. Maintaining a professional appearance a. Daily bath/shower and use of deodorant b. Shampoo hair on a regular basis, treat dandruff and other	A. Lecture/Discuss B. Role play scenarios	A. Written test B. Demonstrates professional behavior and appearance

g. Uniform should be clean and pressed daily. h. Follow facility policy for body piercings and tattoos.		
Objective 7 **Explain the ethical behavior expected of the Nurse Assistant.** A. Ethical behavior for patient/resident care means the Nurse Assistant should 1. Protect life 2. Promote health 3. Preserve dignity 4. Keep personal information confidential 5. Respect each person as an individual (e.g. religious beliefs, cultural differences) 6. Give care based on need, not gratuities B. Ethical behavior for work includes 1. Working assigned shift 2. Arriving on time for work 3. Being absent only when necessary 4. Notifying employer prior to necessary absences in a timely manner 5. Following instructions given by supervisor within scope of practice 6. Being a loyal, flexible cooperative team member C. Unacceptable behaviors which may result in dismissal 1. Any abuse of patients/residents 2. Stealing or willfully damaging property 3. Insubordination 4. Neglecting duties 5. Altering or falsifying records or reports 6. Working under the influence of alcohol or drugs 7. Dishonesty in any form 8. Breaching confidentiality	A. Lecture B. Discussion	A. Written test B. Demonstrates ethical behavior in patient/resident care
Objective 8 **Describe behaviors that maintain confidentiality.** A. Confidentiality can be maintained by discussing personal information only with appropriate health team members at appropriate times and appropriate places	A. Lecture/Discussion B. Have students access the HIPAA guidelines	A. Written Test B. Maintains patient/resident

B. Examples of maintaining confidentiality 1. Adhering to HIPAA guidelines 2. Discussing observations with nurse or patient's/resident's physician 3. Discussing the patient's/resident's care while participating in team conference/planning C. Examples of breaching confidentiality include discussing personal information with: 1. Another patient/resident 2. Concerned friends or visitors 3. Members of the news media 4. Members of Nurse Assistant's family 5. Persons in the community 6. Health team not directly involved with patient/resident care	online. https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html	

Sample Test: Module 1- Introduction to Nurse Assistant

1. The term used for persons living in long-term care facilities is:
    A. Senior citizen
    B. Elder adult
    C. Retiree
    D. Patient/resident

2. The successful Nurse Assistant should be:
    A. Honest
    B. Dependable
    C. Organized
    D. All of the above

3. The responsibilities of a Nurse Assistant are listed in a:
    A. Job description
    B. Procedure
    C. Job title
    D. Resume

4. As a Nurse Assistant, your scope of practice includes:
    A. Bathing and dressing patients/residents
    B. Taking telephone orders from the doctor
    C. Assigning patient care
    D. Giving medications

5. What should the Nurse Assistant do if asked to do something he or she doesn't know how to do?
    A. Ask another Nurse Assistant to do the task
    B. Tell the nurse he or she is uncertain and ask for help
    C. Refrain from doing the task
    D. Do the task anyway

6. Which member of the long-term health care team provides the most hands-on care to the resident?
    A. Physician
    B. Charge nurse
    C. Nurse Assistant
    D. Nursing supervisor

7. The direct supervisor of the Nurse Assistant is the:
    A. Physician
    B. Charge nurse
    C. Administrator
    D. Director of Nursing

8. California Code of Regulations, Title 22 establishes:
    A. Salary for certified Nurse Assistant's
    B. Minimum standards of patient care
    C. The certified Nurse Assistant's work schedule
    D. Maximum standards of patient care

9. Which of the following describes the minimum number of theory and clinical hours in a Nurse Assistant program approved by the California Department of Health Services?
    A. 54 Hours theory, 180 hours supervised clinical training
    B. 48 Hours theory, 150 hours supervised clinical training
    C. 40 Hours theory, 60 hours supervised clinical training
    D. 60 Hours theory, 100 hours supervised clinical training

10. A California Nurse Assistant is renewing his/her certification. How many in-service/continuing education hours must an individual take in a two-year period in order to renew Nurse Assistant certification?
    A. 28 Hours
    B. 30 Hours
    C. 48 Hours
    D. 58 Hours

11. How many hours must a Nurse Assistant work for pay in each renewal period?
    A. 48 Hours
    B. 8 Hours
    C. 24 Hours
    D. 50 Hours

12. Which best defines Medicare?
    A. State Medical Welfare Funding
    B. Medical funding for persons under 65 years of age
    C. Medical funding for children only
    D. Medical benefits for persons age 65 and over

13. Which of the following situations should the Nurse Assistant report to the Director of Nursing?
    A. A patient/resident has fallen
    B. The nurse in charge is suspected of abusing a patient/resident
    C. The physician has asked for the Nurse Assistant's help
    D. A patient/resident refuses to cooperate with treatment

14. The role of the ombudsman is to:
    A. Drive the buses for special outings
    B. Listen to and resolve patient/resident problems
    C. Serve snacks
    D. Bring newspapers and magazines

15. HIPAA refers to:
    A. Hepatitis A
    B. Confidentiality
    C. Standard precautions
    D. Nutrition

16. A Nurse Assistant may insure a patient's/resident's dignity by:
    A. Knocking on the patient's/resident's room door before entering
    B. Introducing him/herself prior to giving care
    C. Calling the patient/resident by his/her proper name
    D. All of the above

17. The Nurse Assistant must submit fingerprints to the CDPH:
    A. After taking the state test
    B. When changing employers
    C. Every 2 years
    D. Once in a lifetime upon enrollment in a Nurse Assistant course

18. A mandated reporter:
    A. Must report suspected abuse
    B. Must report actual abuse
    C. Must report abuse told to them by a visitor
    D. All of the above

19. Prior to working directly with patients/residents, the Nurse Assistant must complete a facility orientation and:
    A. Have a TB clearance
    B. Buy a wrist watch
    C. Have a negative drug test
    D. Receive CDPH certification

20. The responsible Nurse Assistant will arrive at work:
    A. Exactly at the designated time
    B. A few minutes before the designated time
    C. Within 15 minutes of the designated start time
    D. With enough time to be ready to start work at the designated time

21. Upon successful completion of a Nurse Assistant training program, the candidate has how much time to complete the state competency exam?
    A. 4 months
    B. 6 months
    C. 1 year
    D. 2 years

22. The overall purpose of OBRA is to:
    A. Set hours when clinical training may be done
    B. Improve quality of life for patients/residents in nursing facilities
    C. Keep safety records up to date
    D. Prevent injuries

23. What is the maximum number of times that the State Competency Exam may be taken?
    A. Once (1)
    B. 3 times
    C. 5 times
    D. 10 times

24. A Nurse Assistant may be dismissed from a job because of:
    A. Falsifying documents or records
    B. Patient/resident neglect
    C. Theft of a patient/resident or hospital property
    D. All of the above

25. The Nurse Assistant should not:
    A. Make a self-introduction to the patient/resident
    B. Ask about the patient's/resident's bank account
    C. Ask how the patient/resident would like to be addressed
    D. Knock each time before entering the patient's/resident's room

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

Date Completed

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE.
SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information (Ombudsman use only - WIC 15636(a))

Name (Last Name, First Name)	Age	Date of Birth	SSN

Gender Identity	Sexual Orientation	Ethnicity	Race
☐ Male ☐ Female ☐ Transgender ☐ Other/Nonbinary ☐ Unknown/Not Provided	☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Questioning ☐ Unknown/Not Provided		Language (Check one) ☐ Non-Verbal ☐ English ☐ Other (Specify) _____

Address (If facility, include name and notify ombudsman)	City	Zip Code	Telephone

Present Location (If different from above)	City	Zip Code	Telephone

☐ Elderly (65+) ☐ Developmentally Disabled ☐ Mentally Ill/Disabled ☐ Physically Disabled ☐ Unknown/Other

☐ Lives Alone ☐ Lives with Others

B. SUSPECTED ABUSER Check if ☐ Self-Neglect

Name of Suspected Abuser			

Address	City	Zip Code	Telephone

☐ Care Custodian (Type)_____ ☐ Parent ☐ Son/Daughter ☐ Other _____
☐ Health Practitioner (Type)_____ ☐ Spouse ☐ Other Relation _____

Gender ☐ Male ☐ Female	Ethnicity	Age	D.O.B

Height	Weight	Eyes	Hair

C. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section "Reporting Responsibilities and Time Frames" within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.) or concerns about the client's mental health.

☐ CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

D. REPORTING PARTY Check appropriate box if reporting party waives confidentiality to
☐ All ☐ All but victim ☐ All but perpetrator

Name	Signature	Occupation	Agency/Name of Business

Relation to Victim/How Abuse is Known	Street	City	Zip Code

Telephone	E-mail Address

E. INCIDENT INFORMATION - Address where incident occurred

Date/Time of Incident(s)

Place of Incident (Check One)
☐ Own Home ☐ Community Care Facility ☐ Hospital/Acute Care Hospital
☐ Home of Another ☐ Nursing Facility/Swing Bed ☐ Other (Specify)_____

F. REPORTED TYPES OF ABUSE (Check All that Apply)

1. Perpetrated by Others (WIC 15610.07 & 15610.63)
a. ☐ Physical (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication)
b. ☐ Sexual
c. ☐ Financial
d. ☐ Neglect (including Deprivation of Goods and Services by a Care Custodian)
e. ☐ Abandonment
f. ☐ Isolation
g. ☐ Abduction
h. ☐ Psychological/Mental
i. ☐ Other _____

2. Self-Neglect (WIC 15610.57 (b)(5))
a. ☐ Neglect of Physical Care (e.g. personal hygiene, food, clothing, malnutrition/dehydration)
b. ☐ Self-Neglect of Residence (unsafe environment)
c. ☐ Financial Self-Neglect (e.g. inability to manage one's own personal finances)

Abuse Resulted In (Check All that Apply)
☐ No Physical Injury ☐ Minor Medical Care ☐ Hospitalization ☐ Care Provider Required
☐ Death ☐ Mental Suffering ☐ Serious Bodily Injury* ☐ Other (Specify)_____
☐ Unknown ☐ Health & Safety Endangered

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE
(Family, significant others, neighbors, medical providers, agencies involved, etc.)

Name	Relationship
Address	Telephone
Name	Relationship
Address	Telephone

H. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE
(If known, list contact person) If Contact person check ☐

Name			Relationship
Address	City	Zip Code	Telephone

I. TELEPHONE REPORT MADE TO ☐ APS ☐ Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of State Hospitals ☐ Calif. Dept. of Developmental Services

Name of Official Contacted by Phone	Telephone	Date/Time

J. WRITTEN REPORT Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury*, please refer to "Reporting Responsibilities and Time Frames" in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.

Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed
Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed
Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed

K. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received By	Date/Time

2. Assigned ☐ Immediate Response ☐ Ten-Day Response ☐ No Initial Response (NIR) ☐ Not APS ☐ Not Ombudsman ☐ No Ten-Day (NTD)

Approved By	Assigned To (optional)

3. Cross-Reported to ☐ CDPH-Licensing & Cert.; ☐ CDSS-CCL; ☐ Local Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Calif. Dept. of State Hospitals; ☐ Law Enforcement; ☐ Professional Licensing Board; ☐ Calif. Dept. of Developmental Services; ☐ APS; ☐ Other (Specify) _____
Date of Cross-Report _____

4. APS/Ombudsman/Law Enforcement Case File Number

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. **Abuse** means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. **Neglect** means the negligent failure of an elder or dependent adult or of any person having the care or custody of an elder or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. **Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES AND TIME FRAMES:

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

*__Serious bodily injury__ means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury, report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:

    - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.

    - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.

- For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

REPORTING PARTY DEFINITIONS

Mandated Reporter (WIC Section 15630 (a)) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

Care Custodian (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing are or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders; (g) Independent living centers; (h) Camps; (i) Alzheimer's Disease Day Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging; (o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

Health Practitioner (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.

Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, "Report of Suspected Dependent Adult/Elder Financial Abuse".

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine (WIC Section 15630(h)).

No one, including a supervisor, employer, or lawyer, can excuse a mandated reporter from his or her personal legal duty to report known or suspected abuse. Anyone who attempts to impede or inhibit a mandated reporter from reporting may be prosecuted for a misdemeanor punishable by a fine, imprisonment, or both. Mandated reporters are therefore expected to report any such efforts to law enforcement, as well as any other responsible agency (see Welfare and Institutions Code Section 15630(f) and (h).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under "Reporting Responsibilities and Time Frames"); and keep one copy for the reporter's file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.

DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.

State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:
California Department of Public Health (CDPH)
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE (916) 327-2445 FAX (916) 552-8785

CERTIFIED NURSE ASSISTANT (CNA) / HOME HEALTH AIDE (HHA) IN-SERVICE TRAINING / CONTINUING EDUCATION UNITS (CEUs)

To assure the availability of trained personnel in Skilled Nursing (SNF) and Intermediate Care Facilities (ICF), the Legislature intends that all such facilities in California participate in approved training programs. All approved In-Service Training programs are specified to enhance the knowledge and skills, assure continuing competency, and address performance issues one may be experiencing as a CNA/HHA. CNAs are to receive the normal hourly wage for attending the In-Service on their regularly scheduled shift or during another shift. **Only CDPH-approved In-Service Training Programs and CDPH-approved CEU providers with a Nurse Assistant Certification Number (NAC#) are accepted.** CNAs and HHAs that are employed in a SNF, ICF, or Home Health Agency will submit the information below to ATCS for validation of the renewal requirements. CNAs or HHAs that obtain CEUs from CDPH-approved CEU providers must attach a copy of each individual CEU course certificate for renewal validation.

A. **CNAs:** Must obtain forty-eight (48) hours of In-Service Training/CEUs within the certification period. A minimum of twelve (12) of the forty-eight (48) hours shall be completed in each year of the two (2) year certification period. A maximum of twenty-four (24) of the forty-eight (48) hours may be obtained only through a CDPH-approved online computer training program listed on our website. Online CEU certificates must be attached to this form for validation. Please visit www.cdph.ca.gov for a complete listing of CDPH-approved classroom and online computer CEU providers. If the CDPH-approved HHA Training Program (40-hour program) was completed during the certification period, twenty-six (26) hours of the forty (40-hour) training program may count towards CEUs. Training less than 50 mintues increments cannot be counted towards the CEU/In-Service training renewal requirement.

B. **HHAs:** Must obtain twenty-four (24) hours of In-Service Training/CEUs within the certification period. Twelve (12) of the twenty-four (24) hours are required in each year of the two (2) year certification period (HHAs may not use online CEUS to meet the renewal requirement).

C. **CNA & HHA:** Follow section A and B to renew both certificates.

D. **Continuing Education:** CEUs must be obtained only through a **CDPH-approved provider with a valid NAC#**. Courses taken for credit must enhance the knowledge and skills of the CNA/HHA and enhance the skills in the employer-based healthcare settings.

E. **Continuing In-Service Training:** This training must be provided by a department-approved provider that is a health facility where the CNA/HHA has been employed within the most recent certification period.

F. **Licensed Vocational Nurse / Registered Nurse / Licensed Psychiatric Technician programs:** CNA/HHA certificate holders will receive In-Service Training/CEUs for completion of these courses by converting the units into hours as follows: one (1) semester unit = fifteen (15) hours, one (1) quarter unit = ten (10) hours. You must submit a copy of your school transcript to verify your enrollment and completion of this coursework.

Training obtained from:	**Sections to be completed on Form CDPH 283A**
Skilled Nursing and/or Intermediate Care Facility	Complete column A, B, C, D and E
Hospice	Complete column A, B, C, D and E
Home Health Agency	Complete column A, B, C, D and E
CDPH-approved providers with a NAC# (In-class and online)	Complete column A, B, C and D. **Certificates of completion must be submitted for renewal validation.**
Licensed Vocational Nurse / Registered Nurse / Licensed Psychiatric Technician programs	Complete column A, B, C and D. **A copy of your school transcripts must be attched to this form to verify enrollment and completion of this coursework.**

UNDERSTANDING THE CERTIFICATION PERIOD

The initial CNA/HHA certificate is issued for two birthdays, not two calendar years, and will expire on your birthday. Each year of the certification period will be from one birthday to the following birthday. Any additional time from the effective date until the first birthday will be counted towards the first year of the certification period.

Example:

Effective Date – 03/20/18
Expiration Date – 05/15/20
Birthday – 05/15/XX

First year of certification period – 03/20/18 - 05/15/19
Second year of certification period – 05/16/19 - 05/15/20

From the expiration date on, it will expire every two years

Next certifiation period

First year of certification period – 05/15/20 - 05/15/21
Second year of the certification period – 05/16/21 - 05/15/222

This record shall be submitted with the Renewal Application (CDPH 283 C) and retained by the CNA/HHA for a period of four (4) years.

State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:
California Department of Public Health (CDPH)
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE (916) 327-2445 FAX (916) 552-8785

CERTIFIED NURSE ASSISTANT (CNA)/ HOME HEALTH AIDE (HHA) IN-SERVICE TRAINING/CONTINUING EDUCATION UNITS (CEUS)

USE THIS PAGE TO LOG YOUR FIRST YEAR OF CONTINUING EDUCATION/IN-SERVICE

First year of my certifcation period: **From:** _____ **To:** _____

Printed Name of CNA/HHA _____ **Social Security Number:** _____ **Certificate Number:** _____

A	B	C	D	E
TITLE OF TRAINING OR COURSE ☒ **(Check box for Online Training)**	**SNF/ICF/HOSPICE/HOME HEALTH AGENCY NAME AND CDPH IN-SERVICE ID# OR CDPH-APPROVED PROVIDER NAME AND NAC#**	**DATE OF ATTENDANCE** (MM/DD/YY)	**HOURS OBTAINED**	**SIGNATURE OF INSTRUCTOR RESPONSIBLE FOR TRAINING** (FOR INSTRUCTOR USE ONLY)
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			TOTAL HOURS FOR FIRST YEAR OF CERTIFICATION PERIOD:	

I certify under penalty and perjury under the state and federal laws that the information contained in this application and supporting documents, is true and correct. It shall be unlawful for any person not certified under Health and Safety Code (1200-1797.8) to hold himself or herself out to be a certified nurse assistant and/or home health aide.

_____ _____
Signature of Applicant Date

Please copy this page if additional pages are needed for first year CEUs

This record shall be submitted with the Renewal Application (CDPH 283 C) and retained by the CNA/HHA for a period of four (4) years.

INFORMATION COLLECTION AND ACCESS-PRIVACY STATEMENT

Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code Section 17520, subdivision (d), the California Department of Public Health CDPH) is required to collect social security numbers from all applicants for nursing assistant certificates, home health aide certificates, hemodialysis technician certificates or nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number will result in the return of your application. Your social security number will be used by CDPH for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

Module 2: Patient/Resident Rights
Minimum Number of Theory Hours: 3
Suggested Theory Hours: 5
Recommended Clinical Hours: 1

Statement of Purpose:
The purpose of this unit is to introduce the Nurse Assistant to patient/resident rights. The fundamental principle behind patient/resident rights is that each patient/resident is a member of a family and of society as a whole. They must be cared for in a manner that protects their rights and meets the individual family, psychosocial and spiritual needs in a long-term care setting. These rights are protected by federal and state regulations.

Terminology:

1. Abuse
2. Advance Directive
3. Aiding and abetting
4. Assault
5. Battery
6. Choice
7. Chronic
8. Coercion
9. Confidential
10. Defamation
11. Defamation of character
12. Do Not Resuscitate (DNR)/ No Code
13. Ethical standard
14. False imprisonment
15. Financial abuse
16. Grievances
17. HIPAA
18. Informed consent
19. Involuntary seclusion
20. Laws
21. Legal standard
22. Libel
23. Mandated reporter
24. Neglect
25. Negligence
26. Ombudsman
27. Physical abuse
28. Policy and Procedure
29. Privacy
30. Psychological abuse
31. Resident council
32. Restraints
33. Scope of practice
34. Sexual abuse
35. Slander
36. Social services
37. Theft
38. Verbal abuse

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):
Upon completion of the three (3) hours of class plus homework assignments and one (1) hour of clinical experience, the learner will be able to:

1. Define key terminology
2. Explain the purpose of a long-term care facility
3. Recognize the role of the Nurse Assistant in maintaining patient/resident rights, as stated in federal and state regulation
4. Compare California Code of Regulations Title 22, Division 5, Chapter 3, 72527, with Title 42 Code of Federal Regulations 483.10 regarding patient/resident rights
5. Explain the Nurse Assistant role in preventing negligent acts and violation of patient/resident rights
6. Describe the Nurse Assistant role in reporting patient/resident rights violations
7. Describe the role of an ombudsman
8. Identify examples of patient/resident rights, which support a patient's/resident's need for security, belonging and self-esteem

References:

1. Acello, B. & Hegner, B. (2016). Nursing Assistant: A Nursing Process Approach. (11th ed). Boston, MA. Cengage Learning.
2. Acello, B. (2016). Workbook to accompany: Nursing Assistant: A Nursing Process Approach. (11th ed). Boston, MA. Cengage Learning
3. CA Attorney General's publications available at https://www.safestates.org/page/Publications
4. California Code of Regulations, Title 22, Division 5, Chapter 3, Section 72527 (2014). Patients'/Residents' Rights. http://carules.claws.us/code/t.22_d.5_ch.3_art5_sec.72527
5. California Department of Public Health (CDPH) Nursing Home Residents' Rights https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NursingHomeResidentsRights.aspx
6. California Health and Safety Code, Sections 1599.1, 1599.2, 1599.3 http://www.search-california-law.com/research/section/ca/HSC/4.25/index.html
7. Carter, P. J. (2017). Lippincott Essentials for Nursing Assistants: a Humanistic Approach to Caregiving. (4th ed.) Philadelphia, PA. Lippincott Williams & Wilkins
8. Code of Federal Regulations, Title 42, 483.1, 483.12, 483.13, 483.15 https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-part483.xml
9. Deck, M. L. (2004). Instant Teaching Tools for the New Millennium. St Louis, MO. Mosby
10. Hedman, S. A., Fuzy, J., & Rymer, S. (2018). Hartman's Nursing Assistant Care: Long-Term Care (4th ed.). Albuquerque, NM. Hartman Publishing, Inc.
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12. Haroun, L. & Royce, S. (2004). Teaching Ideas and Activities for Health Care. Albany, NY. Delmar Publishers
13. HIPAA Regulations https://www.hhs.gov/hipaa/for-professionals/index.html
14. Patient's Bill of Rights from Center for Medicare & Medicaid Services https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Patients-Bill-of-Rights.html
15. Pearson Vue (2018) California Nurse Assistant Candidate Handbook for National Nurse Aide Assessment Program. Philadelphia, PA. Pearson Education, Inc.
16. Sorrentino, S. A., Remmert, L., & and Kelly, R. (2018) Workbook and Competency Evaluation Review for Moby's Textbook for Nursing Assistants (9th ed.) St. Louis, MO. Mosby Company
17. Sorrentino, S.A. and Remmert, L. (2018) Mosby's Textbook for Nursing Assistants. (9th ed.). St Louis, MO. Elsevier
18. The Omnibus Budget Reconciliation Act of 1987, 1989, 1990.1993
    1987- https://www.ncbi.nlm.nih.gov/pubmed/2671955
    1989- 1990- https://www.congress.gov/bill/101st-congress/house-bill/3299/text
    1993- https://www.congress.gov/bill/103rd-congress/house-bill/2264
19. Weaver, L. & Wilding, M. (2013) The Dimensions of Engaged Teaching: a Practical Guide for Educators. Bloomington, IN. Solution Tree Press

Content Outline	Recommended Teaching	Clinical Demonstration/

	Strategies and Assignments	Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Explain the purpose of a long-term care facility.** A. Provide physical care B. Provide focused care for patients/residents with special needs C. Provide a team approach to care and services D. Prevent illness/injury and loss of function E. Promote recovery and health in a setting that serves as both care facility and residence F. Assist patient/resident in reaching their maximum potential both physically and mentally	A. Lecture/Discussion B. Arrange for tour of a long-term care facility C. Arrange for a guest speaker from a long-term care facility	A. Written test B. Class participation
Objective 3: **Recognize the role of the Nurse Assistant in maintaining patient/resident rights, as stated in federal and state regulations.** A. The Nurse Assistant is responsible for being familiar with regulations that provide for patient/resident rights and for assisting patients/residents to exercise their rights B. Patient/resident rights are protected by federal regulations for long-term care facilities C. Title 42, Code of Federal Regulations Resident Rights (483.10): Residents living in a health care facility	A. Lecture/Discussion B. Locate facility policies, procedures, and patient/resident rights documents C. Role-play a situation that involves a threat to	A. Written test B. Class participation C. Locate facility policies, procedures, and patient/resident rights documents D. Consistently promotes

should have the same rights as those held by all U.S. Citizens. 1. Residents have the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising their rights. They include: a. Quality of life 1) Residents have the right to the best care available 2) Dignity, choice and independence are important b. Services and activities to maintain high level of wellness 1) Residents must have the correct care that should keep them as healthy as possible every day 2) Health should not decline as a direct result of the facility's care c. The right to be fully informed about rights and services 1) Residents must be told what care and services are available 2) They must be told the charges for each service 3) Legal rights must be explained in a language they understand, a written copy is given to them a) Right to be notified in advance of any room change or roommate b) Right to communicate with someone who speaks their language c) Right to obtain assistance for any sensory impairment, e.g., blindness 4) Informed consent is a concept that goes along with this. A person has the right to direct what happens to his or her body d. The right to make independent choices 1) Residents have the right to make choices about their doctors, care and treatments 2) Rights to make personal decisions. These include what to wear and how to spend their time. They can join in community activities, both inside, and outside the nursing home e. The right to privacy and confidentiality 1) Residents can expect privacy with care given. Their	patient/resident rights	patient/resident rights

medical and personal information cannot be shared with anyone but the healthcare team 2) Residents have the right to private, unrestricted communication with anyone they choose (HIPAA protects residents' privacy) f. The right to dignity, respect and freedom 1) Resident must be treated with dignity by caregivers 2) They cannot be abused in any way g. The right to security of possessions 1) Resident's personal possessions must be safe at all times. They cannot be taken or used by anyone without resident's permission 2) Residents have the right to manage their own finances h. The right to complain 1) Residents have the right to complain without fear or punishment 2) Facility must quickly try to resolve complaints i. The right to participate in their own care j. The right to visits, receive mail, and telephone calls D. Admission, Transfer and Discharge (483.12): 1. Residents have the rights to stay in a facility unless a transfer or discharge is needed. Location changes must be made safely and with resident knowledge and consent 2. Policies related to the admission of the resident must be based on the ability to provide adequate care 3. Those policies for transfer and discharge activities must be based on the resident's needs and welfare, concern for the safety and welfare of other residents, or as a result of nonpayment for services a. Transfer and discharge requirements 1) Notice of 7 days bed-hold policy and readmission requirements 2) Equal access to quality care regardless of payment b. Admission policy 1) Resident care policies 2) 30 days' notification prior to permanent discharge		

E. Resident Behavior and Facility Practices (483.13) 1. The resident has the right to be free from any physical restraints imposed, or from psychoactive drugs that are administered for the purpose of discipline or convenience and are not required for treatment of the resident's medical symptoms 2. Restraint a. Physical (i.e. soft belt, bed rails, geri-chair, mittens, soft ties, locked wheelchair, lap buddy-if cannot be removed by patient) b. Chemical (i.e. psychotropic drugs) 3. Freedom from abuse a. Financial; stealing or borrowing items or accepting gifts b. Verbal; teasing, profanity, racial slanders, threats c. Sexual; overtures, innuendo, gestures, inappropriate touching d. Physical; battery, kicking, biting, hitting, shoving, pulling hair, rough handling e. Psychological; ridiculing, ignoring, manipulating f. Involuntary seclusion; isolation g. Abandonment; leaving someone unattended h. Neglect; failure to provide care that a reasonable person would provide. (i.e. not answering call light, smells of urine and not being cleaned/changed) F. Role of Nurse Assistant 1. Self-care; personal stress management (i.e. identify stressors), take breaks, take lunch, proper nutrition, exercise, sleep, support network of family and friends, seek out professional intervention as needed 2. Communication with supervisors 3. Identify resident abuse; signs and symptoms, suspected, verbal account, witnessed or known 4. Mandated reporter; SOC341 (reporting form), aiding and abetting, ombudsman, California Department of Public Health (CDPH) 5. Documentation		

G. Quality of Life (483.15) 1. The resident must be cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life 2. Care and environment includes: a. Dignity b. Self-determination and participation c. Participation in resident and family groups d. Participation in other activities e. Accommodation of needs f. Activities g. Social Services h. Personal living environment 3. Identify environmental and personal living area hazards to prevent incidents and/or accidents		
Objective 4: **Compare California Code of Regulations Title 22, Division 5, Chapter 3, 72527, with Title 42 Code of Federal Regulations 483.10 regarding patient/resident rights.** A. Residents shall be encouraged/assisted to exercise their rights as a patient and as a citizen, 72527(a). Written policies regarding patient rights must be established and available 1. Patient must be informed of rights, rules and regulations regarding patient conduct 2. Patient must be informed of services and charges 3. Patient must be informed of medical condition by doctor and have opportunity to participate in planning of medical treatment 4. Patient can refuse treatment and be informed of consequences (informed consent) 5. Patient can be transferred or discharged only for medical reasons, welfare, other patients' welfare, or for nonpayment 6. Patient shall be assisted to exercise rights, voice grievances, recommend changes in policy and services, have outside representation, and freedom from restraint, interference, coercion, discrimination and reprisal	A. Lecture/Discussion B. Handout 2.4a: California Code of Regulations, Title 22, Division 5, Chapter 3, 72527 C. Handout 2.4b- California Health and Safety Code	A. Written test B. Class participation

7. Patient allowed to manage their personal finances 8. Patient has right to be free from mental and physical abuse and chemical and physical restraints 9. Confidential treatment of records a. Health Insurance Portability and Accountability Act (HIPAA) b. Standards and safeguards for documentation and transmission of health records to assure privacy and security of this data 10. Patient has right to be treated with consideration, respect, dignity, and individuality, including privacy 11. Patient has right to not be required to perform work 12. Patient has right to be able to communicate privately and send/receive mail 13. Patient has right to participate in social or religious activities 14. Patient has right to be allowed to retain and use personal clothing and possessions 15. If married, to be provided privacy and share a room if both are patients in the facility 16. Patient has right to have daily visiting hours 17. Patient has right to have visit by clergy at any time 18. Patient has right to have relatives, or person responsible to visit critically ill patient at any time 19. Patient has right to be allowed privacy for visits 20. Patient has right to be allowed access to telephone and confidential calls 21. Right to participate in the electoral process - voting B. Patient rights may only be denied or limited for good cause evidenced by doctor's order and may be denied or limited only if allowed by law C. California Health and Safety Code (Skilled Nursing and Intermediate Care Facility Patient's Bill of Rights) 1. [1599.1] Written policies regarding the rights of patients shall be established and made available to patient, guardian, next of kin, sponsor, and public a. In addition to patient rights and obligations defined in the		

regulations 1) The facility shall employ adequate, qualified staff 2) Assure personal hygiene of patients, including prevention of pressure ulcers and incontinence 3) Provide diet to meet patient needs 4) Activities and promotion of self-care b. The facility shall be clean, sanitary and in good repair including the nurses call system 2. [1599.2] Written information informing patients of their rights include facility requirements in the Health and Safety Code and Title 22. a. Violations of either code may be grounds for civil or criminal proceedings against the facility or its personnel b. Patients have the right to voice grievances free of reprisal and to submit complaints to the Department of Public Health Services (CDPH) 3. [1599.3] Rights of patients who are determined to be incompetent, incapable of understanding, exhibits a communication barrier are to be carried out/protected by guardian, next of kin, conservator, sponsoring agency or representative unless it is the facility		
Objective 5 **Describe the Nurse Assistant role in preventing negligent acts and violations patient/resident rights.** A. Explain the difference between negligence and abuse B. Recognize the evidence of negligent acts and violations of patient/resident rights C. Explain how to prevent violations of patient/resident rights D. Define facility, state, and federal policies and procedures related to violation of patient/resident rights	A. Lecture/Discussion B. Video from Textbook C. Downloadable publications from CA Attorney General's office available at https://www.safestates.org/page/Publications	A. Written test B. Class participation

Objective 6 **Describe the Nurse Assistant role in reporting patient/resident** rights **violations.** A. Identify patient/resident rights violations B. Discuss your observations with a licensed nurse/appropriate personnel C. Report observations as a mandated reporter, following federal mandate for reporting suspected or actual patient/resident rights violations D. Follow up on reported incident with licensed personnel	D. Lecture/Discussion E. Video from Textbook	A. Written test B. Class participation
Objective 7 **Describe the role of an ombudsman.** A. Patient advocate and member of the health care team B. Impartial person who investigates complaints and acts as an advocate for patients/residents and/or families to resolve conflicts C. Legal responsibility of an ombudsman to follow facility protocol D. Gives information to the public	A. Lecture/Discussion B. Arrange for an ombudsman to speak to the class	A. Written test B. Class participation
Objective 8 **Identify examples of patient/resident rights, which support a patient's/resident's need for security, belonging, and self-esteem.** A. Physiological 1. Food 2. Water 3. Oxygen 4. Sleep 5. Sex 6. Temperature extremes B. Safety & Security: asepsis, knowledge of patient's/resident's individual needs 1. Freedom from fear and anxiety 2. Stability 3. Consistency in routine 4. Freedom from pain	A. Lecture/Discussion B. Handout 2.7a- Maslow's Hierarchy of Needs C. Handout 2.7b- Example of Human Needs as related to Maslow	A. Written test B. Class participation

C. Belonging: love and affection 1. This is the patient's/resident's home 2. Sense of belonging (psychosocial needs) 3. Acceptance and love 4. Receive family, friends, and visitors in home-like environment D. Self-esteem 1. Ask opinion and really listen 2. Feeling competent 3. Gaining respect, approval and recognition E. Self-actualization 1. Pride in accomplishment; opportunity to do their best 2. Attain full learning, creative, and spiritual potential		

Sample Test: Module 2- Patient/Resident Rights

1. The Patient's Bill of Rights is:
   A. Given to patients/residents when they request it
   B. Provided to all patients/residents upon admission
   C. Given to clients who are receiving home care
   D. Not a legal document

2. Consumers of health care are responsible for:
   A. Being honest with the physician
   B. Withholding information from health care providers
   C. Requesting a Nurse Assistant who will care for them
   D. Doing what the physician says

3. Healthcare consumers always have the right to:
   A. Receive respectful and considerate care
   B. Refuse to pay their bill
   C. Select the Nurse Assistant they want to care for them
   D. Have visitors any hour of the day or night

4. Documents that provide instructions about the patient's/resident's wishes for treatment when the patient/resident is unable to communicate their wishes are called:
   A. Medical records
   B. Advanced Directives
   C. Resident Bill of Rights
   D. Policies and Procedures

5. Informed consent means that the:
   A. Physician makes all health care decisions for the patient/resident
   B. The nurse makes some decisions for the patient/resident
   C. The patient/resident makes decisions based on full disclosure of procedures, benefits, and risks
   D. The patient/resident is old enough to sign for treatment

6. A grievance is:
   A. A form the patient/resident fills out when they have a complaint
   B. Denial of services or treatment due to insurance
   C. Patient/resident refusing to pay a bill
   D. A complaint

7. Healthcare workers:
   A. Do not need to know the Patient's Bill of Rights
   B. Should refer questions about "rights" to the admissions coordinator
   C. Must not discuss patient/resident rights because of confidentiality concerns
   D. Must be familiar with the Patient's Bill of Rights

8. When an elderly person is admitted to the long-term care facility, they have the right to:
   A. Have relatives stay overnight in their room
   B. Have personal items in their room
   C. Have the kitchen prepare food for them on their request
   D. Bring their pet with them

9. The rights of patients/residents in long –term care facilities:
   A. Were legislated by OBRA in 1987
   B. Include the right to make independent medical choices
   C. Are more restrictive than rights in other healthcare settings
   D. Do not include informed consent

10. The purpose of a long-term care facility is to:
    A. Provide care for persons who cannot care for themselves at home
    B. Provide emergency care for the elderly
    C. Provide surgical care for the elderly
    D. Keep elderly people together and away from other age groups

11. A resident has been at home with his family all day. The Nurse Assistant notices new bruises on the patient's/resident's back when he returns. The Nurse Assistant should:
    A. Report the bruises to the licensed nurse
    B. Ask family members the next time they visit
    C. Say nothing to the patient/resident about the bruises
    D. Wait to see if it happens again

True or False

12. _____ The Nurse Assistant does not need to be familiar with the Patient's Bill of Rights.
13. _____ The patient/resident has the right to be free from restraints.
14. _____ The patient/resident has the right to know about his or her diagnosis and prognosis.
15. _____ The patient/resident has the right to refuse treatment.
16. _____ The patient/resident has the right to know if a student is providing care for him or her.
17. _____ The patient/resident has the right to know the cost of care.
18. _____ If a visitor asks you a question about a patient's/resident's medical condition, it is alright to tell them.
19. _____ You may be found guilty of invasion of privacy if you open a patient's/resident's mail.
20. _____ Upon admission to the long-term care facility, the patient/resident should receive notices of right, rules, and services.
21. _____ An ombudsman is someone who helps resolve grievances between a patient's/resident's family and the facility.
22. _____ An Advance Directive is part of the admission process and is required.

Matching

A. Patient/Resident Rights	E. Grievance
B. Confidentiality	F. Advanced Directive
C. Client's Rights in Home Care	G. Corporal Punishment
D. Informed Consent	H. HIPAA

23. _____ Not revealing private information
24. _____ Standards and safeguards for documentation and transmission of patient health records
25. _____ Use of physical force
26. _____ The document that guarantees the rights of the consumer of home care facilities
27. _____ Complaint
28. _____ The document that guarantees the rights of the consumer in a long-term care facility
29. _____ A document that states the patient's/resident's wishes for care in the event they are unable to
30. _____ Permission given for care after the procedures have been explained

California Code of Regulations, Title 22, Division 5, Chapter 3, 72527

Patients/Residents have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

1. To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.
2. To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.
3. To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.
4. To consent to or to refuse any treatment or procedure or participation in experimental research.
5. To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).
6. To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.
7. To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.
8. To be free from discrimination based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status.
9. To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.
10. To be free from mental and physical abuse.
11. To be assured confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.
12. To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

13. Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.
14. To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened.
15. To meet with others and participate in activities of social, religious and community groups.
16. To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.
17. If married or registered as a domestic partner, to be assured privacy for visits by the patient's spouse or registered domestic partner and if both are patients in the facility, to be permitted to share a room.
18. To have daily visiting hours established.
19. To have visits from members of the clergy at any time at the request of the patient or the patient's representative.
20. To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.
21. To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.
22. To have reasonable access to telephones and to make and receive confidential calls.
23. To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.
24. To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.
25. Other rights as specified in Health and Safety Code, Section 1599.1.
26. Other rights as specified in Welfare and Institutions Code, Sections 5325 and 5325.1, for persons admitted for psychiatric evaluations or treatment.
27. Other rights as specified in Welfare and Institutions Code Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.
    (a) A patient's rights, as set forth above, may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.
    (b) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.
    (c) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid

Durable Power of Attorney for Health Care, patient's next of kin, other appropriate surrogate decision maker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor.

(d) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

1. How the facility will verify that informed consent was obtained or a treatment or procedure was refused pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.
2. How the facility, in consultation with the patient's physician, will identify consistent with current statutory case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Section 51, Civil Code; Sections 297 and 297.5, Family Code; Sections 1276, 1320, 1599, 1599.1, 1599.2, 1599.3, 131050, 131051 and 131052, Health and Safety Code; and Cobbs v. Grant (1972) 8 Cal.3d 229.

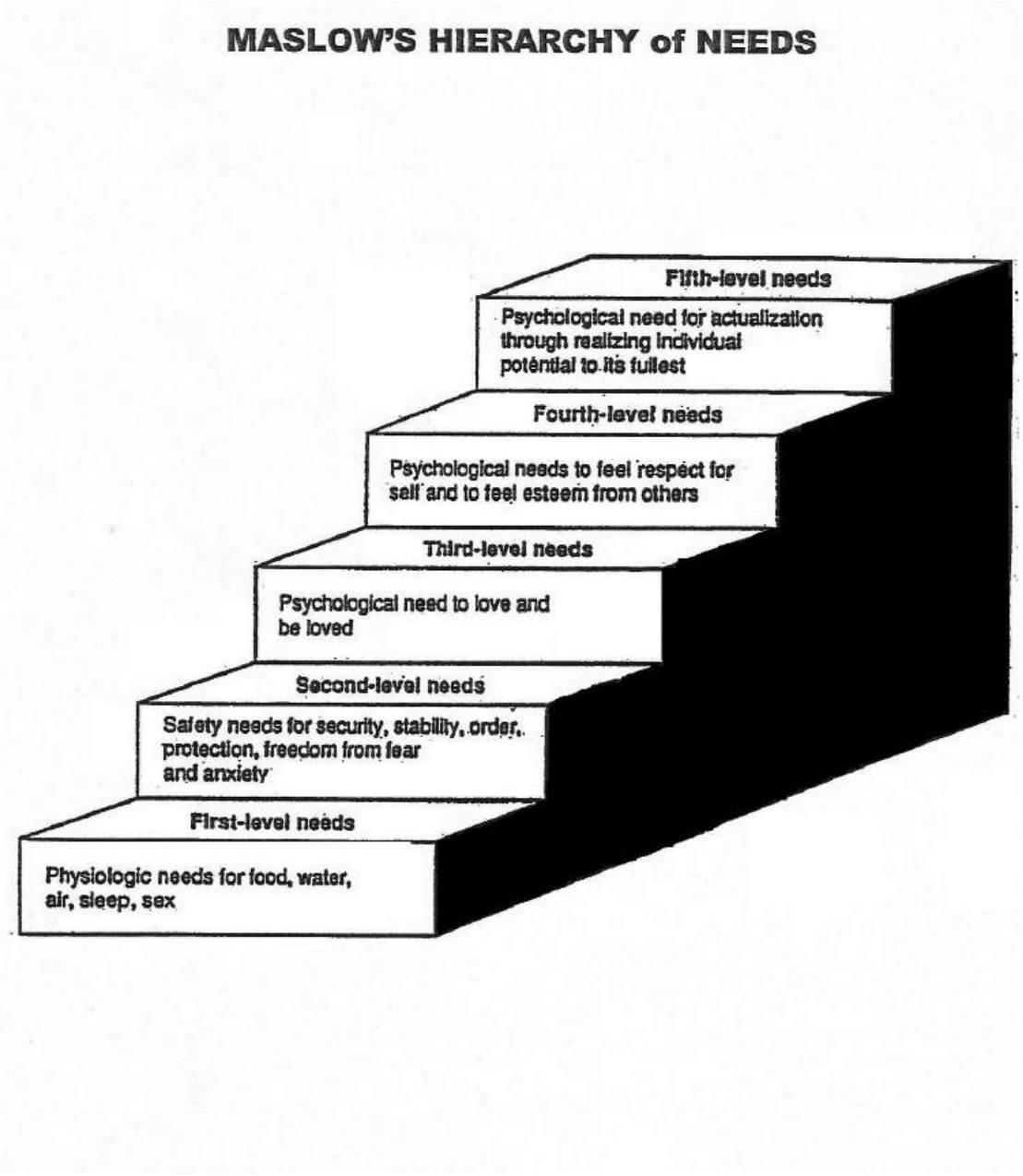
California Health and Safety Code

(Skilled Nursing and Intermediate Care Facility Patient's Bill of Rights)

1599.1 Written policies regarding the rights of patients shall be established and made available to patient, guardian, next of kin, sponsor, and public. In addition to patient rights and obligations defined in the regulations, the facility shall employ adequate, qualified staff; assure personal hygiene of patients including prevention of decubiti and incontinence, provide diet to meet patient needs; activities and promotion of self-care. The facility shall be clean, sanitary and in good repair, including nurses call system.

1599.2 Written information informing patients of their rights include facility requirements in the Health and Safety Code and Title 22. Violations of either code may be grounds for civil or criminal proceedings against the facility or its personnel. Patients have the right to voice grievances free of reprisal and to submit complaints to the Department of Health Services.

1599.3 Rights of patients who are determined to be incompetent, incapable of understanding, exhibits a communication barrier are to be carried out/protected by guardian, next of kin, conservator, sponsoring agency or representative unless it is the facility. Guidelines for Reporting to Team Leader.


MASLOW'S HIERARCHY of NEEDS
Fifth-level needs
Psychological need for actualization through realizing individual potential to its fullest
Fourth-level needs
Psychological needs to feel respect for self and to feel esteem from others
Third-level needs
Psychological need to love and be loved
Second-level needs
Safety needs for security, stability, order, protection, freedom from fear and anxiety
First-level needs
Physiologic needs for food, water, air, sleep, sex

Example of Human Needs as Related to Maslow

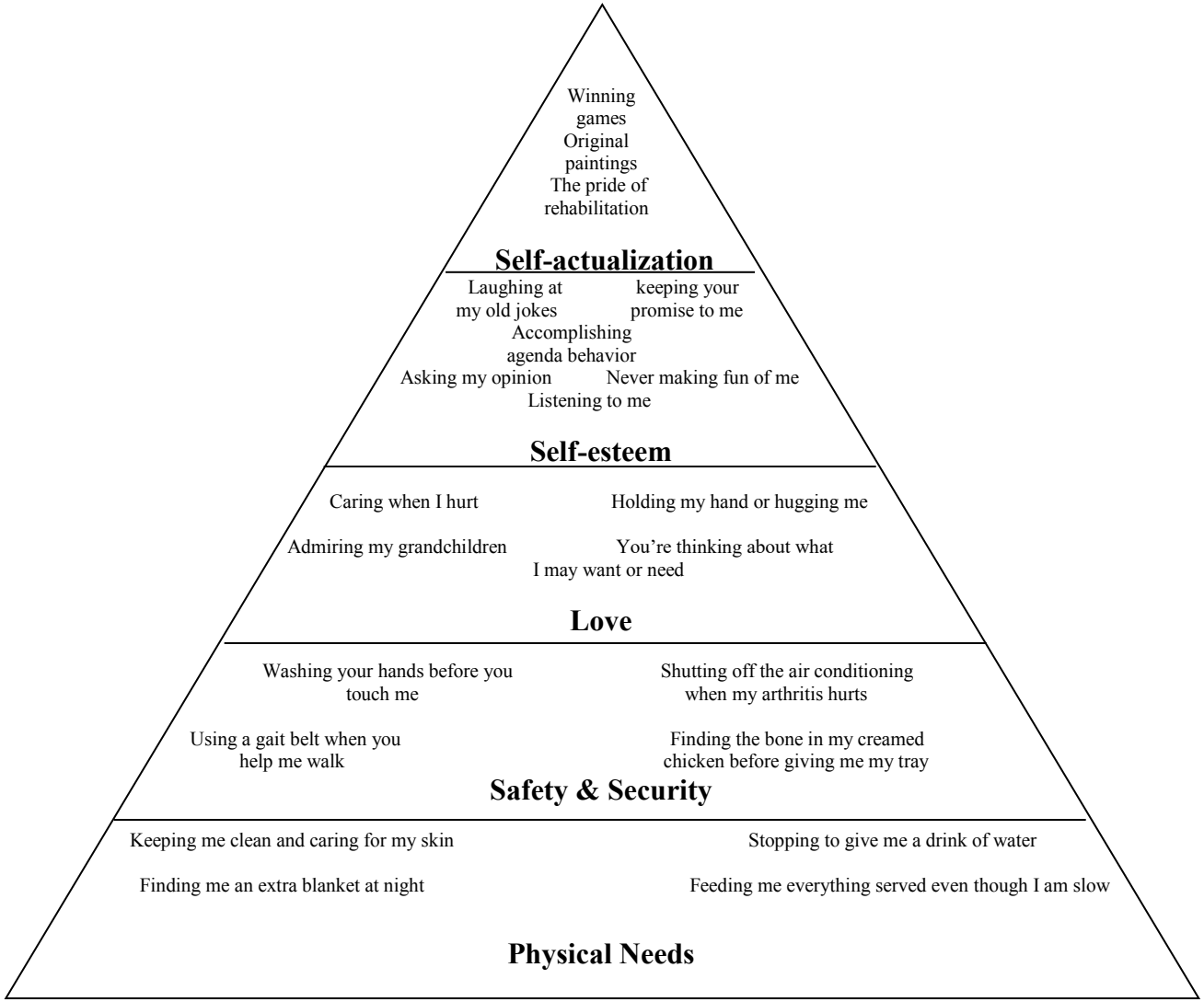


Illustration from The Nurse Assistant in Long-Term Care: A Rehabilitative Approach, by Hazel Castillo, RN., BA, MSG., pg. 409 Copyright 1992 by Mosby- year book, Inc. Reproduced by permission of Mosby

Module 3: Communication/Interpersonal Skills
Minimum Number of Theory Hours: 2
Recommended Theory Hours: 6
Recommended Clinical Hours: 0

Statement of Purpose:
The purpose of this unit is to introduce concepts and skills required for the Nurse Assistant to communicate effectively and interact appropriately with patients/residents, patient's/residents' families and guests, and other members of the health care team.

Terminology

1. Anger
2. Aphasia
3. Basic human need
4. Body language
5. Communication
6. Conflict
7. Conversion
8. Defense mechanisms
9. Denial
10. Displacement
11. Dyslexia
12. Dysphasia
13. Empathy
14. Family
15. Identification
16. Medical chart
17. Message
18. Myth
19. Non-verbal communication
20. Personal space
21. Physiological
22. Projection
23. Psychosocial
24. Rationalization
25. Receiver
26. Regression
27. Report
28. Repression
29. Sender
30. Sublimation
31. Substitution
32. Sympathy
33. Verbal communication
34. Voice pitch
35. Voice tone

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of two (2) hours of class plus homework assignments and clinical assignments, the learner will be able to:

1. Define key terminology.
2. Identify and discuss the five basic physiological and psychosocial needs of all humans, as described by Maslow's Hierarchy of Needs.
3. Recognize and report patient/resident behaviors that reflect unmet human needs.
4. Define communication and therapeutic communication and identify two routes of communication.
5. Describe the key steps involved in the communication process and methods used in communication.
6. Describe reasons for communication breakdown.
7. Describe effective communication/interpersonal skills used with patients/residents, their families and guests.
8. Describe conflict and measures for conflict resolution.
9. Discuss touch as a form of communication, including body language and personal space.
10. Identify common psychological defense mechanisms.
11. Describe family communication/interaction patterns and the role of the Nurse Assistant.
12. Describe social and cultural factors influencing communication and emotional reactions to illness and disability.
13. Describe communication between the members of the health care team.

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes E. Handout 3.1a- Communication Skills Crossword F. Handout 3.1b- Communication Skills Crossword- KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2: **Identify and discuss the five basic physiological and psychosocial needs of all humans, as described by Maslow's Hierarchy of Needs.** A. Basic human needs and how they can be met by Nurse Assistant 1. Physiological a. Oxygen, food, water, elimination, shelter, sleep, sex b. Example: Delivers meal trays, assists patient/resident with set-up and feeding as needed 2. Safety and Security a. Clothing, protection from harm or danger, freedom from	A. Lecture/Discussion B. Handout 3.2- Examples of Human Needs as Related to Maslow C. Group Activity: in groups of 3-5, ask students to identify and categorize	A. Written test B. Identifies actions by Nurse Assistant to assist in meeting each of the five basic human needs for one or more patients/residents

fear, stability and order, family, economics b. Example: Responds promptly to patient/resident 's call light 3. Belonging a. Meaningful relationships with others, acceptance by peers and community, love, intimacy, and formal and informal social and work groups b. Example: Encourages family and friends to visit patient/resident 4. Esteem a. Respect, recognition, approval, self-confidence, self-respect, self-esteem b. Example: Addresses each patient/resident by the name they prefer 5. Self-actualization a. Achievement, creativity, success, full use of individual talents b. Example: Sincerely acknowledges a patient's/resident's accomplishments B. Value of using Maslow's Hierarchy of Needs 1. Satisfactory achievement of each level is based on meeting the needs of prior levels 2. Meeting basic physiological needs is essential to life 3. Provides a way to set priorities and organize activities 4. Encourages a holistic approach to patient/resident care planning 5. Increases awareness of reasons for patient/resident behaviors 6. Unmet basic needs may result from and/or contribute to illness, disease, or injury	additional examples of how Nurse Assistants meet patient/resident needs	C. Uses hierarchy to prioritize patients/residents' activities to meet needs
Objective 3: **Recognize and report patient/resident behaviors that reflect unmet human needs.** A. Behaviors that demonstrate unmet human needs 1. Physiological needs unmet a. Irritability, weakness, complaints of hunger, complaints of being cold or too warm b. Changes in vital signs and level of consciousness 2. Psychosocial needs unmet a. Anxiety, depression, anger, withdrawal, isolation	A. Lecture/Discussion B. Have students identify and discuss examples of observations or experiences in which physical or psychosocial needs were not met for	A. Written test B. Recognizes behaviors that may express a patient's/resident's unmet needs and reports to licensed nurse

b. Physical ailments with no apparent cause c. Expressions of feelings of loneliness and worthlessness B. Responses to patient/resident behaviors suggesting unmet basic needs 1. Look beyond uncooperative, demanding, and rude behavior 2. Recognize that a patient/resident has underlying needs for comfort and understanding 3. Respond with patience, caring, concern, kindness, and empathy 4. If problem continues, ask licensed nurse for assistance	self or others	
Objective 4 **Define communication and therapeutic communication and identify two routes of communication.** A. Communication is a sharing of ideas, thoughts, information, and feelings with at least one person B. Communication may be verbal or non-verbal C. Therapeutic communication is used to promote optimum wellness 1. Patient/resident-centered and goal oriented 2. Can be verbal or non-verbal D. Two routes of communication 1. What is seen, heard, touched - internal senses 2. What is spoken, written, or gestured - external senses	A. Lecture/Discussion B. Group Activity: How to fold a Napkin 1. Give each student a cloth napkin- Preferably at least 12 x 12 inches 2. Divide the class into three groups 3. Ask that students not look at what will be handed out, not discuss the activity with other classmates, and wait for directions 4. Each Group will have different tasks a. Group 1- give each student a copy of the written directions for folding a napkin (Handout 3.4a)	A. Written test B. Applies appropriate verbal and non-verbal actions to facilitate therapeutic communication with patients/residents

	This group will do the napkin fold individually and without talking b. Group 2- Give each student a copy of the directions with pictures for folding a napkin (Handout 3.4b) This group will do the napkin fold individually and without talking Group 3- Give two students a copy of the directions with pictures for folding a napkin (Handout 3.4b) One student will give the directions verbally while the other demonstrates how to fold the napkin to the rest of Group 3 The students who are folding will be allowed to ask questions while in the folding process Note: Group 3 will need to work with students so they know how to fold the napkin	

	d. Stop the activity after 5 minutes (A shorter time may work also) e. Look at everyone's folded napkins 5. Topics for discussion: a. Differences between working alone and with two people? b. Any differences between written and picture directions? c. Amount of questions asked and directions repeated with Group 3? d. How can communication be improved? e. Application to clinical setting &communicating with patients/residents, families, guests, and other members of the health care team	

	C. Handout 3.4a- How to Fold a Napkin Written Instructions D. Handout 3.4b- How to Fold a Napkin with Pictures	
Objective 5: **Describe the key steps involved in the communication process and methods used in communication.** A. Important steps in communication 1. Message 2. Sender 3. Receiver 4. Interpretation B. Methods 1. Verbal; Spoken words 2. Non-verbal; Conscious and unconscious a. Types 1) Body language 2) Touch 3) Eye contact at patient's eye level b. Written 1) Labels; stickers or armbands for patient/resident precautions, room numbers, unit signs 2) Visual labels; name tag, picture, uniform, picture board 3. Electronic a. Devices to create sounds of words (verbal) 4. Computers/touch pads to type words/phrases onto screen(non-verbal) 5. Specialized communication skills a. Dementia-related communication skills including person-centered care, validation therapy, gentle orientation to time and place, reassure with words and touch b. Use of a continuum of verbal and non-physical techniques, such as redirect for combative patients	A. Lecture/Discussion B. Group Activity C. Telephone Game Create message that is at least three sentences long and contains several points of information 2. Have students form a line or divide into groups of 5-8 3. First student in line whispers the message to the second student who whispers what was heard to the third student, etc. 4. Final student in line reports what was heard as the message 5. Discuss what occurred where the message changed, how message changed	A. Written test B. Identifies all methods used by the facility and unit to communicate patient/resident information and precautions C. Correctly follows confidentiality and precaution measures

Objective 6 **Describe reasons for communication breakdown.** A. Verbal Factors- can be the patient/resident or health care worker 1. Criticism 2. Value statements 3. Interruptions 4. Judgment 5. Language differences 6. Changing subjects 7. Excessive talking 8. Cliché and automatic answers such as “Don’t worry” – “It will be OK” – “I know how you feel” B. Non-verbal factors; can be the patient/resident or health care worker 1. Body language 2. Eye contact 3. Cultural beliefs, customs, and practices 4. Environmental-time and space C. Physiological and aging factors 1. Hearing loss 2. Vision loss 3. Slowing of response time 4. Medication 5. Cognitive changes 6. Speech loss D. Not listening; can be either the patient/resident or health care worker 1. Lack of concentration a. Preoccupied b. Distracting noises c. Monotone voice d. Negative attitude 2. Selective hearing – what one wants or expects to hear C. Emotional - verbal or non-verbal responses to words or situations	A. Lecture/Discussion B. Have students recall Napkin Folding and Telephone Game Discuss factors that led to miscommunication and ways to avoid future miscommunication C. Discuss the role of listening in miscommunication	A. Written test B. Identifies verbal and nonverbal behaviors and actions in self and in patients/residents that may block effective communication

Objective 7: **Describe effective Communication/Interpersonal Skills used with patients/residents, their families and guests.** A. Communication/Interpersonal Skills for use with a patient/resident, family, or guest 1. Introduce self 2. Use the patient's/resident's formal name initially 3. After initial introductions, ask patient/resident how he or she would like to be addressed. Add this information to the nursing care plan so all staff members have the information 4. Explain all tasks to the patient/resident before doing them 5. Be patient and a good listener 6. Use short sentences, ask for feedback 7. Use eye contact 8. Speak clearly, avoid criticizing, and avoid interrupting 9. Clarify information or conversation as needed 10. Be aware of body language of self and others 11. Verbal and non-verbal messages should agree 12. Use words that are easily understood 13. Show interest and respect 14. Use a friendly tone of voice 15. Be positive while being appropriate to each interaction 16. Ensure confidentiality	A. Lecture/Discussion	A. Written test

B. Additional skills when communicating with patients/residents with special needs 1. Language/cultural differences a. Ask for an interpreter if the patient/resident or family speaks little or no English or the language of the Nurse Assistant b. Know cultural beliefs and practices for word meanings and uses, personal space, time and timing, gestures, and touching 2. Visual impairment a. Describe surroundings to a visually impaired patient/resident b. Encourage use of other senses c. Identify self when entering patient's/resident's room d. Speak aloud before touching patient/resident e. Explore the room with patient/resident f. Do not rearrange the room g. Provide patient/resident with explanations about what will be and is being done h. Let patient/resident know when you are entering and leaving the room i. Keep doors open j. Assist as needed with meal set-up and eating k. Speak in a normal tone of voice 3. Hearing impaired a. Gain the attention of the patient/resident, using touch as appropriate b. Determine which ear has hearing loss. It may be both ears c. Check to see if hearing aids are in, turned on and working d. Face the patient/resident directly e. Do not block/cover your mouth or chew gum f. Reduce/eliminate background noise and other distractions g. Speak slowly, directly, and clearly when addressing a hearing-impaired patient/resident. Do not speak loudly	B. Role play activity: Communication Challenges 1. Divide into groups of 4-5 students Assign each member of the group to one of these challenges- one visually impaired, one hearing impaired, one unable to speak, one confused, and one with Hemiplegia 3. Assign a topic to be discussed, including a written component (terminology, reviewing theory content) 4. Allow at least 15 minutes for group interaction	B. Demonstrates use of effective communication strategies and actions with patient/resident, families, guests, and other healthcare workers C. Provides care for patient/resident with a hearing, visual, or cognitive impairment Creates picture board for a patient/resident who has impairment in verbal and written communication

h. Use short sentences and simple words i. Repeat and rephrase statements as needed j. Ask the patient/resident to repeat instructions to ensure understanding k. Be aware of messages sent by facial expressions and body language 4. Speech impairment (dysphasia, aphasia) a. Provide writing materials and assistance as needed b. Let patient/resident use own words – Allow sufficient time for response c. Use picture boards or point boards d. Stand in front of patient/resident e. Avoid finishing words and sentences for the patient/resident 5. Mental impairment (confusion, dementia) a. Keep directions simple b. Repeat information as needed c. Offer frequent general reassurance d. Always have patient's/resident's attention before speaking		
Objective 8 **Describe conflict and measures for conflict resolution.** A. Definitions 1. Conflict a. A disagreement or controversy b. When what a person has and what a person wants is different c. A pattern of energy d. Nature's primary motivation for change 2. Conflict resolution; a range of processes aimed at alleviating or eliminating sources of conflict B. Conflict Myths 1. Conflict is a negative 2. Conflict is a contest 3. The presence of conflict is a sign of poor management 4. Conflict, if left alone, will take care of itself 5. Conflict must be resolved	A. Lecture B. Discussion C. Handout 3.8a- Myths about Conflict D. Handout 3.8b- Conflict Self-Assessment Activity E. Handout 3.8c- Five Conflict Handling Modes F. Handout 3.8d- 4 E's of Constructive Feedback	A. Written test B. Recognizes indications of potential and actual conflict for a patient/resident and reports information clearly and accurately to licensed nurse

C. Conflict handling modes, characteristics, and uses 1. Competing a. Assertive and uncooperative b. Power-oriented c. Uses 2. Accommodating a. Unassertive and cooperative b. Self-sacrifice c. Uses 3. Avoiding a. Unassertive and uncooperative b. Doesn't address conflict c. Uses 4. Collaborating a. Assertive and cooperative b. Seeks mutual satisfaction c. Uses 5. Compromising a. Somewhat assertive and cooperative b. Mutual satisfaction c. Middle ground d. Uses D. Potential Areas of Conflict for Nurse Assistant 1. Attendance 2. Punctuality 3. Safety a. Personal b. Patient/resident 4. Professional behavior 5. Attitude 6. Appearance and hygiene 7. Performance 8. Confidentiality E. Constructive Feedback 1. Definition 2. Use		

F. The 4 "Es" of giving constructive feedback 1. Engage a. Prepare b. Link feedback with goals c. Focus discussion 2. Empathize a. Environment b. Timing 3. Educate a. Describe observations b. Identify impact of behavior c. Remain objective 4. Enlist a. Elicit response b. Guide toward solution		
Objective 9 **Discuss touch as a form of communication, including body language and personal space.** A. Cultural beliefs regarding touch 1. Modesty; covering of head, face, arms 2. Gender of care giver 3. Touching of body after death 4. Hugging and kissing B. Observing body language 1. Hands and extremities 2. Eyes 3. Gestures 4. Posture 5. Regression to child-like postures or behaviors C. Personal space	A. Lecture/Discussion B. Activity: 1. Create a list of cultures and religious practices of students and instructors 2. Add cultures and religions not represented in the class 3. Identify specific information about touching, body language, and personal space for each culture	A. Written test B. Appropriately gathers information about patient/resident preferences regarding touch and personal space C. Provides culturally appropriate care for all patient's/resident's

Objective 10 **Identify common psychological defense mechanisms.** A. Denial B. Projection C. Anger D. Rationalization E. Regression F. Displacement G. Conversion H. Repression I. Sublimation J. Substitution/compensation K. Identification	A. Lecture/Discussion B. Flashcards for terms C. Handout 8.10- Defense Mechanisms	A. Written test B. Recognizes possible reasons for a patient's/resident's use of defense mechanisms C. Identifies and applies appropriate therapeutic communication techniques with patients/residents who are angry and/or experiencing regressive behaviors
Objective 11 **Describe family communication/interaction patterns and the role of the Nurse Assistant.** A. General principles when communicating with patient/resident families 1. Show respect for all family structures and members 2. Listen to family members a. Show courtesy, respect, and support b. Allow uninterrupted time c. Provide privacy as indicated 3. Avoid involvement in family matters 4. Maintain patient/resident confidentiality 5. Encourage family to participate in care planning and care as allowed by facility policy B. Provide information about the facility 1. Telephone numbers 2. Cell phone regulations 3. Visiting hours 4. Location of cafeteria/vending machines	A. Lecture/Discussion B. Have group share examples of communication difficulties C. Role play examples of providing clear and concise information to another student playing the role of a family member. Have the student playing the role of the family member give feedback regarding the communication. Use one of the Mandatory	A. Written test B. Interacts appropriately with others at all times when in the clinical facility. Maintains confidentiality

6. Gift shop 7. Public restrooms 8. Orient to patient/resident activities 9. Social Services 10. Chaplain C. Encourage family to provide information about patient/resident preferences	Skills as an example	
Objective 12 **Describe social and cultural factors influencing communication and emotional reactions to illness and disability.** A. Culture 1. Shared, learned customs, beliefs and values of a group of people 2. Includes attitudes, beliefs, religion, values, likes and dislikes, rituals, celebrations, food, and language 3. Culture influences the reaction of residents and families to health and health care services 4. Rituals –ceremonies to cure or protect from disease based on beliefs about health, health care, and causes of illness B. Physical and psycho-social reactions to illness and disability 1. Stress responses a. Common physiological responses vary with each individual b. Can become a pattern of responses based on experiences c. Have desirable and undesirable effects 2. Physical loss or disability a. Loss of spouse, family, friends b. Loss of homes, employment, economics, security c. Loss of control of life, independence, driving d. Loss of control and function of body and mind e. Fewer choices and options 3. Emotional reactions a. Anger b. Uselessness c. Fear	A. Lecture/Discussion B. Activity: Using the cultures and religions identified in Objective 9, discuss health, illness, and health care beliefs and practices C. Have students share strategies for relieving stress	A. Written test B. Recognizes patient/resident behaviors that may be influenced by cultural beliefs and practices. Reports information appropriately C. Recognizes patient/resident behaviors that may be influenced by physical, social, and/or emotional factors. Reports information appropriately

d. Grief e. Feelings of damage f. Dependency g. Depression h. Suspicion i. Sense of helplessness j. Loneliness k. Anxiety l. Guilt m. Frustration C. Helpful Nurse Assistant actions 1. Observe patient/resident for indications of emotional stress 2. Be a good listener; take time to visit 3. Be patient and understanding; meet needs promptly 4. Help patient/resident function as independently as possible; focus on abilities not disabilities 5. Let patient/resident know that staff cares about his or her well-being 6. Be non-judgmental 7. Always treat all patients/residents with dignity 8. Be respectful of all cultures and belief systems 9. Take time to learn about cultures and practices		
Objective 13: **Describe communication between the members of the health care team.** A. Health Care Communication 1. Methods of communicating a. Verbal b. Non-verbal c. Written: chart, patient summary/care plan, report sheets, Activity of Daily Living form, and weight and vital signs forms d. Electronic: computer, fax, telephone, intercom system 2. Legal aspects of communications a. Must document what has been reported verbally to licensed nurse b. Must document statements heard from the patient/resident and family that are important	A. Lecture/Discussion B. Activity: Create a list of simulated patients/residents with various diagnoses, ADLs, etc. Divide class into small groups. Have students take turns giving report	A. Written test B. Interacts appropriately at all times with unit staff and other members of the health care team C. Communicates patient/resident information accurately and clearly both verbally and in writing D. Follows unit policy regarding answering telephone and intercom

B. Rules for effective communication 1. Identify self by name and title in any form of communication 2. Verbal reports should be a. Brief b. Organized c. Appropriate and focused 1) Diagnosis 2) Allergies 3) Activity and tolerance 4) Elimination 5) Special needs 6) Diet and appetite 7) Vital signs and weight 8) Code status d. Timely e. Respectful of patient/resident confidentiality 3. Telephone communication a. Take notes during the call b. Name of person the message is for c. Verify correct spelling of caller's name d. Indicate time of call e. Clarify the message with the caller by repeating it and repeating the telephone number f. Clearly sign full name and title to the message 4. Answering a patient/resident call signal a. Answer promptly, quietly, and in a friendly manner b. If an intercom is used, call the patient/resident by name, identify self and politely inquire as to the patient's/resident's need c. Make sure the patient/resident can always reach the call light		

Sample Test- Module 3- Communication/Interpersonal Skills

1. Which of the following is a physiological need?
    A. Employment
    B. Friendship
    C. Water
    D. Love

2. Which of the following would be a barrier to effective communication?
    A. Listening to a patient/resident tell stories about his or her past
    B. Letting a patient/resident express his or her fears and concerns about dying
    C. Changing the subject each time a patient/resident brings up an uncomfortable topic
    D. Allowing a patient/resident to talk freely about his or her health problems

3. Avoiding eye contact when talking to another person is an example of which type of communication?
    A. Verbal
    B. Non-verbal
    C. Written
    D. Electronic

4. A charge nurse uses a medical word that the Nurse Assistant does not understand. What should you do?
    A. Pretend to understand
    B. Look the word up in a medical dictionary
    C. Ask the nurse to explain the meaning
    D. Ask another Nurse Assistant what the word means

5. A patient/resident asks to see his chart. What is the correct action for the Nurse Assistant?
    A. Give the chart to the patient/resident
    B. Report this to the charge nurse
    C. Report this to the patient's/resident's doctor
    D. Make a copy of the chart for the patient/resident

6. When patients/residents express their feelings and concerns, the Nurse Assistant will best respond by:
    A. Adding his or her opinions
    B. Giving the patient/resident suggestions for feeling better
    C. Sharing personal problems and concerns
    D. Listening to the patient's/resident's concerns

7. A patient's/resident's family asks to meet their mother's new roommate who is sitting in the day room. The nursing assistant will most correctly:
    A. Inform the patient's/resident's family that this is against hospital policy
    B. Take the family and patient/resident to the day room and introduce them to the new roommate
    C. Ask the family to wait until the new roommate has been in the facility at least a week
    D. Report this request to the charge nurse to handle as time permits

8. A Nurse Assistant works on the first floor of a skilled nursing facility. The Nurse Assistant's uncle is a patient/resident on the second floor. Which statement is true about this relationship?
    A. The Nurse Assistant can access her uncle's medical record
    B. The Nurse Assistant can visit her uncle during lunch time
    C. The Nurse Assistant can attend patient/resident care conferences with her uncle
    D. The Nurse Assistant can assist with her uncle's care plan

9. Which form of communication may reveal the most about a patient's/resident's true feelings?
    A. Listening skills
    B. Written communication
    C. Verbal communication
    D. Body language

10. What is the most appropriate way to answer a patient's/resident's telephone?
    A. "Good morning. Mrs. Gray's room"
    B. "Good morning. Third floor"
    C. "Hello. Who is calling?"
    D. "Good morning. Mrs. Gray's room, this is Mary Jones, Nurse Assistant speaking"

11. What information must be included when giving an end of shift report?
    A. The full name and address of the patient/resident.
    B. Facts and specific information that were observed and care given by the Nurse Assistant.
    C. Number of visitors
    D. Personal feelings about the patient/resident

12. Listening skills are enhanced by:
    A. Engaging a patient/resident in an activity
    B. Being animated while listening
    C. Conversing in a public location
    D. Empathy

13. A patient/resident tells the Nurse Assistant that he misses participating in religious activities. The most helpful action by the Nurse Assistant at this time is to:
    A. Tell the patient/resident that it is against policy for the Nurse Assistant to discuss religion with patients/residents
    B. Memorize each patient's/resident's religious preference
    C. Insist that the patient/resident attend the religious services offered by the agency
    D. Talk with the patient/resident about religion to encourage discussion

14. A confused patient/resident was recently moved to a private room at the family's request. The Nurse Assistant understands that:
    A. The patient/resident may experience an increased appetite
    B. Patients/residents with dementia cannot tolerate isolation
    C. Any change in routine can produce anxiety in a patient/resident
    D. The patient/resident probably did not want to change rooms

15. Information that can be seen, heard, or smelled is called:
    A. Assessment
    B. Observation
    C. Objective data
    D. Subjective data

16. When should changes in a patient's/resident's condition be reported?
    A. Right away
    B. As soon as possible
    C. During the patient/resident care conferences
    D. During the end-of-shift report

17. When charting, it is essential to record:
    A. Safety measures performed
    B. What co-workers observed
    C. What co-workers did
    D. Comments of the family and guests

18. A patient/resident was moved out of her home and into a long-term care facility. She is angry about being moved. How will the Nurse Assistant be most helpful for this patient/resident?
    A. Ignore her behavior
    B. Sit with her and let her express her feelings
    C. Tell her that she will get used to the facility
    D. Ask another patient/resident to talk with the new patient/resident

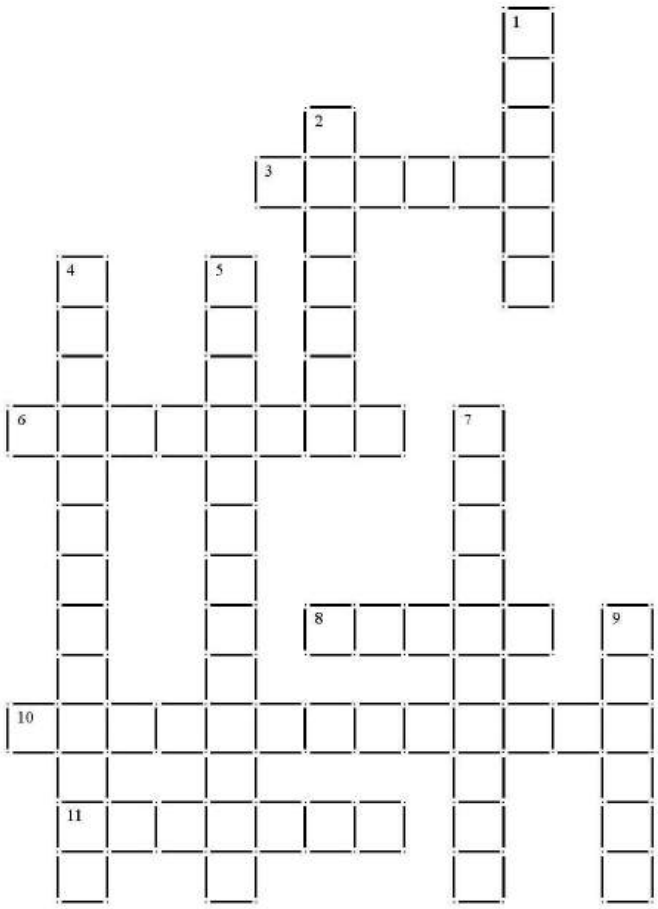
19. Which action is best to do before transferring a telephone call?
    A. Explain that the call is going to be transferred and where
    B. Set the phone down and find out where to transfer the call
    C. Take a message
    D. Find out the reason for the call

20. Stress is best defined as
    A. A vague feeling of apprehension
    B. A response to any demand made on an individual
    C. The main cause of illness
    D. Blaming another for one's problems

21. The Nurse Assistant is assigned to the care of a newly admitted patient/resident who does not speak English. What is the best approach for the Nurse Assistant when beginning care?
    A. Use pictures and gestures to communicate with the patient/resident
    B. Ask the charge nurse to get an interpreter
    C. Delay care until the family can come in to interpret
    D. Find a television station in the language the patient/resident understands

Module 3: Communication Skills Handout 3.1a- Crossword

Communication Skills Crossword



ACROSS

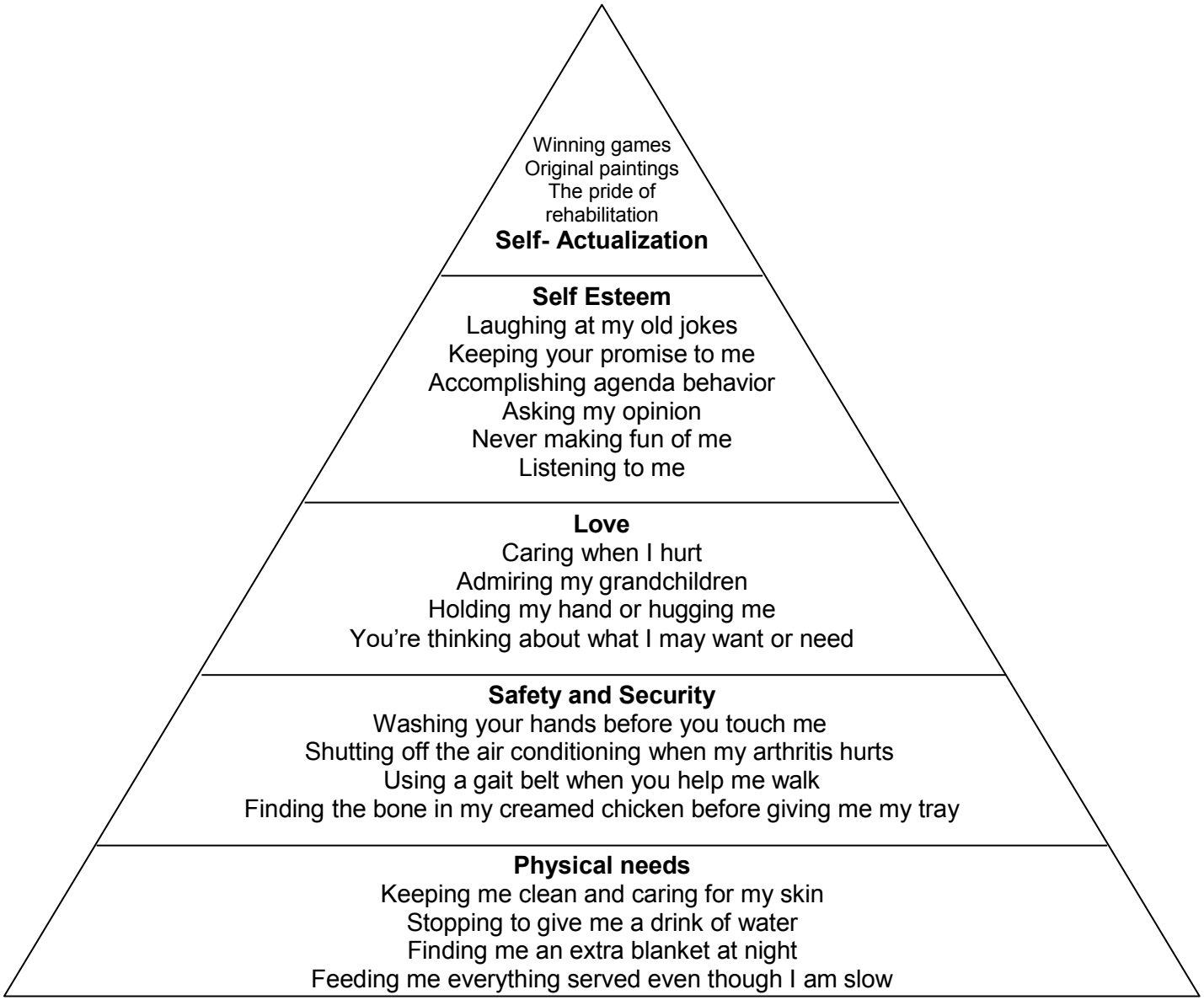
3 A refusal to believe or accept.
6 Person who takes the information.
8 Hostile feelings.
10 Exchange of information.
11 Loss of the ability to speak.

DOWN

1 The person who wrote about the needs of humans.
2 The information sent to the receiver.
4 Type of communication that occurs between two people.
5 Factors which influence communication.
7 To extend one's feelings onto someone else. Rationalization/ To make up acceptable explanations for one's beliefs or acts.
9 The person who sends the message.

1 of 1

Examples of Human Needs as Related to Maslow

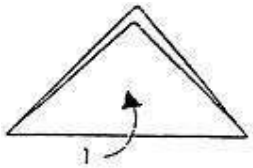


How to Fold a Napkin- Written Instructions

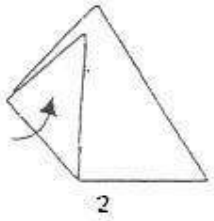
"Fleur de Lis" Shape

1. Fold napkin in half diagonally to form a triangle.
2. Bring right and left points to the center to form a diamond.
3. Fold bottom points up to about one inch from top and fold it back on itself.
4. Turn napkin over bringing corners together, tucking one into the other.
5. Turn the napkin back over.
6. Peel down the right and left side from the top center to make petals.
7. Open base to stand upright.

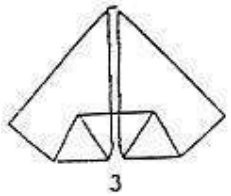
How to Fold a Napkin—Fleur de Lis



Fold napkin in half diagonally to form a triangle.



Bring right and left points to the center point to form a diamond.



Fold bottom points up to about one inch from top and fold it back on itself.

Turn napkin over bringing corners together, one into the other.

Turn napkin back over. Peel down the right and left side from the top center to make petals. Open base to stand.

Myths About Conflict

Myth #1: "Conflict is Negative"

Conflict is natural, neither positive nor negative, it just is. It is the outcome of conflict that can be good or bad. In nature, friction between elements (wind, sand, and water) acts as its primary motivator for change, creating beaches and canyons, mountains, and pearls. It is not the situation that causes upset and bad feelings, but how people handle it. A disagreement between friends can lead to an end of the friendship or a chance to gain a better understanding of how the other person views things.

Myth #2: "Conflict is a Contest"

Conflict is not a contest. Conflict just is. People choose whether to make it a contest, a game in which there are winners and losers. There doesn't always have to be a winner and a loser. That's great for a game, which people decide to play that way, but to be a loser at work or in a family or community doesn't feel great for anyone. The ideal is to create solutions in which everyone's needs are met and they are all winners. Resolving conflict is rarely about who is right. It is about acknowledgement and appreciation of differences.

Myth #3: "The Presence of Conflict is a Sign of Poor Management"

An effective leader anticipates conflict when possible, deals with conflict when it arises and enjoys its absence when possible. Conflict, in itself will not affect the way other people feel about someone else. If however, they choose to ignore the conflict and allow it to continue, their employees will see them as a less-than-effective leader. On the other hand, if they address the conflict and motivate the staff, they will win their support and respect. They may avoid future conflicts as well.

Myth #4: "Conflict, if Left Alone, Will Take Care of Itself"

This is a half-truth. People can avoid conflict – it is a valid coping strategy, but not the only strategy. The intensity of the conflict varies. Left unchecked, conflict can escalate as easily as dissipate.

Myth #5: "Conflict Must Be Resolved"

This myth stifles creativity, causing the leader to become solution-oriented. Some conflict is best managed by endurance, while other events require multiple solutions. Quick movement toward resolution can limit success.

Conflict Self- Assessment Activity

Directions: Answer each of the following questions. This self-assessment will not be handed in nor graded.

1. What is your definition of conflict?

2. What is your definition of conflict resolution?

3. Give an example of a previous conflict in your life and your method of resolving the conflict.

4. What are the ways you usually resolve conflicts?

5. Give an example of a conflict and/or conflict resolution that you have observed in a clinical setting.

The Five Conflict-Handling Modes

A. **Competing:**
   1. Assertive and uncooperative.
   2. Power-oriented.
   3. Useful for:
      a. Standing up for rights.
      b. Defending an important position.
      c. Trying to win.

B. **Accommodating:**
   1. Unassertive and cooperative.
   2. Involves self-sacrifice.
   3. Useful for:
      a. Charitable causes/generosity.
      b. Obeying orders.
      c. Yielding to another point of view.

C. **Avoiding:**
   1. Unassertive and uncooperative.
   2. Does not address the conflict.
   3. Useful for:
      a. Diplomatic sidestepping.
      b. Avoiding until a better time.
      c. Withdrawing from a threatening situation.

D. **Collaborating:**
   1. Assertive and cooperative.
   2. Seeks to satisfy both sides.
   3. Useful for:
      a. Gaining additional insights.
      b. Avoiding negative competition for resources.
      c. Solving interpersonal problems.

E. **Compromising:**
   1. Somewhat assertive and somewhat cooperative.
   2. Solutions are mutually satisfying; acceptable to all.
   3. Middle ground mode.
   4. Useful for:
      a. Splitting the difference.
      b. Making concessions.
      c. Finding a quick middle-ground position.

4 “E’s” of Giving Constructive Feedback

Definitions:

1. **Feedback:** Information given to and received by an individual about his or her performance.
2. **Behavior:** What an individual does or says.
3. **Objective:** Specific description of a behavior or action rather than judgment, evaluation or interpretation.
4. **Constructive Feedback:**
   A. Provides information to improve performance
   B. Is a vehicle to promote constructive relationships
   C. Promotes an environment of openness and mutual respect
   D. Provides a way to monitor how things are going
   E. Creates a way for issues to come to the forefront before they become major problems
   F. Keeps lines of communication open and assists staff in owning problems and creating solutions

4 “E’s”:

Engage: Set the stage to convey your positive intent in the spirit of mutual respect and learning.

- Preparation:
  - Think about the positive outcome you want to achieve. Even if you are giving feedback “on the spot,” frame it in terms of what behavior, issue, and situation you want to improve. Don’t give feedback unless there is a constructive outcome you wish to achieve. Have that outcome in mind when you give feedback
- Link feedback to common goals:
  - How will the feedback improve processes, meet deadlines, enhance the work environment
- State what you want to discuss
  - “I have a concern about…”
  - “People need to talk about…”
  - “I have some thought on…”

Empathize: Determine the best time and place to convey the message focusing on facts and feelings, while utilizing active listening.

- Environment and Timing
  - Think about distraction, other people that may be around, or whether or not the person is upset
  - Address feeling that may emerge to enable you to move on to the point of the discussion
  - If “on the spot” feedback is necessary, move to a private area

Educate: Describe observation and impact of behavior: Focus on the situation, issue or behavior, not the person.

- Descriptive observation
  - State the facts and avoid judgment, evaluation, or interpretation
  - Be specific and to the point
  - Convey respect and support
  - Stay focused on the issue at hand; avoid past or unrelated situations
  - Don’t let issues go unaddressed or you run the risk of unleashing stored up concerns
- Impact of behavior
  - Describing the impact of the behavior helps to keep the discussion objective and will help minimize defensive responses
  - Link behavior to business goals or challenges:
    - Improved patient/resident care
    - Customer satisfaction
    - Better access to patient/resident information
    - Improved work environment
  - Point out one or two of the most significant consequences
- Remain objective
  - Avoid getting caught up in your own emotions
  - If this may be a “hot button” issue for you, practice ahead of time or role-play with a colleague

Enlist: Set the stage for the person to respond: Focus discussion on solutions. Promote open discussion.

- Elicit the person’s response.
  - Use feedback as a tool to ascertain what the person thinks
  - Use questions to probe, such as:
    - “What are your thoughts about…?”
    - “How do you think people can improve this situation?”
    - “What do you suggest can be done?”
  - Listen and summarize what you heard. This will let you validate what you heard and demonstrate that you are interested in what the person has to say
  - Proceed based on the person’s response
- Guide toward a solution
  - Move the discussion toward a solution based on standard practice and/or your expectations. Avoid telling the person exactly what to do
  - Guide and assist the person in developing possible solutions to promote ownership of the problem
  - Assist the person in selection and implementation of behaviors supporting resolution

DEFENSE MECHANISMS

Introduction:

In order to better understand patient/resident behavior, as well as our own and our co-workers, it is necessary to know something about mental mechanisms, what they are and how and when they are used.

Assignment:

1. What are the basic needs of every individual? List them below:

   _____

   _____

   _____

2. What happens when these needs are not met? Sometimes they can't be satisfied because of:

   A. Cultural and social restrictions. Give an example:

   _____

   B. Environmental limitations. Give an example:

   _____

   C. Personal, social, religious beliefs. Give an example:

   _____

   D. Personal, physical or intellectual limitations. Give an example:

   _____

3. When people's needs cannot be met – they feel insecure, their self-image (the way they see themselves) is threatened, they may experience frustration and develop anxiety and tensions. This is often true of patients/residents in the hospital. Hospitalization often makes a patient/resident feel:

    A. Helpless and insecure
    B. Isolated
    C. That self-identify is threatened or lost

    What are some of the symptoms of anxiety? List them below.

    _____

    _____

4. What do people do when their needs cannot be met and they are frustrated and anxious? If their actions are:

    A. Successful – they will:
        1. Recognize the problem troubling them
        2. Think through possible solutions
        3. Do something about the situation – change their environment, themselves or both

    B. Unsuccessful – this may lead to all sorts of problems, mental illness, psychosomatic disorders, etc.

    C. People may resort to using mental mechanisms to assist in coping with frustrations and anxieties.

5. Mental mechanisms are patterns of behavior that consciously or unconsciously help people handle their anxieties and feel better and more comfortable with themselves. These are actions which keep people from facing reality. They help the symptoms but not the real problem. They protect a person's self-image. They are useful if used in moderation and can help people in trouble. When used habitually, they can become like big thick walls which protect people from reality. It is hard to get through to people who have developed such strong defenses. They may never learn to face and solve problems maturely. Mentally ill people sometimes carry this to the extreme. People may use several of these mechanisms and tend to use those which have been successful in the past, so that this sort of response may become habitual.

    A. **Regression-** Reverting to childish behavior. There aren't as many responsibilities to face and this type of behavior gets attention. For example, a child may return to thumb sucking when a new baby is born, or a sick patient/resident may make childish demands and become increasingly dependent on the nurse for personal care. At the other extreme there is the mentally ill patient/resident who curls up on the floor in the fetal position, soils himself, and is dependent on the nurse for feeding, bathing, toileting, and daily hygiene.

    B. **Rationalization** - Is an unconscious mechanism sometimes confused with reasoning. It is important for people to think well of themselves. Rationalizing can make this possible. It is face-saving. It is developing good, socially acceptable reasons to explain behavior and feelings so that the self-esteem and the approval of others are retained. Continual dependence on this mechanism develops the type of personality who never assumes responsibility for personal behavior, rather goes through life making excuses for personal failures. For example, an individual who is unable to do acceptable schoolwork drops out of school and claims it is because he can no longer go along with "the dumb stupid type of education that is being offered". Another example is a patient/resident who states he cannot give up smoking because he would gain weight and that would be more dangerous to his health than cigarettes. Remember this is <u>not</u> a conscious deception.

    C. **Projection** – Is an <u>unconscious</u> mental mechanism which is close to rationalization. A person attributes or imputes to other people his own intolerable and unacceptable feelings, wishes or thoughts. For instance, a nurse may dislike a particular patient/resident very much. As a good nurse she may feel she shouldn't dislike a patient/resident and it hurts her own self-image as a good nurse, so she may say that the patient/resident does not like her. A student, who cheats and wishes that he could stop, may accuse other people of cheating. In the mentally ill patient/resident this may lead to blaming others and paranoia.

D. **Displacement** – Is the redirecting of thoughts, feelings and impulses directed at one person or object but t a k e n out upon another person or object "unconsciously". For example, a hospital administrator criticizes a head nurse when something has gone wrong. The head nurse feels hurt, his self-image as a good head nurse is threatened, and he feels insecure. He returns to the floor and criticizes the team leader. The team leader in turn criticizes the nursing assistant and the Nurse Assistant becomes crabby and irritable with a patient/resident.

E. **Denial** – Is one of the simplest and most primitive of a person's ego defenses. Material, facts, feelings, and experiences that are intolerable are disowned by the unconscious denial of their existence. For example, parents may have all sorts of evidence that their children are misbehaving, but do not believe it. "Our children wouldn't do that."

F. **Conversion** – Substituting acceptable physical symptoms for unacceptable emotions and feelings. For example, a student has a test and is nervous and afraid of failing, develops nausea and vomiting.

G. **Repression** – Probably the most widely used defense mechanism. It is an unconscious, involuntary, and automatic pushing away of a person's intolerable ideas and unacceptable impulses into the subconscious where they are not normally subject to recall. One example is forgetting a dentist appointment. Feelings associated with the repressed material may still be present. For example, a man who was rejected by his mother as a child has difficulty in relationships with women, even though he has long forgotten the initial rejection.

H. **Sublimation** – Consciously unacceptable drives (urges) are channeled into personally and socially accepted behaviors. Those who work off sexual drives in athletic competition, or an angry housewife who scrubs the kitchen to work off her temper are two examples.

I. **Substitution (or compensation).** An unconscious process by which an unacceptable emotion or unattainable goal or object is replaced by a more acceptable or attainable one. Example: a childless woman becomes a nursery school teacher.

J. **Identification** – the process, unconscious, by which an individual patterns himself on another, perhaps by transferring to himself the thoughts, behaviors, and body language of the other person. For example, a person may believe he is Napoleon, or that she is Queen Mary.

Module 4: Prevention and Management of Catastrophe and Unusual Occurrences
Minimum Number of Theory Hours: 1
Recommended Theory Hours: 3
Recommended Clinical Hours: 1

Statement of Purpose:
The purpose of this unit is to introduce the student to the concepts and procedures related to the patient's/resident's safety including environmental emergency issues The Nurse Assistant 's role in creating a safe environment for the patient/resident is discussed.

Terminology:

1. Circulation, Sensation & Movement (CSM)
2. Disaster plan
3. Emergency
4. Emergency codes
5. Escape routes
6. External disaster
7. False imprisonment
8. Fire plan
9. Internal disaster
10. Material Safety Data Sheet (MSDS)
11. National Patient Safety Goals
12. Occupational Safety and Health Administration (OSHA)
13. Omnibus Budget Reconciliation Act (OBRA)
14. Oxygen (O_2)
15. Oxygen precautions
16. Postural supports
17. Pull, Aim, Squeeze, Sweep (PASS)
18. Quality Assurance (QA)
19. Rapid Response Team (RRT)
20. Rescue, Alarm, Contain, Extinguish (RACE)
21. Restraints
22. Safety Device Reminders (SDR)
23. Soft protective device
24. STAT
25. Total Quality Improvement (TQI)
26. Workplace violence

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

After completion of one hour of class, plus homework assignments, and one hour of clinical experience the learner will:

1. Define key terminology
2. Explain the role of the Nurse Assistant in emergency, disaster, and fire situations
3. Describe ways the Nurse Assistant can help patients/residents, families, and visitors remain calm in an emergency situation
4. Describe common emergency codes used in facilities
5. Describe general rules for providing a safe environment for the Nurse Assistant
6. Describe general rules for providing a safe environment for the patient/resident
7. Identify two safety issues for the patients/residents and interventions to prevent them
8. Describe major causes of fire and general fire prevention rules
9. List the safety rules to be followed for the patient/resident receiving oxygen therapy
10. Describe the safe application of postural supports and the implication for their use
11. Discuss the legal and psychological implication of the use of postural supports
12. Discuss the overview of bioterrorism
13.

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration	A. Ask students to select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test
Objective 2: **Describe the role of the Nurse Assistant in emergency, disaster, and fire situations.** A. Be prepared 1. Know emergency codes (facility rules) 2. Know fire and disaster plans 3. Know location of fire exit, extinguishers, and alarms B. Remain calm C. Use emergency call system 1. Telephone numbers used within each facility 2. The licensed nurse activates the EMS (Emergency Medical System) by dialing 911 D. Remain calm and do not shout “fire” or “cardiac arrest”, etc. E. “STAT” means to respond at once or there is an immediate need G. Use RACE and PASS per policy (see Objective 8) H. Do not act beyond level of knowledge I. Move patient/resident if in immediate danger J. Remain with patient/resident K. Keep patient/resident comfortable and calm L. Evacuate patient/resident to safety according to facility fire & disaster plans F. Send family or visitors to the facility-designated area	A. Lecture/Discussion B. Refer to Objective 4 for Code descriptions C. Review emergency codes and plans from each clinical site before visiting the facility D. Show pictures of fire exit signs and pull boxes E. At facility, instruct students to locate emergency equipment, fire extinguishers, and alarm boxes	A. Written test B. Provide mock situations at facility and ask students to respond according to facility policy

Objective 3: **Describe ways the Nurse Assistant can help patients/residents, families and visitors remain calm in an emergency situation.** A. Stay calm and use a calm voice B. Project confidence C. Know and use facility emergency codes and plans D. Stay with the patient/resident and keep them comfortable and quiet E. Move or direct families and visitors to the designated area in the facility or a safe environment F. Close fire doors	A. Lecture/Discussion B. During clinical experience, instruct students to locate designated safe areas in the facility C. Role play emergency situations and ask students to respond to patients/residents D. Unit/facility scavenger hunt	A. Written test B. Responds to mock emergency according to policy
Objective 4 **Describe common emergency codes used in facilities.** A. Each facility may have different codes B. Patient/resident safety issue; examples may be manpower or a special alarm sound C. Disaster code 1. Example may be Disaster Level Three 2. May be different for internal or external disaster D. Emergency colors and meanings 1. Code Red – fire 2. Code Blue – adult medical emergency (cardiac/pulmonary) 3. Code Yellow – bomb threat 4. Code Gray –combative person 5. Code Silver –person with weapon or hostage 6. Code Orange – hazardous waste spill or release	A. Lecture/Discussion B. Review emergency codes and plans from each clinical site before visiting the facility C. Have students write out each code and the meaning D. Use game or crossword to review	A. Written test B. Recognizes emergency codes and responds according to policy

Objective 5 **Describe general rules for providing a safe environment for the Nurse Assistant.** A. Use body mechanic principles B. Use ergonomics C. Know the policy and procedures regarding OSHA safety laws on use of equipment and handling hazardous materials (MSDS) D. Wipe up spills immediately and identify wet floors with the appropriate signs E. Walk, never run in halls and watch carefully at intersections F. Use contents of containers only if they have proper labels/dates and you know how to use them correctly G. Tag and report broken equipment H. Report unsafe situations I. Use 3-pronged plugs on electrical equipment J. Refuse to do any task that you do not know how to do K. Know proper operation of equipment L. Watch linen and garbage cans for safety hazards (sharps) M. Report if sharps container is over half full N. Know procedure to follow in case of personal injury 1. Report the injury immediately to the supervisor 2. Fill out an incident report/unusual occurrence form as per facility policy and procedure 3. Seek medical help as necessary O. Patient/resident and staff safety is an important quality assurance issue	A. Lecture/Discussion B. Show examples of incident form C. Discuss TQI and performance improvement issues	A. Written test B. Reports safety issues C. Follows policy to protect self from injury
Objective 6 **Describe general rules for providing a safe environment for the patient/resident.** A. Know the National Patient Safety Goals B. Check wrist bands/name tags before performing any task on a patient/resident C. Use side rails when appropriate and know facility policy and procedure on side rails D. Have the patient/resident use handrails/appropriate assistive device when unstable	A. Lecture/Discussion B. Show pictures of hazards and have students identify them and describe how to report/correct hazard C. Observe student in	A. Written test B. Responds to mock safety issue according to policy

E. Have patient/resident wear non-skid footwear when ambulatory F. Place the call signal light within the reach of the patient/resident and instruct them on correct use G. Lock wheels on bed/gurney/wheelchair when transferring the patient/resident H. Answer call lights promptly I. Use night-lights to help ensure good lighting and reduce obstacle hazards J. Keep the bed in the lowest position except when tending to the patient/resident K. Check bed/chair alarms ensuring working condition L. Keep environment clutter free	patient/resident room Ask if it is a safe environment and if not how to correct it	
Objective 7 **Describe two of the top safety issues for patients/residents and interventions to prevent them.** A. Falls are 70% of all patient/resident-related accidents. Most falls occur during 4:00pm and 8:00pm and during shift changes B. Ways to prevent falls 1. Proper position in bed/wheelchair and readjust every two hours 2. Soft protective devices as ordered and necessary 3. Side rails as necessary and use caution when raising and lowering Watch for arms/legs & tubing. Make sure the rails are locked in the up position 4. Brakes should be on when transferring patient/resident to or from wheelchair/bed/gurney 5. Comfort items (water, call bell, urinal, etc.) should be easy for patient/resident to reach 6. Answer call lights promptly 7. Areas should have good lighting and be free of clutter 8. Check to ensure foot latches on beds and foot supports on the wheelchair are out of the way to prevent tripping or hitting staff or patient's/resident's legs 9. Wipe up spills promptly 10. Meet the comfort needs of the patient/resident promptly (water and elimination)	A. Lecture/Discussion B. Shows videos for use of devices C. Demonstrate use of devices including gait belt and heating pads D. Review transfer and ambulation techniques E. Demonstrate use of soft restraints F. Show examples of equipment hazards G. Show pictures of various types of burns	A. Written test B. Uses assistive devices according to policy C. Reports and corrects fall hazards D. Monitors temperature of liquids used for patients/residents and avoids exposure of patient/resident E. Uses heating pads according to policy

11. Fall precautions; identify at risk patients who are taking medications that cause patient to be weak, dizzy or sleepy 12. Check patients/residents for weakness, dizziness and ambulation/transfer hazards 13. Use the appropriate assistive device as directed by the licensed nurse and ask for help if in doubt 14. Be aware of patient's/resident's location at all times C. Assistive devices used to reduce falls and maintain safe mobility of the patient/resident 1. Assessed for need by the licensed nurse, physical therapy (PT), or rehab aid with input from the Nurse Assistant 2. Cane a. Types of canes include single tip, tri-tip, and quad cane b. Use on the strong side c. Check the rubber tip and height appropriate for the patient/resident 3. Walker a. Provides stability and support b. Types of walkers include pick-up, front-wheeled, and four-wheeled rolling Some might have seats c. Check rubber tips and height appropriate for patient/resident d. Give instruction on the correct use 4. Gait belt if facility permits 5. Wheelchair a. Provide mobility for the non-ambulatory patient/resident b. Different types c. Remember removable arm rests and foot rests d. Check that the brakes are locked when transferring the patient/resident 6. Mobility alarm a. Used to warn staff and patient/resident of fall hazard b. Used in bed or in chair c. Make sure it is in place and all parts are connected d. Respond immediately to the alarm and check the patient/resident D. Burns are the second most common hazard for patients/residents and often can be prevented		

1. Types and causes of burns a. Steam or water burns 1) Bath temperature 2) Hot drinks b. Flame, smoking c. Chemical, cleaners like "Periwash" d. Thermal 1) Heating pads 2) Sunburn 2. Prevention and interventions for burns a. Prevention (best approach) 1) Check the water temperature and report if it is too hot 2) Monitor smoking 3) Monitor hot drinks and risk for spills 4) Be familiar with the use of equipment such as heating pads and hot packs and know the policy and procedure 5) Protect patient/resident from sunburn with a hat, sunscreen and brief exposure 6) Know the policy and procedure on fire response 7) Follow directions on the use of chemical cleansers b. Intervention (initial first aid) 1) First degree burns – ice and cold water only for discomfort a) Never use butter, shortening, etc., it may cause the burn to become worse 2) Deeper or large burns require immediate medical attention a) Notify licensed nurse immediately b) Describe the cause of burn, if possible (e.g. flame, chemical, etc.)		
Objective 8 **Describe major causes of fire and general fire prevention rules.** A. Major causes of fire 1. Smoking is the number one cause of fire 2. Sparks from faulty electrical equipment 3. Heating systems (fireplaces, butane/propane heaters or electrical heaters)	A. Lecture/Discussion B. Show examples of fire hazards	A. Written test B. Locates facility fire extinguishers and alarm

4. Spontaneous ignition, chemical reaction leading to heat and fire 5. Improper disposal of rubbish including disposed of cigarettes, cigars, matches with flammable materials B. Three things are needed to start a fire 1. Fuel 2. Flame 3. Oxygen C. Fire prevention 1. Electrical a. Report frayed electrical cords, smoke or burning smells b. Refrain from using too many electrical devices on one wall socket c. Use 3-pronged grounded plugs 2. Smoking fire hazard prevention a. Empty waste paper into proper containers b. Supervise patients/residents who smoke if they are confused, lethargic or weak c. Be sure materials in ash trays are completely extinguished before throwing them away d. Always use ashtrays when smoking e. Smoking is allowed in designated areas only D. The role of the Nurse Assistant during fire emergencies 1. RACE a. R-remove the patient/resident from the fire area and close the room door b. A-activate the fire alarm system c. C-contain the fire d. E-extinguish if possible 2. PASS a. P-Pull safety pin b. A-Aim at base of fire c. S-Squeeze 3. S-Sweep low 4. Be sure patients/residents are not placed near automatic fire doors 5. Know and follow the facility's specific policy and procedure related to fires and fire prevention	C. Provide samples of facility policy and procedures related to fire/fire prevention D. Demonstration of use of fire extinguisher by facility E. Handout 48a-PASS F. Handout 48b-RACE	boxes C. Reports fire hazards D. Responds to fire drills according to policy E. Follows facility policy regarding smoking and disposal of smoking materials F. Properly disposes of trash

Objective 9 **List the safety rules to be followed for the patient/resident receiving oxygen therapy.** A. Oxygen therapy 1. Oxygen is abbreviated O_2 and measured in liters per minute (L/min) 2. A colorless, odorless, tasteless gas is essential for respiration (breathing) 3. Some patients/residents need supplemental oxygen to assist them in breathing 4. Oxygen is supplied in portable tanks, through wall outlets or concentrators 5. Oxygen increases the risk of fire since it supports combustion and is one of the three elements needed for fire B. When oxygen is in use, specific safety precautions need to be followed 1. Place a "no smoking, oxygen in use" sign on the door of patient's/resident's room as well as over their bed 2. Smoking is never allowed near the oxygen by anyone, including the patient/resident or visitor 3. Keep oxygen-tubing open and free of kinks 4. Check electrical equipment use in presence of oxygen (electric razors, fans and radios) Electrical items must be turned off before unplugging 5. No flammable liquids, such as alcohol, nail polish remover or petroleum based products (Chap Stick, Vaseline) 6. Watch for static when combing patient's/resident's hair, using wool blankets, or nylon materials in clothing, etc. C. Types of oxygen equipment 1. Green metal portable tanks: (E tank/ H tank) a. Under pressure and must be handled carefully to prevent dropping and possible explosion when in storage b. Must be secured to wall c. Must be on movable stand and strapped in place 2. Portable tanks a. Large ones covered with plastic casing and small ones that patient/resident can carry or hang on assistive device when moving	A. Lecture/Discussion B. Show Video on oxygen use C. Show examples of oxygen equipment like nasal cannula, masks, oxygen tank, etc. D. Demonstrate placement of oxygen devices E. Demonstrate oxygen tank on/off procedure	A. Written test B. Observes safety guidelines when caring for patient/resident with oxygen

3. Wall outlets use wall mount flow meter and plastic tubing 4. Patient/resident equipment used to deliver flow of oxygen: a. Nasal cannula b. Face mask c. Concentrators D. Nursing care 1. A physician's order is needed for oxygen because it is considered a medication 2. Make sure the patient/resident wears mask/cannula at all times a. If oxygen needs to be turned off, there needs to be an order that the patient/resident may have it off at certain times b. When the oxygen is not in use for a short period of time, then the oxygen needs to be turned off It is very expensive and poses a fire hazard 3. The Nurse Assistant must follow the policy and procedure for their facility in filling the oxygen tanks, turning the tanks on and off, as well as the setup 4. Oxygen is very drying to nasal passages a. Check patient's/resident's nose and cleanse b. Maintain the water level in humidifier to reduce dryness 5. Check for redness and discomfort over the ears where the tubing rests and on the face when wearing the mask 6. If redness or discomfort noted, report to the licensed nurse 7. The Nurse Assistant may turn the tank on and off, but may not adjust the oxygen flow rate, as that is administration of medication and not in their scope of practice		
Objective 10 **Describe the safe application of postural supports and the implications for their use.** A. Postural supports/soft protective devices/restraints description and purpose 1. Used to prevent the patient/resident from harming self or others 2. Used to prevent patient/resident from a. Falling out of bed/chair b. Crawling over side rails or the end of the bed c. Interfering with therapy by removing tubing or dressings d. Hurting themselves or others	A Lecture/Discussion	A Written test

3. Description of terms a. Soft protective device – a device that serves as a reminder to the patient/resident of safety issues, like a waist device or Posey (also called safety device reminders-SDR) b. Postural supports – are devices that help to keep the patient/resident in the correct posture position when in a chair, like a jacket or vest c. Restraints 1) Control behavior and are used only in extreme measures like limb devices 2) Side rails can be considered as a restraint if all four side rails are up 3) Infringe on patient's/resident's right to freedom of movement as it holds back or limits a patient's/resident's movements and may be considered "false imprisonment" when inappropriately used B. Alternative to the use of devices 1. Place the patient/resident where they can have constant supervision 2. Make sure patient's/resident's comfort needs are met like water, toilet, reposition, etc. so there is a reduced risk of them attempting to meet needs unassisted and agitation is reduced Check for pain or discomfort 3. Devices are used as a last resort and never for nursing convenience or as punishment C. Types of protective devices and postural supports 1. Vest or jacket device – has an opening in the front, watch for choking and cutting into patient/resident 2. Wrist or ankle device – this soft limb device restricts limb movement 3. Hand mitt device – this device helps to prevent scratching and removal of tubes and dressings 4. Waist device – this can be a soft cloth that may be self-releasing to remind the patient/resident that they need assistance before walking or standing to reduce falls 5. Pelvic support – this keeps the patient/resident from sliding down in the wheelchair and are wide in the front and narrow	B. Show video on postural supports/restraints C. Show examples of types of devices D. Demonstrate and return demonstration for various types of devices including quick release tie E. Discuss alternative methods to protective devices F. Manual Skill 410 Applying Postural Supports	B. Applies and removes protective devices according to policy C. Documents use of devices

D. Regulations regarding the Nurse Assistant's role in the use of postural supports concern patient/resident rights and improper application which can be dangerous 1. Approach the patient/resident in a calm manner to reduce anxiety and agitation during application 2. Explain to the patient/resident and their family in a non-threatening manner by using terms like "safety" and "soft protective" 3. Use only on a patient/resident in a bed or chair that has wheels in case of an emergency 4. Place patient/resident in a good body alignment and position 5. Pad bony prominences 6. Use "quick release" bow-tie knot to secure postural support to bed frame or chair to ensure easy removal in an emergency 7. Tie securely, but allow some slack for movement – two-finger check between support and skin 8. Check circulation, sensation, and movement (CSM) every two hours 9. Tie support to the bed frame that moves with the patient/resident, not side rail 10. Remove the support, reposition patient/resident and do ROM to the joints every two hours for at least ten minutes or more frequently per facility policy 11. Offer fluids, bedpan, or urinal on a frequent, regular basis 12. Place the call bell in reach 13. Apply vest device with the open area of the vest in the front to prevent choking or use according to the manufacturer's instructions 14. Document type of device, reason for device, time on and off, CSMs, effectiveness, and nursing care that is needed		

Objective 11 **Discuss the legal and psychological implications of the use of postural supports.** A. Legal implications of the use of postural supports 1. Must have a doctor's order to use protective devices including stated reason for use, type of device, and for how long 2. Must have informed consent 3. Patient/resident rights require that patient/resident not be restrained unnecessarily or for the convenience of the staff 4. Unnecessary restraint of a patient/resident could constitute false imprisonment Ask nurse for explanation of needs if in doubt B. Psychological implication of the use of postural supports 1. Explain to the patient/resident and the family the reason for using protective devices 2. The patient/resident is usually aware of restricted movement and may struggle against the supports 3. Reassure and support the patient/resident and the family	A. Lecture/Discussion B. Review patient/resident rights	A. Written test B. Observes patient rights when using postural supports, protective devices and restraints

Objective 12 **Describe the overview of bioterrorism.** A. Define terrorism B. Possible terrorist acts 1. Biological threat a. Bacteria – Anthrax b. Viruses – Smallpox c. Toxins – Ricin 2. Chemical threat 3. Explosions 4. Nuclear blast 5. Radiation threat C. Possible types of bioterrorism threats 1. Explosion 2. Chemical/Biological Attack 3. Nuclear/Radiological Attack D. National Terrorism Advisory System (NTAS) replaces the Homeland Security Advisory System (HSAS) that was color- coded 1. Imminent Threat 2. Elevated Threat Alert E. Sunset Provision – expires after a specific time period	A. Lecture/Discussion B. Handout 412 – Homeland Security Advisory System C. Ask students to view information on US Department of Homeland Security website http://wwwdhsgov/national-terrorism-advisory-system	

Sample Test- Module 4: Prevention and Management of Catastrophe and Unusual Occurrences.

1. Mrs. S, the charge nurse, wants blood work results on Mr Jones immediately. Which of the following terms would indicate "immediately" to the lab?
   A. ASAP
   B. STAT
   C. PRN
   D. AD LIB

2. The Nurse Assistant finds a fire burning in a wastebasket in a patient's/resident's room. What should the Nurse Assistant do first?
   A. Go out into the hall and call out "fire"
   B. Remove the patient from the area of the fire
   C. Run out of the room to find a fire extinguisher
   D. Keep the patient's/resident's room dark to keep him in bed

3. Falls are a common cause of injury. Which of the following might help prevent the patient/resident from becoming injured from falls?
   A. Keep the patient's/resident's bed in the low position
   B. Place a small rug or towel on the floor by the bed to prevent slipping
   C. Have the patient/resident wear only socks when ambulating
   D. Keep the patient's/resident's room dark at night to keep him in bed

4. Mr. B is receiving oxygen therapy. Which of the following is a rule that should be followed with oxygen therapy?
   A. Use nylon blankets so there will be static electricity
   B. Do not allow smoking when oxygen is in use
   C. Use oil-based lotions to lubricate the skin
   D. Use electric razors for shaving the face

5. Mrs. A is being placed in a vest device to keep her from falling from her wheelchair. What should the Nurse Assistant do?
   A. Keep Mrs. A in her room out of sight of other patients/residents
   B. Apply the restraint to help control the patient's/resident's behavior
   C. Explain kindly to Mrs. A that the postural supports are being used to help prevent her from falling
   D. Use electric razors for shaving the face

6. When applying postural supports (restraints) the Nurse Assistant should keep in mind that:
    A. Careful use of restraints can decrease the need for direct patient care
    B. Patients/residents frequently become more calm, docile and compliant when restraints are used
    C. Registered nurses are allowed to order the use of restraints in long-term care facilities
    D. Unauthorized (unordered) use of restraints can result in accusation of “false imprisonment”

7. The Nurse Assistant enters a patient’s/resident’s room and sees the bed is at its highest level. The Nurse Assistant should know that:
    A. The patient/resident wants to get closer to the television set
    B. The patient/resident is very independent and will not be injured
    C. Nurse Assistant’s do not deal with safety issues
    D. The bed should be placed in the lowest position

8. RACE is a term representing activities to be carried out in the event of a fire. The “R” stands for which of the following?
    A. Run for help
    B. Remain at the fire site
    C. Reduce the fire risk
    D. Remove the patient/resident

9. To help prevent fires, the Nurse Assistant should:
    A. Remove the grounding prong from electrical cords
    B. Report frayed electrical cords immediately
    C. Empty ashtrays immediately into the wastebasket (trash)
    D. Encourage patients/residents to smoke only in their beds

10. The Nurse Assistant finds a frayed electrical cord on a fan in a patient’s/resident’s room. Which of the following actions is correct?
    A. Obtain electrical tape and cover the broken wire
    B. Report the situation to the nurse
    C. Activate the fire alarm and remove the patient/resident
    D. Check the fan by turning it on

11. Mr. B is receiving oxygen therapy and requests assistance with shaving. What should the Nurse Assistant do?
    A. Use alcohol to soften the patient’s/resident’s beard
    B. Shave with soap and a safety razor
    C. Use only grounded electrical razors
    D. Refuse to shave the patient/resident because oxygen interferes with blood clotting

12. Suffocation is?
    A. The loss of memory and thinking and reasoning abilities
    B. A sudden event in which people are killed and injured
    C. When breathing stops
    D. When electrical current passes through the body

13. Which person has the greatest risk for accidents and injuries?
    A. A 78-year old woman
    B. A person with dementia
    C. A person with a hearing impairment
    D. A person with impaired smell and touch

14. The Nurse Assistant sees water on the floor. The Nurse Assistant should immediately:
    A. Call the housekeeping staff
    B. Clean up the water
    C. Report the water to the nurse
    D. Place a paper towel over the water

15. Falls are most likely to occur:
    A. During change of shift
    B. During meal times
    C. When visitors are visiting
    D. When care is given

16. Who has the greatest risk of getting caught in the bed rails?
    A. Mr. S - uses bed rails to move and turn in bed
    B. Mrs. W- feels safer with upper bed rails
    C. Mr. G - is confused and disoriented
    D. Mrs. R – has bedrails down

17. For safety reasons, the wheelchair brakes must be locked:
    A. At all times
    B. When transferring into or out of the wheelchair
    C. When wheelchair is parked
    D. Wheelchair brakes should never be locked

18. Hazardous substances include the following EXCEPT:
    A. Oxygen
    B. Drugs used in cancer therapy
    C. Cleaning solutions
    D. Soaps and shampoos

19. You are injured while transferring a person to a wheelchair. Which is true?
    A. This is workplace violence
    B. You need to complete an incident report
    C. This is negligence
    D. This is patient/resident abuse

20. Which of the following items is NOT a fire hazard?
    A. A damaged electrical cord
    B. A full waste basket
    C. A broken three-pronged electrical plug
    D. An open can of cleaning fluid

21. The Nurse Assistant is ambulating a patient/resident with crutches. The Nurse Assistant should:
    A. Walk directly behind the patient/resident
    B. Replace the crutch every week
    C. Hold the patient's/resident's shoulder
    D. Have the patient/resident wear non-skid shoes

22. When applying soft postural supports to a patient/resident, the Nurse Assistant MUST:
    A. Apply the postural supports tightly
    B. Tie the postural supports to the side rails
    C. Apply lotion to the skin
    D. Apply padding over bony areas

23. To use a fire extinguisher, you must first:
    A. Remove the safety pin
    B. Direct the hose at the fire
    C. Squeeze the top handle
    D. Sound the nearest fire alarm

24. When making a patient/patient's/resident's bed, the Nurse Assistant discovers a damaged electrical cord. Which of the following actions should a Nurse Assistant take?
    A. Report the situation to the charge nurse
    B. Unplug the cord
    C. Wrap the exposed wires with tape
    D. Make the patient/patient's/resident's bed

25. To prevent patients/residents from falling, the Nurse Assistant should keep patients/residents
    A. Beds at the highest position, with side rails up
    B. Beds at the lowest position, with side rails up, if ordered
    C. Walkers and canes away from the beds and out of reach when not in use
    D. Wheelchair and walker wheels unlocked for easy movement

26. A patient/resident who is receiving oxygen has a visitor who wants to smoke. The Nurse Assistant should tell the visitor:
    A. To smoke at least three feet away from the patient/resident
    B. To go outside the building to smoke in a designated area
    C. That the oxygen can be stopped when the visitor smokes
    D. That the visitor can only smoke for five minutes

27. Which of the following safety precautions should the Nurse Assistant recognize as one to be used when caring for patients/residents who are receiving oxygen?
    A. Smoking is allowed in the room five feet away from the source of oxygen
    B. The nasal cannula or nose piece should be lubricated with petroleum jelly
    C. The humidifying container should not be connected to nasal oxygen
    D. A "No Smoking: Oxygen in Use" sign is placed on the door of the room

28. The Nurse Assistant discovers that the three-pointed ground plug has a point missing. The Nurse Assistant should:
    A. Plug the cord into the wall outlet
    B. Immediately tell the maintenance department
    C. Plug the cord in and look at it for problems
    D. Continue patient/resident care

29. Upon entering a patient's/resident's room, the Nurse Assistant discovers a fire. Which of the following is the correct sequence of steps that the Nurse Assistant should take?
    A. Contain and extinguish (put out) the fire, activate the safety alarm, and remove the patient/resident
    B. Activate the safety alarm, remove the patient/resident, and contain and extinguish (put out) the fire
    C. Extinguish (put out) the fire, remove the patient/resident, and activate the safety alarm
    D. Remove patient/resident, activate the safety alarm, and contain and extinguish (put out) the fire

30. The Nurse Assistant enters a patient's/resident's room and checks the patient/patient's/resident's environment. Which of the following problems must be taken care of immediately?
    A. The window is open
    B. The lights are flickering
    C. Electrical wires are exposed
    D. The faucet is dripping

31. During a disaster, the Nurse Assistant must:
    A. Know the disaster plan for the facility
    B. Know the facility administrator's telephone number
    C. First call home
    D. Call each patient/patient's/resident's family

32. After hearing the emergency code for fire, the Nurse Assistant should:
    A. Provide a list of all assigned patients/residents by name and room number
    B. Close all room doors and report to the nurse in charge
    C. Wait for the nurse in charge to give directions
    D. Wait for the fire fighters to give directions

33. The Nurse Assistant is caring for a patient/resident who is wearing wrist restraints. The Nurse Assistant should remove the restraints and perform passive range-of-motion exercises for the patient/resident at least every:
    A. 2 hours
    B. 4 hours
    C. 8 hours
    D. 24 hours

34. When a patient/resident is wearing a jacket restraint while in a chair, the Nurse Assistant should:
    A. Tie the restraints tightly as possible
    B. Close the patient's/resident's door to provide privacy during restraint
    C. Release the restraint every two hours for repositioning
    D. Tie the restraint to the side rail of the patient's/resident's bed

35. A patient/resident tells the Nurse Assistant that her wheelchair is broken The Nurse Assistant should FIRST:
    A. Tell the charge nurse
    B. Try to repair the wheelchair
    C. Ignore the situation
    D. Notify the patient's/resident's family

36. Which of the following devices would not be used for patient/resident activities of daily living?
    A. Plate guards and silverware with cuffs or curved handles
    B. A cup or glass holder and silverware attached to a splint
    C. A walker, a cane, and crutches
    D. A stethoscope, a blood pressure cuff, and a thermometer

37. The Nurse Assistant should use a gait belt:
    A. To help the patient/resident ambulate safely
    B. As a patient/resident restraint
    C. For back support when transferring patients/residents
    D. To hold the patient's/resident's oxygen tank on its cart

38. The Nurse Assistant is cleaning the nose of a patient/resident who is receiving continuous oxygen by a nasal tube. The Nurse Assistant should NOT use:
    A. A water-based lubricant
    B. Warm water
    C. An oil-based lubricant
    D. Soap and water

39. Which is the main reason that the Nurse Assistant MUST report broken equipment?
    A. The Nurse Assistant could be held legally responsible for the broken equipment
    B. The Nurse Assistant must care about patient/resident and staff safety
    C. The information will go in an incident report
    D. The information is needed by the nurse in charge

MANUAL SKILL: Applying Postural Supports (Restraints)

EQUIPMENT:

Authorization from a licensed nurse.
Postural support (as appropriate, ie limb, jacket (vest), waist).

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly Maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

A. Raise bed to comfortable working position.
B. Check body alignment and position.
    1. Limb device:
        a. Place soft edge of restraints against patient's/resident's skin Wrap restraint smoothly around the limb Make sure no wrinkles are present.
        b. Pull both ends of straps through tab or ring on the restraint; then pull the restraint secure, but not too tight, against the skin.
        c. Test for fit and comfort by inserting two fingers between the restraint and the patient's/resident's skin.
        d. Position arm or leg in comfortable position, limiting movement only as much as necessary.
    2. Jacket device:
        a. Assist patient/resident to sit in upright position Slip armholes of jacket onto patient's/resident's arms Be sure that vest is applied according to manufacturer's instructions.
        b. Test for fit and comfort by inserting two fingers between the restraint and the patient's/resident's skin.
    3. Waist device:

   a. Place waist device low over pelvis and down between wheelchair sides and seat to “the foot-bars” in back of the wheelchair.
   b. Test for fit and comfort, etc.

C. Secure straps to each side of movable part of bed frame or to back of wheelchair with easily removable tie, out of patient’s/resident’s reach Do not tie to side rails.
D. Observe color and temperature of skin below restraint (for vest restraint, observe respirations).
E. Check patient/resident every 15 to 30 minutes or according to facility policy.
F. Remove restraint and change position every two hours Offer toileting, fluids, range-of-motion exercises and position changes as needed. Provide skin care.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

P Pull safety pin

A Aim

S Squeeze

S Sweep low

R Remove the patient/resident from the fire area and close the room door

A Activate the fire alarm system

C Contain the fire

E Extinguish the fire, if possible

Module 5: Body Mechanics
Minimum Number of Theory Hours: 2
Recommended Theory Hours: 4
Recommended Clinical Hours: 4

Statement of Purpose:
The purpose of the unit is to provide students with an understanding of efficient and proper use of the body in performing tasks related to the role of the CNA. Students will understand the principles of positioning and transporting patients/residents and will implement these principles when providing patient/resident care.

Terminology:

1. Activities of Daily Living (ADL)
2. Alignment
3. Ambulate
4. Base of support
5. Body mechanics
6. Dangle
7. Dorsal recumbent
8. Fowler's position
9. Gait belt
10. Grasp
11. Hoyer lift
12. Lateral position
13. Lift/draw/turn
14. Lift team
15. Lithotomy
16. Logroll
17. Mechanical lift
18. Pivot
19. Prone position
20. Sim's position
21. Supine position
22. Trapeze
23. Trendelenburg
24. Total Quality Improvement (TQI)
25. Work-related musculoskeletal disorder (WRMD

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of the two (2) hours of class plus homework assignments and four (4) hours of clinical experience, the learner will be able to:

1. Define key terminology.
2. Explain the purpose and rules of proper body mechanics.
3. Identify comfort and safety measures used to lift, turn, move, and position patients/residents in bed.
4. List and describe body positions for bedridden patients/residents.
5. Describe patient/resident transfers.
6. Describe appropriate body mechanics used to ambulate a patient/resident.

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Explain the purpose and rules of proper body mechanics.** A. Proper body mechanics ensures the Nurse Assistant is using the body in an efficient and safe way 1. Practice body mechanics at all times 2. Everyone should use good body mechanics even patients/residents and families 3. Protects both employee and patient/resident from injury B. Basic rules of body mechanics 1. Assess the "job" to be done 2. Use wide base of support; feet 12 inches apart or shoulder width 3. Use stronger, larger muscle groups like legs, not the back and arms 4. Use correct posture and keep body aligned – back straight, knees bent 5. Keep objects close to body when lifting or carrying	A. Lecture/Discussion B. Show pictures or video on proper body mechanics C. Handout 5.2a- Body Mechanics Crossword D. Handout 5.2b- Body Mechanics Crossword-KEY	A. Written test B. Uses proper body mechanics when performing patient/resident care tasks

6. Never twist your body, turn or pivot feet – face work 7. Push, slide, or pull heavy objects instead of lifting – pivot 8. Avoid sudden jerky motions; use smooth movements 9. Use both hands when lifting 10. Team work – one leader who communicates/directs the group 11. Explain procedure to patient/resident C. Legal and Total Quality Improvement (TQI) issues 1. Legal a. Must protect and safeguard patient/resident b. Skin abrasion is reason for citation and a reportable incident 2. TQI issue: a. Back injuries-refer to Work-related musculoskeletal disorder (WRMD) b. Patient/resident safety-refer to OSHA		
Objective 3: **Identify comfort and safety measures used to lift, turn, move, and position patients/residents in bed.** A. Comfort measures for lifting and moving patients/residents 1. Inform the patient/resident of what you are doing and why 2. Provide privacy 3. Raise bed to working height to promote safe body mechanics 4. Position the patient/resident in proper body alignment 5. Use pillows and/or foam pads to support and cushion the patient/resident and protect bony prominences 6. Protect all tubing 7. Do not slide or drag to prevent skin shearing, abrasion, tear B. Safety measures for lifting and moving patients/residents 1. Assess the task a. Size up the load b. Obtain help if needed 1) If more than two people are needed, a mechanical lift is recommended 2) Some facilities have a lift team 2. Using appropriate body mechanics, reposition patient/resident in bed	A. Lecture/Discussion B. Demonstrate stoop, reach, lift, pivot, push/pull, and carry close techniques C. Demonstrate use of pull/draw sheet, gait belt D. Show videos demonstrating techniques E. Manual Skills 5.3a-Turning and Positioning the Patient/resident F. Manual Skills 5.3b-Moving the Helpless Patient/resident to Head of Bed	A. Written test B. Uses proper body mechanics to move patient/resident up in bed with single or double assist

a. Move the patient/resident up in bed 1) Use lift sheet if appropriate 2) Two people needed to move patient/resident and should stand at head of bed b. Turn patient/resident on side 1) Move patient/resident toward Nurse Assistant 2) Move patient/resident away from Nurse Assistant 3) Log roll patient/resident – all one position like a log with two Nurse Assistants 3. Why turn, lift, move and position patient/resident a. Comfort b. Prevent skin breakdown c. Stimulates body systems d. Encourages patient/resident to do ADL	using Two Assistants	
Objective 4 **List and describe body positions for bedridden patients/residents.** A. Positioning the patient/resident 1. Technique a. Do at least every two hours b. Use lift-sheet and move patient/resident to opposite side of bed you wish to turn the patient/resident to (for side lying position) c. Turn and position 2. Basic positions a. Supine – back b. Prone – abdomen c. Lateral – side d. Sim's e. Fowler's f. Semi-Fowler's g. Trendelenberg h. Reverse Trendelenberg i. Lithotomy B. Use supportive devices to provide comfort and support limb position (pillows and foam wedges)	A. Lecture/Discussion B. Demonstrate positioning C. Share policies from facilities used for clinical D. Manual skills 5.4- Positions on side	A. Written test B. Properly positions patients/residents in five basic positions using supportive devices

Objective 5 **Describe patient/resident transfers.** A. Transfers 1. Bed to chair 2. Chair to bed 3. Bed to gurney B. Transfer techniques C. Assistive equipment used to transfer patients/residents 1. Mechanical lift 2. Trapeze – patient/resident uses arms to help lift 3. Slide board – requires at least two healthcare workers to turn sheet to "slide" patient/resident over 4. Gait belt (transfer belt) a. Use to promote safety b. Apply to patient's/resident's waist c. Check for wounds, colostomy, and tubes on abdomen prior to application of belt d. Apply over clothing, not next to skin e. Check if belt is too tight or too loose f. Watch for continued proper placement of gait belt	A. Lecture/Discussion B. Demonstrate and return demonstration of transfer techniques C. Practice using slide board and turn sheet D. Manual skills 5.5a-Assisted Transfer from Bed to Chair/Wheelchair and Return to Bed E. Manual skills 5.5b-Mechanical Lift	A. Written test B. Uses proper techniques when transferring patient/resident from bed to chair and chair to bed C. Uses transfer equipment at facility
Objective 6 **Describe appropriate body mechanics used to ambulate a patient/resident.** A. Ambulation procedures 1. Dangle before ambulation 2. Ambulate patient/resident 3. Ambulate patient/resident with assistive devices a. Walker b. Cane c. Gait belt B. Prevention of injury if fall occurs during ambulation 1. Protection of patient/resident a. Guide the patient/resident to the floor b. Protect the patient's/resident's head c. Keep firm grip on the gait belt 2. Protection of self	A. Lecture/Discussion B. Show video ambulation techniques C. Demonstrate and return demonstration of a. Protective fall procedure b. Ambulation techniques D. Manual skills 5.6a-Assisted Ambulation of Patient/resident C. Manual skills 5.6b-	A. Written test B. Uses proper techniques when ambulating patient/resident C. Uses gait belt as required

a. Keep back straight b. Slide patient/resident to floor using the upper leg for support	Assisting the Patient/resident to Ambulate with Walker/Cane D. Manual skills 5.6c- Assists to ambulate using a transfer belt	

Sample Test: Module 5- Body Mechanics

1. The best reason to use proper body mechanics is to:
    A. Avoid lifting
    B. Prevent injury to the patient as well as the Nurse Assistant
    C. Prevent damage to the equipment in the facility
    D. Use back to lift heavy objects

2. The patient/resident is positioned in bed with the head of the bed in a partial sitting position at a 45 degree angle. This position is referred to as the:
    A. Prone position
    B. Supine position
    C. Sim's position
    D. Semi-fowler's position

3. When placing a patient/resident in the lateral position, you promote good body alignment by placing pillows for support under the:
    A. Head, abdomen and upper arms
    B. Head, shoulders and ankles
    C. Head, upper arm, upper leg and behind the back
    D. Head, lower back, arms and patient's/resident's sides

4. The Nurse Assistant has been asked to assist a patient/resident with ambulation. During the procedure, the Nurse Assistant should:
    A. Stand behind the patient/resident and provide support by holding the patient/resident around the waist
    B. Walk beside the patient/resident with the assistant's arm locked with the patient's/resident's arm
    C. Walk in front of the patient/resident with patient's/resident's hands placed on the assistant's shoulders for support
    D. Walk slightly behind and to one side of patient/resident providing support with the gait belt

5. Nurse Assistants are encouraged to use a gait belt when assisting with patient transfers. The purpose of a gait belt is to:
    A. Hold the patient's/resident's clothing in place
    B. Support the patient/resident when seated and protect the patient/resident from falling out of the chair
    C. Assist in transferring a dependent patient/resident and protect both the patient/resident and Nurse Assistant from injury
    D. Provide a safety handle for the patient/resident

6. Once an object has been lifted, the Nurse Assistant should keep the object:
    A. Under your arm
    B. Held to the side of the body
    C. As close to the body as possible
    D. In front of the body at shoulder height

7. When the Nurse Assistant is moving a patient/resident toward the head of the bed, they should remove:
    A. The foot cradle from the bed and place on floor
    B. The pillow from under the patient's/resident's head and place it against the headboard
    C. The bed covers from the patient/resident and fold at the end of the bed
    D. Any traction equipment that may be attached to the bed

8. When assisting a patient/resident with left sided weakness to transfer from the bed to a chair, the chair should be located:
    A. At the head of the bed, on patient's/resident's right side
    B. At the foot of the bed, on patient's/resident's left side
    C. At the middle of the bed directly across from where the patient/resident sits in the bed
    D. Across the room to encourage the patient/resident to get up and walk

9. When positioning a patient/resident in a side lying position, the Nurse Assistant must first:
    A. Log roll the patient/resident toward the nearest side rail
    B. Move the patient/resident toward the foot of the bed
    C. Move the patient/resident to the side of the bed where the Nurse Assistant is standing
    D. Log roll the patient/resident toward the opposite side rail by yourself

10. When a patient/resident is in good body alignment it means that the patient's/resident's:
    A. Head is in a straight line with the spine
    B. Arms and legs are positioned in a flexed position
    C. Body is used in a careful and efficient manner
    D. Performing exercises to provide movement for the joints

11. Before performing any task at the bedside, the Nurse Assistant should:
    A. Elevate the bed to a comfortable position to help
    B. Lower the bed to the lowest position to prevent the patient from falling out of bed
    C. Move surrounding furniture away from the bed so the Nurse Assistant won't bump into it
    D. Elevate the head of the bed so that the patient/resident can observe what you are doing

12. Which of the following describes the prone position?
    A. Lying on the left side with the upper leg flexed
    B. Lying on the back with toes pointed toward the foot of the bed
    C. Lying on the abdomen with the head turned to one side
    D. A semi-sitting position with knees flexed

13. A patient/resident is being transferred back to bed after being up in the wheelchair for a long period of time. As the Nurse Assistant you can best protect your back by:
    A. Using the stronger muscles of your lower arms and back
    B. Keeping a wide base of support and keeping the patient/resident as close as possible to you as you perform the transfer
    C. Pulling the patient/resident with sudden jerky movements so that you are able to move the patient/resident alone
    D. Providing a lot of space between you and the patient/resident so that you have room for movement

14. Miss Polly Walker has the head of her bed elevated 60 degrees. This position is referred to as:
    A. The supine position
    B. Fowler's position
    C. Sims' position
    D. The prone position

15. Your patient/resident is paralyzed from the waist down (paraplegia) and has maintained good upper body strength. The patient/resident wants to be able to move himself in bed, somewhat, without assistance. Which of the following pieces of equipment might be used for this purpose?
    A. Gurney
    B. Gait belt
    C. Trapeze
    D. Pillow

16. Two surfaces rub together. This is called:
    A. Friction
    B. Shearing
    C. Pressure
    D. Ergonomics

17. Good body alignment is needed:
    A. When standing
    B. When sitting
    C. When lifting
    D. All the time

18. When giving bedside care, the bed should be:
    A. At its highest horizontal level
    B. At its lowest horizontal level
    C. Level with your waist
    D. In Fowler's position

19. Before moving Mr. G up in bed, you need to:
    A. Put nonskid footwear on him
    B. Lock the bed wheels
    C. Apply a transfer belt
    D. Raise the head of the bed
20. You need to transfer Mr. H with a transfer belt. The belt is applied:
    A. After the transfer
    B. Under his clothing
    C. Over his clothing
    D. On his legs

21. Mr. H has weakness on his right side. Where should you position the wheelchair?
    A. Next to the bed on his right side
    B. Next to the bed on his left side
    C. At the foot of the bed
    D. At the head of the bed

22. To prevent falls during transfers, wheelchair, bed, shower chair, and stretcher wheels must:
    A. Be fully inflated
    B. Be locked
    C. Make noise
    D. Be clean

23. After transferring Ms. G to the toilet, you should:
    A. Close the bathroom door and stay in her room
    B. Close the bathroom door and leave the room
    C. Stay in the bathroom with her
    D. Leave the room

24. When ambulating, a patient/resident should be wearing:
    A. Socks
    B. Bedroom slippers
    C. Nonskid shoes
    D. Shower thongs

25. The Nurse Assistant is ambulating a patient/resident with a gait belt. If the patient/resident begins to fall, the Nurse Assistant should:
    A. Lower the patient/resident into a chair
    B. Hold the patient/resident up
    C. Gently lower the patient/resident to the floor
    D. Call out for assistance

26. The Nurse Assistant can prevent a weak patient/resident from falling in the shower by providing a:
    A. Shower chair
    B. Pick-up walker
    C. Gait belt
    D. Three-prong cane

27. An example of poor body mechanics is:
    A. Keeping objects close to the body when lifting them
    B. Keeping knees straight when working at the bedside
    C. Keeping feet apart to provide a wide base of support
    D. Pushing heavy objects rather than lifting them

28. When transferring a patient/resident with a mechanical lift (Hoyer lift), the patient's/resident's arms should be:
    A. Holding the sling
    B. On her chest
    C. Over her head
    D. Dangling at her side

MANUAL SKILL: Turning and Positioning the Patient/resident

EQUIPMENT:

Pillows

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves, if necessary

SKILL STEPS:

1. Raise the bed to your working height; make sure wheels are locked and the top sheet and blanket is loosened.
2. Lower side rail nearest you. Be sure the opposite side rail is elevated and locked in place.
3. Slide arms under patient's/resident's shoulders and, using good body mechanics, move the patient's/resident's legs toward you on your arms.
4. Slide both arms under the patient's/resident's buttock (upper thighs and lower back) and, using good body mechanics, move the patient's/resident's buttocks toward you on your arms.
5. Slide both arms under the patient's/resident's lower legs and, using good body mechanics move the patient's/resident's shoulders toward you on your arms.
6. Cross the patient's/resident's arm across his/her chest.
7. To turn the patient/resident away from you, cross the leg nearest to you over the far leg at the ankle, or bend the knee up with foot on bed.
8. Place one hand on the patient's/resident's shoulder nearest you and your other hand on the hip nearest you.
9. Turn the patient/resident gently to his/her side facing away from you. Make sure patient/resident will not be lying too close to either side rail. Spine should be straight and in alignment with the bed. Extended bottom leg should be in alignment with back and shoulder.
10. Position a pillow lengthwise against the patient's/resident's back for support. Place pillow under top arm with arm slightly flexed

and in front of patient/resident. Shoulder, elbow, and wrist should be supported to the same height. Place pillow(s) between legs with top leg slightly flexed and forward. Hip, knee, and ankle should be supported to the same height. The bottom arm should be flexed with

palm of hand facing up. Support the patient's/resident's head in one hand and slide a pillow under the head and neck using the other hand. (Be sure the patient's/resident's ear is not bent).
11. Make sure patient/resident is in correct body alignment, and is comfortable.
12. Straighten top linen.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Dispose of gloves (without contaminating self) into correct waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Place bed in low position
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

MANUAL SKILL: Moving the Helpless Patient/resident to the Head of the Bed Using Two Assistants.

EQUIPMENT:

Lift sheet

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Have a co-worker help in this procedure.
2. Raise the bed to the position most comfortable for you during lifting. Lower the head and foot of the bed if raised.
3. Position your co-worker on one side of the bed and yourself on the other side.
4. Both of you should lower the side rail beside you.
5. Remove the pillow from under the patient's/resident's head and place it against the headboard (this prevents the patient's/resident's head from hitting the headboard).
6. Cross the patient's/resident's arms across the chest.
7. The co-worker, using both hands, rolls to the edge of the lift sheet close to the patient's/resident's side, thus forming a secure handle. Make sure the lift sheet is positioned from above the patient's/resident's shoulders to below the buttocks. Grasp the rolled sheet with your hands at the patient's/resident's shoulders and at the hips.
8. Stand with your feet about twelve inches apart (or shoulder width), turn your body and your feet slightly toward the head of the bed.
9. Even when the patient/resident appears unable to understand, explain that on the count of three, he or she will be moved to the head of the bed.
10. Keeping your back straight, bend slightly at the hips and knees.
11. At the count of three, shift your weight from your back foot to your forward foot, while sliding patient/resident toward head of bed.

12. Unroll the lift sheet.
13. Tighten the bottom sheet and lift sheet, making certain no wrinkles remain under the patient's/resident's body.
14. Reposition the patient/resident. Replace pillows under the head and shoulders, between legs and at the back if in a side-lying position.
15. Assess for comfort, place the nurse call signal within easy reach, and thank the patient/resident and your co-worker.
16. Raise the side rails, then adjust the head and foot of the bed and lower the bed to lowest position.

To turn the patient/resident towards you:

1. Follow criteria 1-8 above
2. Be sure the patient/resident is lying in the middle of the bed
3. Raise the side rail nearest you
4. If possible cross the leg farthest from you over the near leg
5. Reach across the patient/resident and put one hand behind the far shoulder
6. Put the other hand behind the far hip and gently roll the patient/resident toward you
7. Position using pillows as described above
8. Make sure patient/resident is in correct body alignment
9. Straighten and tuck in the top linen
10. Raise side rail, lower bed, and position call light within reach

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

MANUAL SKILLS: Positions on Side

EQUIPMENT:

Pillows

BEGINNING STEPS:

1. Gather equipment, if applicable
2. Wash hands
3. Knock and pause before entering the patient's/resident's room
4. Introduce self
5. Identify patient/resident
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact
7. Provide for privacy with a curtain, door, or screen

SKILL STEPS:

1. Raises side rail on side to which the body will be turned
2. Slowly roll onto side as one unit toward raised side rail
3. Places or adjusts pillow under head for support
4. Patient/resident is positioned so they are not lying on arm
5. Supports top arm with supportive device
6. Places supportive device behind patient's/resident's back
7. Places supportive device between legs with top knee flexed; knee and ankle supported

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Position patient/resident comfortably
3. Place call light within reach
4. Lower bed to safe position for the patient/resident
5. Leave room neat
6. Wash hands
7. Document

8. Report abnormal findings to licensed nurse

MANUAL SKILL: Assisted Transfer from Bed to Chair/Wheelchair and Return to Bed.

EQUIPMENT:

Chair or wheelchair
Gait belt
Non-skid shoes/footwear

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Position wheelchair close to bed with arm of the wheelchair almost touching the bed.
2. Position wheelchair on patient's/resident's strong side with brakes locked and footrests removed, flipped back against chair and out of the way, or flipped up and out of the way.
3. Place non-skid shoes on patient's/resident's feet.
4. Help patient/resident sit on side of bed with feet flat on floor.
5. Assess patient/resident for tolerance to an upright position, such as dizziness or nausea.
6. Place gait belt around the patient's/resident's waist outside of his/her clothes.
    a. *With transfer (gait) belt*: Stand in front of patient/resident, positioning self to ensure safety of Nurse Assistant and patient/resident during transfer (e.g. knees bent, feet apart, back straight), place belt around patient's/resident's waist and grasp belt (upward grasp).
    b. *Without transfer belt*: Stand in front of patient/resident, positioning self to ensure safety of Nurse Assistant and patient/resident during transfer (e.g. knees bent, feet apart, back straight, arms around patient's/resident's torso under the arms).
7. Stand in front of patient/resident. Place your feet about shoulder width apart (or 12 inches apart) with the patient's/resident's weak

leg between your knees. Have patient/resident rest his/her hands on your shoulder, upper arms, or your waist. Note: Patient/resident should not put his/her arms around your neck.

8. Firmly grasp the gait belt at the patient's/resident's sides.
9. On count of three, help patient/resident to stand, supporting weak leg with your knees.
10. Pivot with the patient/resident toward the chair (which is toward the patient's/resident's strong side).
11. Have the patient/resident grasp the arm of the wheelchair.
12. When patient/resident is in proper position, lower the patient/resident slowly into the chair, bending your knees, using the strength of your legs, and keeping your back straight.
13. Reposition patient/resident with hips touching back of the wheelchair and remove transfer belt, if used.
14. Re-adjust or re-apply footrests if used and place signaling device within reach.
15. To return the patient/resident to bed, place the wheelchair on the patient's/resident's strong side, with brakes locked and footrests up, removed or flipped back out of the way, then repeat steps 12 to 16 to move the patient/resident from the chair to the bed.
16. Remove the patient's/resident's shoes or slippers.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

MANUAL SKILL: Mechanical Lift

EQUIPMENT:

Hydraulic/Mechanical lift
Sling
Wheelchair or chair

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Secure co-worker to assist
2. Position chair
3. Position sling under the patient/resident by turning the patient/resident side to side. The sling should firmly support the patient's/resident's torso from shoulder to knees
4. Protect patient/resident from injury from metal bars/rings
5. Position the lift over the patient/resident with the base beneath the bed and locked in its widest position
6. Attach sling to mechanical lift with the hooks or straps in place through the metal frame. Be sure to apply hooks with open, sharp end facing away from patient/resident, if present
7. Have patient/resident fold both arms across chest, if possible
8. Inform patient/resident and staff members that lift is going to begin
9. Raise sling so it is clear of the bed
10. Have the assisting co-worker guide the patient's/resident's legs
11. Move lift back until patient/resident is centered over wheelchair
12. Carefully lower patient/resident into chair

13. Remove straps, hooks and bars from sling leaving sling in place while the patient/resident is in the chair
14. To return patient/resident to bed, reverse above procedure and turn patient/resident side to side when in bed to remove sling

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

Manual Skills: Transfers from Bed to Wheelchair Using Transfer Belt

EQUIPMENT:

Transfer belt
Wheelchair

BEGINNING STEPS:

1. Gather equipment, if applicable
2. Wash hands
3. Knock and pause before entering the patient's/resident's room
4. Introduce self
5. Identify patient/resident
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
7. Privacy provided with a curtain, screen, or door

SKILL STEPS:

1. Before assisting to stand.
    1. Wheelchair is positioned alongside of bed, at head of bed facing the foot or foot of bed facing head
    2. Footrests are folded up or removed
    3. Bed is at a safe level
    4. Wheels are in locked position on wheelchair
    5. Check and/or locks bed wheels
    6. Patient/resident is assisted to a sitting position with feet flat on the floor
    7. Nurse Assistant ensures Patient/resident is wearing shoes
    8. Apply transfer belt securely over clothing/gown
    9. Provide instructions to enable patient/resident to assist in transfer including prearranged signal to alert when to begin standing
2. Stands facing patient/resident positioning self to ensure safety of Nurse Assistant and patient/resident during transfer. Counts to three (or says other prearranged signal) to alert patient/resident to begin standing.
3. On signal, gradually assists patient/resident to stand by grasping transfer belt on both sides with an upward grasp (Nurse Assistant's hands are in upward position) and maintaining stability of patient's/resident's legs.
4. Assists patient/resident to turn to stand in front of wheelchair with back of patient's/resident's legs against wheelchair.

5. Lowers patient/resident into wheelchair.
6. Positions patient/resident with hips touching back of wheelchair and transfer belt is removed.
7. Positions feet on foot rests.
8. After completing skill, wash hands.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Position patient/resident comfortably
3. Place call light within reach
4. Leave room neat
5. Wash hand.
6. Document
7. Report abnormal findings to licensed nurse

MANUAL SKILL: Assisted Ambulation of Patient/resident

EQUIPMENT:

Gait belt
Robe
Shoes/non-skid slippers

BEGINNING STEPS:

1. Obtain information on patient's/resident's capabilities such as:
    A. Distance able to ambulate
    B. Assistive device used
    C. Number of people needed
    D. Any weaknesses
2. Wash hands
3. Knock and pause before entering the patient's/resident's room
4. Introduce self
5. Identify patient/resident
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
7. Gather equipment, if applicable
8. Provide for privacy with a curtain, door, or screen
9. Apply gloves (standard precautions)

SKILL STEPS:

1. Lower bed to safe level and lower nearest side rail.
2. Assist the patient/resident to move to the side of the bed and to sit on the side of the bed, with feet flat on floor.
3. Assist the patient/resident to put on robe and shoes/non-skid slippers.
    A. *See page 32-33 With transfer (gait) belt*:
    B. *Without transfer belt*: Stand in front of patient/resident, positioning self to ensure safety of Nurse Assistant and patient/resident during transfer (e.g. knees bent, feet apart, back straight, arms around patient's/resident's torso under the arms).
4. Stand facing the patient/resident with your feet shoulder-width apart.
5. Have the patient/resident place his/her hands on your waist.

6. Grasp the gait belt firmly at each side of the patient/resident.

7. Brace your knees against the patient's/resident's knees.
8. Block the patient's/resident's feet from sliding with your feet.
9. On signal, assist the patient/resident up into a standing position as you straighten your knees.
10. Move behind and slightly to one side of the patient/resident.
11. Grasp the gait belt with one hand and support the patient/resident as needed with the other hand. Do not let go of the gait belt.
12. Walk with the patient/resident with your gait matching the gait of the patient/resident.
13. Frequently assess the patient/resident for dizziness, weakness and need to rest.
14. After ambulation, assist patient/resident to a position of comfort and safety in bed and remove transfer belt, if used.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

MANUAL SKILL: Assisting the Patient/resident to Ambulate with Walker/Cane

EQUIPMENT:

Gait belt (as needed)
Shoes or non-skid slippers
Walker or cane

BEGINNING STEPS:

1. Obtain information on patient's/resident's capabilities such as
    a. Distance able to walk
    b. Type of assistive device
    c. Number of people
    d. Needs and weaknesses
2. Wash hands
3. Knock and pause before entering the patient's/resident's room
4. Introduce self
5. Identify patient/resident
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
7. Gather equipment, if applicable
8. Provide for privacy with a curtain, door, or screen
9. Apply gloves (standard precautions)

SKILL STEPS:

1. Lower bed to lowest position.
    a. With transfer (gait) belt: Stand in front of patient/resident, positioning self to ensure safety of Nurse Assistant and patient/resident during transfer (e.g. knees bent, feet apart, back straight), place belt around patient's/resident's waist and grasp belt.
    b. Without transfer belt: Stand in front of patient/resident, positioning self to ensure safety of Nurse Assistant and patient/resident during transfer (e.g.) knees bent, feet apart, back straight, arms around patient's/resident's torso under the arms).
2. Place shoes or non-skid slippers on patient's/resident's feet.
3. Check walker or cane for worn or loose parts and appropriate height.
4. Place walker or cane close by the patient/resident.

5. Assist patient/resident to stand, count “1, 2, 3.”

6. Hand patient/resident the cane or place walker in front of patient/resident within reach.
7. Have patient/resident use their arms on chair arm to push self to standing position and grasp walker/cane.
8. The cane is to be held on the strong side.
9. The patient/resident should advance cane 10-12 inches followed by weaker leg and then stronger leg.
10. To use a walker, have patient/resident advance walker six inches
    a. Patient/resident then should move weaker leg forward into walker, followed by stronger leg.
    b. Keep patient/resident in the center of the walker.
    c. All four corners of the walker should be in contact with the floor before patient/resident places weight on walker.
11. If using a gait belt, stand slightly behind the patient/resident on the weaker side with hand grasping the belt at patient's/resident's mid-back.
12. After ambulation, return patient/resident to bed or chair
    a. Have patient/resident walk within a step of bed or chair.
    b. Place cane or walker to side.
    c. Assist patient/resident to turn around.
    d. When patient/resident feels bed or chair touching the back of the legs, have the patient/resident reach for the arm of the chair or mattress of bed and lower self into chair or bed. (Use gait belt to assist as needed).
13. Remove gait belt if used.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

MANUAL SKILLS: Assists to Ambulate Using Transfer Belt

EQUIPMENT:

Transfer belt

BEGINNING STEPS:

1. Gather equipment
2. Wash hands
3. Knock and pause before entering the patient's/resident's room
4. Introduce self
5. Identify patient/resident
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible

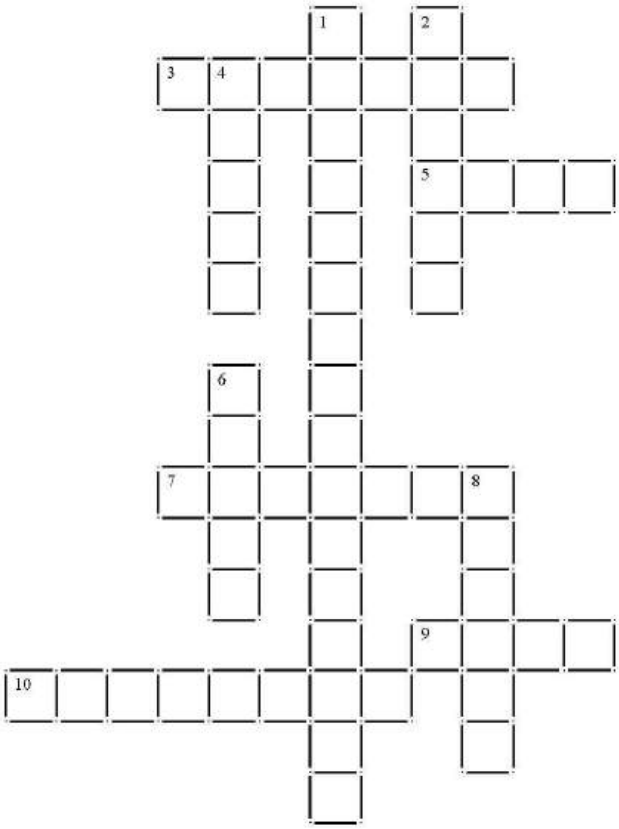
SKILL STEPS:

1. Before assisting to stand.
   a. Nurse Assistant ensures patient/resident is wearing shoes
   b. Bed is at a safe level
   c. Checks and/or locks bed wheels
   d. Patient/resident is assisted to sitting position with feet flat on the floor
   e. Applies transfer belt securely at the waist over clothing/gown
   f. Provides instructions to enable patient/resident to assist in standing including prearranged signal to alert patient/resident to begin standing
2. Stands facing patient/resident positioning self to ensure safety of Nurse Assistant and patient/resident during transfer. Counts to three (or says other prearranged signal) to alert patient/resident to begin standing.
3. On signal, gradually assists patient/resident to stand by grasping transfer belt on both sides with an upward grasp (Nurse Assistant's hands are in upward position), and maintaining stability of patient's/resident's legs.
4. Walks slightly behind and to one side of patient/resident for a distance of 10 (ten) feet, while holding onto the belt.
5. After ambulation, assists patient/resident to bed and removes transfer belt.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

Body Mechanics Crossword



ACROSS

3 A side-laying position
5 A belt used to help residents walk.
7 A semi-sitting position.
9 A side-laying position in which the upper leg is sharply flexed and the lower arm is behind.
10 Walk.

DOWN

1 A piece of equipment used to transfer residents.
2 The resident sits on the side of the bed.
4 The way body parts are arranged.
6 A resident is positioned on the abdomen with the head turned to one side.
8 The resident is positioned on the back.

Module 6: Medical and Surgical Asepsis
Minimum Number of Theory Hours: 2
Suggested Theory Hours: 5
Recommended Clinical Hours: 8

Statement of Purpose:
The purpose of this unit is to present information about asepsis and the control of infection. Procedures and precautions to protect patient/patients/residents, health care workers and others from infection are presented, including standard precautions, transmission-based precautions and biohazardous waste management.

Terminology

1. Acquired Immunodeficiency Syndrome (AIDS)
2. Airborne precautions
3. Asepsis
4. Athlete's foot
5. Bacteria
6. Barriers
7. Biohazard symbol
8. Bloodborne
9. Carrier spore
10. Centers for Disease Control (CDC)
11. Chain of infection
12. Communicable
13. Contact precautions
14. Contagious microbes
15. Contamination
16. Disinfection
17. Disorientation
18. Disposable
19. Droplet precautions
20. Environmental Protection Agency (EPA)
21. Escherichia coli (E. coli)
22. Excretions
23. Exposure incident
24. Flora
25. Fungus
26. Health Care-Associated Infection (HAI)
27. Hepatitis A, B, C, D, E
28. Herpes zoster
29. Host
30. Immunity
31. Infection
32. Infectious agent
33. Influenza
34. Isolation
35. Lice
36. Material Safety Data Sheet (MSDS)
37. Methicillin-Resistant Staphylococcus aureus (MRSA)
38. Microorganisms
39. Nausea
40. Non-intact
41. Nosocomial
42. Occupational Safety and Health Administration (OSHA)
43. Pathogens
44. Personal Protective Equipment (PPE)
45. Pneumonia
46. Precautions
47. Protozoa
48. Reservoir
49. Reverse isolation
50. Rickettsia
51. Scabies
52. Sepsis
53. Standard precautions
54. Sterilization
55. Streptococcus
56. Transmission-based
57. Tuberculosis
58. Vancomycin-Resistant Enterococci (VRE)
59. Virus

Patient, patient/resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of the two (2) hours of class plus homework assignments and eight (8) hours of clinical experience, the learner will be able to:

1. Define key terminology
2. Name four infectious agents (microbes) and discuss the diseases they cause
3. Discuss two antibiotic resistant bacteria
4. State five conditions necessary for infectious agents to grow
5. Identify the six parts of the chain of infection
6. List four lines of defense against infection in the body
7. Describe the signs and symptoms of infection
8. Differentiate between medical and surgical asepsis
9. Identify the roles of the Centers for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA) in the prevention of infections
10. Explain standard precaution procedures
11. Describe personal protective equipment (PPE) and proper use
12. Define transmission-based precautions
13. Identify the psychological effects of standard precaution and transmission based precautions on patient/patients/residents

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Name four infectious agents (microbes) and discuss the diseases they cause.** A. Bacteria 1. Streptococcus – strep throat, pneumonia 2. E. coli – urinary infections 3. Tuberculosis – lung disease 4. Rickettsia a. Lice – itching (body, head and pubic) b. Scabies – skin rash B. Virus 1. HIV (AIDS virus) – acquired immunodeficiency syndrome 2. Hepatitis A, B, C – liver disease 3. Common cold – respiratory infection 4. Influenza – fever, chills, body aches 5. Herpes zoster – shingles	A. Lecture/Discussion B. Share personal experiences with diseases and identify infectious agent involved C. Discuss why the elderly might be more prone to these illnesses D. Discuss possible feelings about caring for a patient/patient/resident with an infectious disease	A. Written test B. Class participation

C. Fungi 1. Tinea pedis – athlete's foot 2. Candida albicans – yeast infection D. Protozoa 1. Malaria		
Objective 3 **Discuss two antibiotic resistant bacteria.** A. Methicillin resistant *staphylococcus auerus* (MRSA) infection B. Vancomycin resistant *enterococcus* (VRE) – infection	A. Lecture/Discussion B. Discuss why microorganisms have become antibiotic-resistant	A. Written test B. Class participation
Objective 4 **State five conditions necessary for infectious agents to grow.** A. Food source B. Moisture C. Oxygen or lack of oxygen D. Warmth E. Darkness	A. Lecture B. Discussion	A. Written test B. Class participation
Objective 5 **Identify the six parts of the chain of infection.** A. Causative agent 1. Bacteria 2. Viruses 3. Fungi 4. Insects B. Reservoir 1. Patient/resident 2. Health care worker 3. Environment 4. Equipment	A. Lecture/Discussion B. Handout 6.5- Chain of Infection C. Demonstrate and return demonstration for passing ice D. Ask class to identify ways to break the chain of infection E. Manual Skills 6.5- Passing Ice	A. Written test B. Class participation

C. Portal of exit 1. Wound drainage 2. Bodily fluids 3. Feces 4. Blood 5. Respiratory, reproductive and urinary tracts 6. Saliva D. Method of transmission 1. Airborne 2. Droplet 3. Contact (direct and indirect) 4. Food/water 5. Animals/insects E. Portal of entry 1. Non-intact skin (cut on hand) 2. Mucous membrane (mouth) 3. Respiratory tract 4. Urinary tract 5. Reproductive tract F. Susceptible host 1. Patient/resident 2. Health care worker 3. Families		
Objective 6 **List four lines of defense against infection in the body.** A. Normal flora B. Intact skin C. Mucous membranes D. Immune system	A. Lecture B. Discussion	A. Written test B. Class participation
Objective 7 **Describe the signs and symptoms of infection.** A. Appetite loss	A. Lecture/Discussion	A. Written test

B. Pain C. Diarrhea D. Drainage E. Disorientation F. Fatigue G. Fever H. Nausea I. Rash J. Redness K. Swelling L. Tenderness M. Vomiting	B. Have class share: 1. How a specific illness might have been prevented? 2. What signs and symptoms would be evident?	B. Identify and report signs and symptoms of infection to licensed nurse
Objective 8 **Differentiate between medical and surgical asepsis.** A. Medical Asepsis/clean techniques 1. Hand washing 2. Disinfection - process of destroying pathogens utilizing water and/or disinfectant B. Surgical asepsis/sterile technique 1. Use of equipment which has been sterilized 2. Use of barriers to prevent transmission of infectious agents	A. Lecture/Discussion B. Demonstrate and return demonstration for hand washing C. Present several examples of violation in aseptic technique and ask students to identify problem and solution D. Hand Hygiene Saves Lives: Patient Admissions Video (free PodCast) from the CDC at: https://tools.cdc.gov/medialibrary/index.aspx#/landing/mediatype/Video/language/english/page/1/sort/desc/group/0/query/Hand%2520Hygiene E. Manual Skills 6.8-Standard Precautions	A. Written test B. Differentiate between items that are sterile, clean, and dirty

Objective 9 **Identify the roles of Center for Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) in the prevention of infections.** A. CDC – Centers for Disease Control and Prevention 1. Located in Atlanta, Georgia 2. Under the Department of Health and Human Services (a federal agency) 3. Makes non-regulatory recommendations for disease control 4. Introduced categories of precautions a. "Standard precautions" b. "Transmission-based precautions" B. Occupational Safety and Health Administration (OSHA) 1. State regulatory agency which publishes and endorses rules to keep workers safe includes an infection control plan 2. Requires written documentation and follow-up on exposure incidents	A. Lecture B. Discussion C. Explore how CDC and OSHA requirements are implemented on the job	A. Written test B. Class participation C. Follow CDC and OSHA regulations
Objective 10 **Explain standard precautions procedures.** A. Standard precautions 1. Precautions used for the care of all patients/residents regardless of their diagnosis or presumed infectious status 2. Designed to reduce the risk of transmission of microorganisms from moist body fluids, including a. Blood b. All body fluids, secretions and excretions except sweat c. Non-intact skin d. Mucous membranes B. Contamination 1. Process by which an object, person or area becomes unclean 2. Microorganisms are present C. Methods to prevent contamination 1. Hand washing a. Beginning of shift	A. Lecture/Discussion B. Video or other A/V on Standard precautions C. Manual Skills 6.10-Washes Hands	A. Written Test B. Consistently follows Standard Precautions

b. Between patients/residents c. After using the bathroom d. Before handling food e. After removing gloves f. After covering nose and mouth when coughing or sneezing g. When providing toothbrushes, drinking glasses, towels and washcloths, etc. h. Prior to handling raw fruit and vegetables before serving 2. Alcohol foams, gels, or disposable antiseptic towelettes a. May be substituted for soap and water and used during procedures which involve multiple patient/resident contact over a period of time b. The use of these products is not recommended if the hands are accidentally soiled with blood or other body fluids 3. Sharps disposal (needles and razors) a. Needles are never bent, broken or recapped by hand b. Dispose in appropriate sharps containers (biohazardous containers) D. Environmental controls 1. Use Environmental Protection Agency (EPA) registered disinfectant on solid surfaces including floors, furniture, bathrooms and utility rooms 2. Reusable equipment must be cleaned or disinfected before reuse 3. Mouthpieces for resuscitation should be available 4. Waste and soiled linen should be placed in plastic bags and disposed of according to agency policy 5. Use separate containers for regular wastes and biohazardous wastes (blood and body fluids that contain blood) 6. Wipe up body fluid spills immediately. Disinfect area according to agency's policy 7. Do not eat, drink, apply cosmetics or handle contact lenses in contaminated areas 8. Labeling a. Biohazard symbol for sharps and liquid blood		

b. Laboratory specimens and specimen containers are potentially infectious c. See agency policies for labeling and transporting		
Objective 11 **Describe personal protective equipment (PPE) and proper use.** A. Gloves 1. Required when a. In contact with blood, body fluids, dressings, tissues or surfaces contaminated with blood or body fluids b. In contact with non-intact skin or mucous membranes 2. Remove gloves when contact is completed and wash hands 3. If gloves become punctured or torn, they should be removed 4. Change gloves between patients/residents 5. Do not reuse gloves B. Gowns or aprons 1. Required when the possibility of soiling with blood or body fluids might occur 2. Remove when procedure is complete and prior to leaving the room 3. Gloves are not to be washed C. Facial protection 1. Masks, goggles or face shields 2. Required when splashing may occur to protect the worker's eyes, nose and mouth	A. Lecture/Discussion B. Audiovisual aids that show donning and removing PPE C. Manual Skills 6.11a- Standard Precautions: Gloving, Gowning and Applying Mask D. Manual Skills 6.11b- Donning and Removing PPE: Gown and Gloves	A. Written test B. Class participation
Objective 12 **Define transmission-based precautions.** A. Transmission based precautions are used for patients/residents known or suspected to be infected with pathogens which can be transmitted through air, droplet, contact, or contaminated surfaces B. Guidelines by CDC indicate specific precautions and barriers to be used Transmission based precautions are used in addition to standard precautions	A. Lecture/Discussion B. Divide into groups to review types of precautions and required PPE	A. Written test B. Consistently uses appropriate transmission-based precautions

1. Airborne precautions a. Used to prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], *Mycobacterium tuberculosis*, and possibly SARS-CoV.) b. The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR) equipped with special air handling and ventilation capacity (i.e., monitored negative pressure) c. In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks for healthcare personnel will reduce the likelihood of airborne transmission until the patient is either transferred or placed in isolation d. Healthcare personnel caring for patients on Airborne Precautions must wear a mask or respirator, depending on the disease-specific recommendations e. Whenever possible, non-immune healthcare workers should not care for patients with vaccine-preventable airborne diseases (e.g., measles, chickenpox, and smallpox) 2. Droplet precautions a. Used to prevent spread through close respiratory or mucous membrane contact with respiratory secretions usually within a three-foot radius b. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling		

and ventilation are not required to prevent droplet transmission c. Infectious agents for which Droplet Precautions are indicated include *B. pertussis*, influenza virus, adenovirus, rhinovirus, *N. meningitides*, and group A streptococcus (for the first 24 hours of antimicrobial therapy) d. Healthcare personnel wear a mask (a respirator is not necessary) for close contact with an infectious patient/resident 3. Contact precautions a. Used to prevent spread by direct or indirect contact with the patient or the patient's environment b. Apply in the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission c. Healthcare personnel caring for patients on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment D. Isolation means to separate the patient/resident with a communicable disease to prevent the spread of pathogens 1. Isolation precautions used are dependent on how pathogen is transmitted 2. Consult agency's guidelines for identification of pathogen and		
Objective 13 **Identify the psychological effects of standard precautions and transmission based precautions on patients/residents.** A. Placing the patient/resident in isolation may interfere with following basic needs as defined by Maslow 1. Safety needs	A. Lecture/Discussion B. Provide a simulation of isolation with students	A. Written test B. Provides emotional support for patients/residents in

2. Love, belonging, affiliation needs 3. Self-esteem 4. Self-actualization B. Methods of assisting the patient/resident to meet these needs 1. Explain the reasons for the isolation to the patient/resident 2. Frequently check on the patient's/resident's condition 3. Provide the patient/resident with newspapers, books, & magazines, if appropriate 4. Instruct the family and visitors on the details of the isolation technique to make it easier for them to visit the patient/resident 5. Make sure the necessary equipment for the isolation technique is available 6. Place the call bell within the patient's/resident's reach and be sure he/she knows how to use it. Respond to the call bell promptly 7. Talk with the patient/resident while in the room giving care	taking turns in role of Nurse Assistant and patient/resident	isolation

Sample Test: Module 6- Medical and Surgical Asepsis

1. A small living plant or animal that cannot be seen without the aid of a microscope is a:
    A. Microwave
    B. Macrocosm
    C. Microphagus
    D. Microorganism

2. The process by which all microorganisms are destroyed is called:
    A. Isolation
    B. Sterilization
    C. Disinfection
    D. Asepsis

3. A body best protects itself against infections through:
    A. The shedding of tears
    B. Maintaining intact skin
    C. Active peristalsis
    D. A productive cough

4. Hepatitis B is an example of a:
    A. Fungus
    B. Virus
    C. Bacteria
    D. Protozoa

5. Strep (streptococcal) throat results from invasion by:
    A. A fungus
    B. A virus
    C. Rickettsia
    D. Bacteria

6. Microorganisms will grow best in:
    A. High temperatures
    B. Moist places
    C. Direct sunlight
    D. Dry places

7. Which of the following is a sign of infection?
    A. High blood pressure
    B. Bruising
    C. Increased appetite
    D. Fever

8. Washing hands is one way to prevent the spread of infectious agents through:
    A. Direct contact
    B. Droplet spread
    C. Airborne transmission
    D. Food and water

9. The health worker can break the chain of infection:
    A. When a susceptible host exhibits the signs of infection
    B. At any link of the chain
    C. Only at the portal of exit
    D. Only with transmission based precautions

10. Following good aseptic techniques, the health worker will wash hands:
    A. After handling food
    B. Before using the bathroom
    C. Between patients/residents
    D. After going home

11. Which of the following is an example of contamination?
    A. Turning gloves inside out when removing them
    B. Carrying linen away from the uniform
    C. Touching the inside of the sink
    D. Using paper towel to turn off the faucet

12. After bathing a patient/resident, the health worker should wash his/her hands:
    A. Keeping the hands pointed up
    B. Only if they are contaminated
    C. With hot water and bar soap
    D. In a circular motion with friction

13. Asepsis means:
    A. Clean technique
    B. The process of destroying pathogens
    C. An infection acquired after admission to a health care agency
    D. Being free of disease-producing microbes

14. Clean technique is the same as:
    A. Sterile technique
    B. Surgical asepsis
    C. Medical asepsis
    D. Normal flora

15. A person has protection against a certain disease. The person has:
    A. Immunity
    B. Personal protective equipment
    C. A vaccine
    D. A germicide

16. A vaccine is:
    A. A suspension containing weakened or killed microorganisms
    B. Used to disinfect supplies and equipment
    C. Used to treat infection
    D. Normal flora

17. Who can develop nosocomial or Healthcare Associated Infection (HAI)?
    A. Patients/residents
    B. Nursing team
    C. Doctors
    D. Health team

18. Which is the easiest and most important way to prevent infections from spreading?
    A. Standard precautions
    B. Wearing gloves at all times
    C. Transmission-Based Precautions
    D. The Blood borne Pathogen Standard

19. When cleaning the perineal area of the female body, you need to clean:
    A. From bottom to top
    B. Away from your body
    C. From front to back
    D. As fast as possible

20. Standard Precautions apply to:
    A. All persons
    B. All patients/residents
    C. The health team
    D. Persons with infections

21. Soiled linens are:
    A. Handled according to the center's policies
    B. Discarded
    C. Sent home with the family
    D. Washed in the person's room

22. The nurse hands you a used plastic syringe with the needle attached. You should:
    A. Bend the needle
    B. Break the needle off of the syringe
    C. Place cap on the needle
    D. Place the needle and syringe in a puncture-resistant container

23. A wet gown is considered to be:
    A. Sterile
    B. Contaminated
    C. Safe
    D. Clean

24. The hepatitis B vaccination involves:
    A. 1 injection
    B. 2 injections
    C. 3 injections
    D. 4 injections

25. Persons needing isolation precautions often experience
    A. Loss of self-esteem
    B. Self-actualization
    C. Love and belonging
    D. Safety

26. The Nurse Assistant is leaving an isolation room. After hand washing, the Nurse Assistant should:
    A. Use a disposable glove to open the door and put glove in the basket outside the room
    B. Use a paper towel to open the door and put the basket inside the room near the door
    C. Use a paper towel to open the door and put the paper towel in the basket outside the room
    D. Open the door with clean, washed hands

27. Standard precautions require the Nurse Assistant to wear gloves when caring for a patient/resident if the Nurse Assistant has:
    A. A cold
    B. Long fingernails
    C. A cut or sore on the hand
    D. Dirty hands

28. The Nurse Assistant should know that the proper hand washing includes soap, friction and:
    A. A clean sink
    B. Running water
    C. Plenty of towels
    D. An antiseptic solution

29. The correct order for removing protective clothing before leaving a patient's/resident's isolation room is:
    A. Gloves, gown, mask, and wash hands
    B. Mask, gown, gloves, and wash hands
    C. Mask, gloves, gown, and wash hands
    D. Gown, gloves, mask and wash hands

30. When changing bed linens, which actions by the Nurse Assistant would ensure that medical asepsis is being followed?
    A. Hold the clean, new linen close to the body
    B. Shake the linens before placing them on the bed
    C. Place all dirty linens on the floor
    D. Place all clean linens on a clean surface

31. Which of the following is NOT a common sign of infection?
    A. Redness or swelling at a wound site
    B. Elevated temperature or chills
    C. Drainage from a wound
    D. Dizziness when getting up

32. The Nurse Assistant is collecting a urine specimen using standard precautions. Which of the following should the Nurse Assistant do?
    A. Wash hands and apply gloves before beginning the urine collection
    B. Have the patient/resident empty the bladder before the urine collection
    C. Place a label on the specimen container before the urine is collected
    D. Wash the perineum with soap and water

33. After hand washing, the Nurse Assistant should turn off the faucet using:
    A. Clean hands before drying them
    B. Clean hands after drying them
    C. Clean, dry paper towel after hands are dried
    D. Clean elbow before hands are dried

34. Between routine patient/resident contacts, the Nurse Assistant should wash or scrub his/her hands under clean running water for at least:
    A. 10 seconds
    B. 20 seconds
    C. 3 minutes
    D. 5 minutes

35. To most effectively prevent the spread of infection while providing patient/resident care, the Nurse Assistant should:
    A. Bathe the patient/resident every day
    B. Wash hands after caring for each patient/resident
    C. Provide proper fluid and nourishment
    D. Change linen daily

36. To ensure medical asepsis when collecting a specimen from a patient/resident, the Nurse Assistant must:
    A. Use only sterile equipment
    B. Refrigerate the specimen for 24 hours
    C. Wash hands before and after the procedure
    D. Send specimen to the laboratory as soon as possible

37. The Nurse Assistant should wear a mask and gloves when the patient/resident:
    A. Has a skin rash
    B. Has a reddened pressure area on the coccyx
    C. Coughs up bloody secretions
    D. Is using a bedpan

38. The Nurse Assistant comes to work with a cold. Which of the following actions would be appropriate?
    A. Put on a mask and perform patient/resident care as usual
    B. Report the cold to the licensed nurse and put on mask
    C. Tell the patient/resident about the cold
    D. Check own temperature regularly

39. Which of the following should the Nurse Assistant recognize as an important part of standard precautions?
    A. Take blood pressure
    B. Enforce a non-smoking policy near oxygen sources
    C. Raise side rails on patient's/resident's bed
    D. Wear gloves when touching body secretions

40. When caring for a patient/resident who is in isolation, how would the Nurse Assistant safely remove soiled linen?
    A. Leave soiled linen in room for housekeeping to remove
    B. Wear gloves when bringing out the soiled linen
    C. Double-bag the soiled linen when required by your facility
    D. Take soiled linen to a container outside of the room

41. The licensed nurse tells the Nurse Assistant that a patient's/resident's bedpan needs to be cleaned. The MOST effective way to kill all the organisms would be to:
    A. Wash the bedpan with soap and water
    B. Use a chemical disinfectant on the bedpan
    C. Put the bedpan in a bedpan washer
    D. Wash the bedpan in hot water

42. The Nurse Assistant should NOT wear gloves when:
    A. Caring for a patient's/resident's pressure sores
    B. Emptying a urinary catheter collection bag
    C. Feeding a patient/resident
    D. Assisting the nurse during a dressing change

MANUAL SKILL: Passing Ice

EQUIPMENT:

Clean water pitcher
Ice chest
Ice machine
Ice scoop

SKILL STEPS:

1. Wash hands
2. Apply gloves
3. Fill ice chest with clean ice from ice machine. Do not touch ice with your hands
4. Return ice scoop to holder
5. Close lid on ice chest during transport
6. Empty old ice and water from patient's/resident's water pitcher into a sink or obtain a clean water pitcher
7. Pick up ice scoop by handle only
8. Fill water pitcher with clean ice. Do not put unused ice into the ice chest
9. Place scoop in holder or tray when not in use. Do not leave scoop in ice
10. Close lid on ice chest
11. Place the filled water pitcher at the bedside

MANUAL SKILL: Standard Precautions - Hand-Washing

EQUIPMENT:

Orange stick or nail file (optional)
Paper towels
Running water
Soap Dispenser
Waste container

SKILL STEPS:

1. Push your watch up 4-5 inches higher on your arm.
2. Stand away from sink so that your uniform does not touch the sink.
3. Turn on the faucet, using a paper towel unless foot pedal is used.
4. Adjust the water temperature until it is warm.
5. Toss the used paper towel into the wastebasket.
6. Completely wet your hands and wrists. Keep your fingertips pointed downward.
7. Press hand soap dispenser or step on foot pedal, collecting soap in palm of one hand.
8. Rub your palms together in a circular motion, work up a good lather, and rub vigorously.
9. Wash your hands for at least 20 seconds generating friction on all surfaces of hands & fingers.
    a. Wash each wrist.
    b. Rub back of each hand by interlacing fingers.
    c. Rub palms of hands together, interlacing fingers.
    d. Clean under fingernails by rubbing the tips of your fingers against your palms to clean with friction around the nail beds.
    e. Never touch inside of sink.
10. Optional: clean your short fingernails with a blunt edge of an orange stick or personal finger brush.
11. Rinse with running water. Rinse from four inches above your wrists down to your hands. Hold your hands and fingertips down, allowing the water to flow off at the fingertips.
12. Pat dry your wrists and hands with paper towels and throw away the towel.
13. Turn off the faucet with a clean paper towel placed between your hands and the faucet to avoid contamination.
14. Toss paper towel into wastebasket.

Note: Waterless antiseptic agents (alcohol-based gels & foams) may be used for when hands are not visibly soiled.

Manual Skills: Hand Hygiene (Hand Washing)

Equipment
Paper towel
Soap

Skill Steps:
1. Addresses client by name and introduces self to client.
2. Turns on water at sink.
3. Wets hands and wrists thoroughly.
4. Applies soap to hands.
5. Lather all surfaces of wrists, hands, and fingers producing friction, for at least twenty seconds.
6. Cleans fingernails by rubbing fingertips against palms of the opposite hand.
7. Rinses all surfaces of wrists, hands, and fingers keeping hands lower than the elbows and the fingertips down.
8. Uses clean, dry paper towel to dry all surfaces of hands, wrists, and fingers then disposes of paper towel into waste container.
9. Uses clean, dry paper towel to turn off faucet then disposes of paper towel into waste container or uses knee/foot control to turn off faucet.
10. Does not touch inside of sink at any time.

MANUAL SKILL: Standard Precautions: Gloving, Gowning, and Applying Mask

EQUIPMENT:

Gloves
Goggles
Gown or Apron
Mask

PRINCIPLES:

1. Wear disposable gloves when touching blood, body fluids, and mucous membranes or materials contaminated by them.
2. Wear disposable gloves when you have cuts, breaks or openings in the skin.
3. Gloves are worn when there is possible contact with urine, feces, vomitus, dressings, soiled drainage, soiled linen, or soiled clothing.
4. Change gloves between patients/residents and wash hands.
5. Remove gloves if they tear or become heavily soiled. Wash hands and apply a new pair.
6. Masks, goggles, or face shields are worn when splattering or splashing of blood or body fluids is possible.
7. Gowns or aprons are worn when splashing, splattering, smearing, or soiling from blood or body fluids is possible.
8. Hand washing is done after contact with mucous membranes, blood or body fluids, non-intact skin, regardless of glove use.

SKILL STEPS:

Gloving:

1. Wear gloves to protect the hands from body fluids from the patient/resident.
2. Put on a pair of gloves over clean hands.
3. Provide necessary care.
4. When both hands are still gloved, be sure to not touch your skin.
5. To remove one glove, grasp it just below the cuff.
6. Pull the glove down over your hand so that it is turned inside out.
7. Hold the removed glove with your other gloved hand.
8. Reach inside the other glove at the wrist with the first two fingers of your ungloved hand.
9. Pull the glove down over your hand and the other glove.
10. Discard the gloves in the regular trash.
11. Wash your hands.

Applying gowns:

1. Remove your watch and all jewelry.

2. If mask and goggles or face shield is required, put on before gowning.
3. Pick up clean gown. Hold it out in front of you so that it can unfold. Do not shake the gown.
4. Put the gown on, making sure the gown covers the front of your uniform. Tie strings at neck.
5. Overlap the back of the gown.
6. Tie the waist strings at the back.
7. Put on gloves if needed.
8. Provide the necessary patient/resident care.

Removing gowns:

1. Remove the gown by untying the neck strings from behind.
2. Untie the waist strings; do not touch the outside of the gown. Slip fingers of one hand into inside cuff of the other hand without touching outside of gown.
3. Using gown-covered hand, pull gown over the dominant hand.
4. Using the gown covered hand, pull gown down over other hand and remove without touching outside of gown.
5. Discard gown in appropriate container.
6. Wash your hands.

Applying masks:

1. Position the mask over your nose. Your nose and mouth must be covered.
2. Place the upper strings over the top of your ears. Tie the strings in the back toward the top of your head.
3. Tie the lower strings at the back of your neck. Make sure the lower part of the mask is under your chin. If you wear glasses, the mask should fit snugly over your nose and under the bottom edge of the glasses.
4. Mold the metal strip over the bridge of your nose.
5. Avoid coughing, sneezing, and unnecessary talking while wearing the mask.
6. Use a new mask for each patient/resident contact when a mask is required.

Removing masks:

1. Wash your hands before untying the mask. Untie bottom ties first, then top.
2. Discard mask by holding strings (avoid touching the inside of the mask).
3. Discard the mask in regular trash.

Applying goggles:

1. Put on mask.
2. Position goggles over eyes.
3. Change goggles and mask if soiled during procedure.

4. Provide necessary care.

Removing goggles:

1. Remove gloves and wash hands.
2. Remove goggles prior to removing the mask.
3. Goggles can be washed with soap and water for future use.

Sequencing for applying barriers (PPE's):

1. Wash hands.
2. Gown.
3. Mask.
4. Goggles.
5. Gloves.

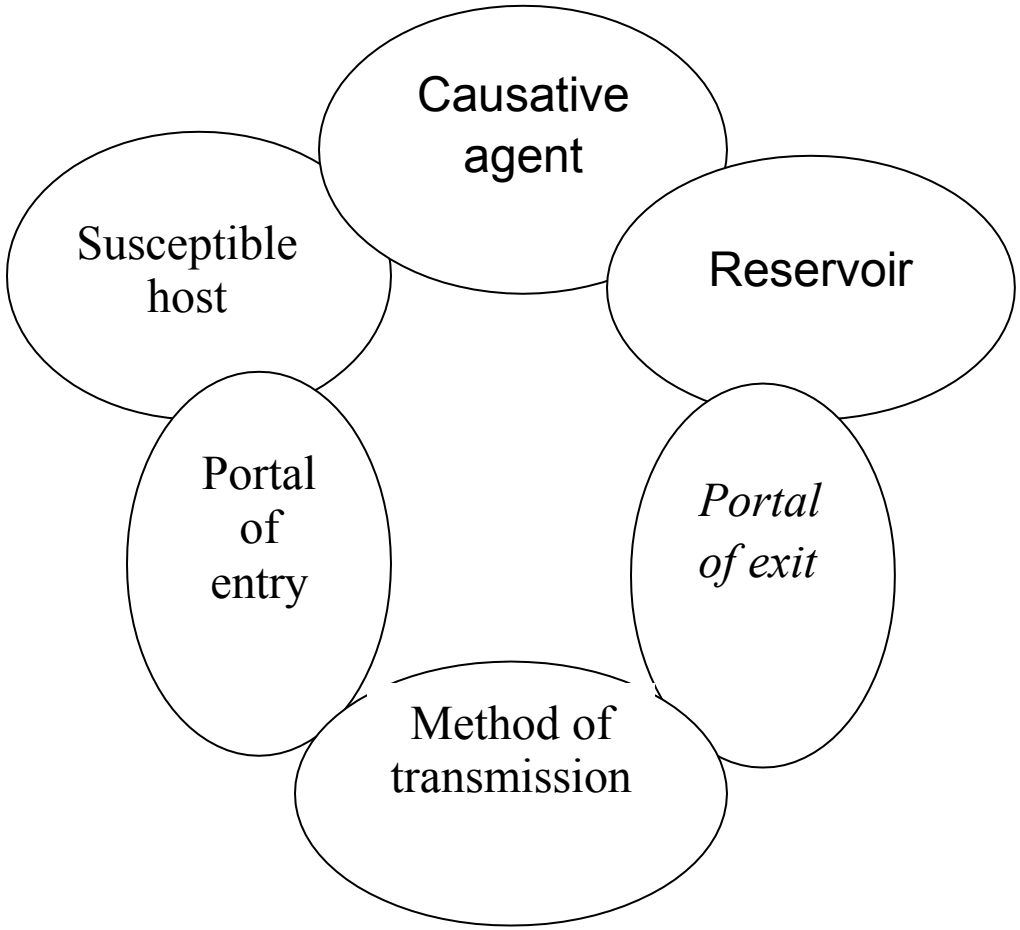
Sequencing for removing barriers (PPE's):

1. Gloves.
2. Wash hands.
3. Goggles.
4. Gown.
5. Mask.
6. Wash Hands.

MANNUAL SKILLS: Donning and Removing PPE: Gown and Gloves

Equipment:
Gloves
Gown

Skill Steps:
1. Picks up gown and unfolds.
2. Facing the back opening of the gown places arms through each sleeve.
3. Fasten the neck opening.
4. Secure gown at waist making sure that back of clothing is covered by gown (as much as possible).
5. Put on gloves.
6. Cuffs of gloves overlap cuffs of gown.
7. Before removing gown, with one gloved hand, grasps the other glove at the palm, remove glove.
8. Slips fingers from ungloved hand underneath cuff of remaining glove at wrist, and removes glove turning it inside out as it is removed.
9. Disposed of gloves into designated waste container without contaminating self.
10. After removing gloves, unfastens gown at neck and waist.
11. After removing gloves, removes gown without touching outside of gown.
12. While removing gown, holds gown away from body, turns gown inward and keeps it inside out.
13. Disposes of gown in designated container without contaminating self.
14. Washes hands.



The Chain of Infection. Components of the infectious disease process.

Module 7: Weights and Measures
Minimum Number of Theory Hours: 1
Recommended Theory Hours: 1
Recommended Clinical Hours: 1

Statement of Purpose:
The purpose of this unit is to introduce a measuring system for weight, length, and volume used by nursing assistant in the clinical setting.

Terminology:

1. Centimeter
2. Fluid ounce (fl oz.)
3. Foot (ft.)
4. Gallon (gal)
5. Gram
6. Greenwich
7. Household system
8. Inch (in)
9. Kilogram (Kg)
10. Liter
11. Meter (M)
12. Metric system
13. Military time (or international time)
14. Milliliter (ml)
15. Millimeter (mm)
16. Ounce (oz.)
17. Pint (pt.)
18. Pound (lb.)
19. Quart
20. Tablespoon (Tbsp.)
21. Teaspoon (tsp.)
22. Yard (yd.)

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of one (1) hour of class plus homework assignments and one (1) hour of clinical experience, the learner will be able to:

1. Define key terminology
2. Identify units of measurement used in the household and metric systems for weight, length, and volume
3. Identify and describe equipment commonly used by the Nurse Assistant for measuring weight, length, height, and volume
4. Convert common measurements between the household and metric systems
5. Measure and record weight, height, and volume using the metric and household systems
6. Convert between standard time and military time (24 hour clock)

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define Key Terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards E. Handout 7.1a- Weights and Measures Crossword F. Handout 7.1b- Weights and Measures Crossword- KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2: **Identify units of measurement used in the household and metric systems for weight, height, and volume.** A. U.S. Customary weights and measurements (household) 1. Weight – ounce (oz) and pound (lb) 2. Length – inch (in), feet (ft), yard (yd), mile (mi) 3. Volume – fluid ounce (fl oz), pint (pt), quart (qt), gallon (gal), teaspoon (tsp), tablespoon (Tbsp) B. International weights and measurements (metric) 1. Weight - gram (gm), kilogram (kg) 2. Length - millimeter (mm), centimeter (cm), meter (M) 3. Volume - milliliter (ml), liter (L)	A. Lecture/Discussion B. Flash cards of terms and abbreviations C. Show examples of equipment used to measure weight, length, and volume	A. Written test B. Correctly identify metric and household measuring equipment and the units of measure for each

Objective 3: **Identify and describe equipment commonly used by the Nurse Assistant for measuring weight, length, and volume (see module 8).** A. Volume measuring equipment 1. Graduated cylinders (metric and household) a. Marked with lines and numbers b. Usually marked in ounces and milliliters c. Measuring cups and spoons (household) d. Serving containers B. Length measuring equipment 1. Yardstick 2. Tape measure 3. Standing scale with measuring rod a. Marked in fractions of inches, feet b. Marked in centimeters C. Weight measuring equipment 1. Scales a. Marked in ounces, pounds, grams, and kilograms b. Can be electronic or digital 2. Types of scales a. Standing 1) Used for patient/resident who can stand unassisted and not hold onto scale 2) Patient/resident must be steady on feet b. Wheelchair 1) Used for patient/resident who cannot stand unassisted 2) Weigh unoccupied wheelchair, then weigh patient/resident in wheelchair and subtract wheelchair weight from total weight c. Mechanical lift 1) Cloth sling to hold patient/resident and a hydraulic lift to raise and lower 2) Weigh sling and any linen first, then subtract	A. Lecture/Discussion B. Show examples of equipment used to measure weight, length, and volume	A. Written test B. Correctly identify metric and household measuring equipment and the units of measure for each

d. Bed scale 1) Used for patient/resident who is on bed rest or unable to be in a chair or ambulate 2) Weigh any linens first then subtract linens from total weight 3) Patient's/resident's body must not be touching mattress e. Chair-used for patient/resident who cannot stand unassisted		
Objective 4: **Convert common measurements between the household and metric systems.** A. Weight (wt) 1 Kg = 2.2 pounds (lb) B. Length 1 inch = 2.5 centimeters (cm) C. Volume 1. 1 ounce = 30 milliliters (ml) 2. 1 cup = 240 ml = 8 ounce (oz) 3. 1 pint = 500 ml 4. 1 quart = 1000 ml = 1 liter (L) 5. 1 teaspoon (tsp) = 5ml 6. 1 tablespoon (Tbsp) = 15 ml	A. Lecture/Discussion B. Handout 7.4- Lab Activity Practice Worksheet C. Have students make flashcards of equivalents and additional abbreviations D. Assign workbook exercises for homework	A. Written test B. Identify instances in which conversion between household and metric systems is required
Objective 5: **Measure and record weight, length, and volume using metric and household systems.** A. Procedure for measuring weight on a standing scale 1. Prior to beginning procedure, make sure the scale is balanced at zero 2. Place paper towel on platform	A. Lecture/Discussion B. Handout 7.5- Fluid Measurement Lab Activity C. Provide sample trays to	A. Written test B. Record accurately all measurements on appropriate facility forms

3. Help patient/resident step onto center of the scale 4. Read the scale when in balance to the nearest quarter pound (or tenth of kilogram) 5. Help patient/resident off the scale 6. Clean and return equipment 7. Record measurement using correct abbreviation for unit of measurement B. Procedure for measuring length 1. Length is also measured as height 2. A measuring tape can be used for a patient/resident who is stooped, contracted, or in bed a. Measure all segments b. Add all measurements together to find total height 3. Measuring a patient's/resident's height using an upright scale a. Assist the patient/resident to remove their slippers b. Raise the height rod on the upright scale c. Assist the patient/resident to stand on the scale platform, arms at sides d. Have the patient/resident turn around and face away from the scale e. Lower the height measurement rod until it rests on patient's/resident's head f. Record the height, reading is made at the moveable point of the ruler g. Assist patient/resident off the platform and put slippers back on h. Record measurement using correct abbreviation for unit of measurement C. Procedure for measuring volume 1. Pour liquid into graduate container 2. Place container on flat surface 3. Read at eye level 4. Use measurement at lowest level of liquid surface 5. Record measurement using correct abbreviation for unit of measurement	calculate fluid intake D. Correctly measure and record weight of two classmates using two different types of scales E. Correctly measure height of two classmates, one standing and one simulating contractures F. Manual Skills 7.5a- Measures and Records Weight of Ambulatory Patient/resident G. Manual Skills 7.5b- Weighing the Patient/resident in Bed H. Manual Skills 7.5c- Measuring Weight of Patient/resident in Wheel Chair I. Manual Skills 7.5d- Measuring the Patient's/resident's Height Using an Upright Scale J. Manual Skills 7.5e- Measuring Height of Patient/resident in Bed	

D. General guidelines when measuring volume, length, and weight 1. Always use safety precautions for patient/resident and self a. Be familiar with how to use measuring equipment before the patient/resident is involved (i.e. scales) b. Make sure equipment is functioning correctly 2. Wash hands before, after, and as needed when doing any procedure 3. Wear gloves when handling body fluids and dispose of fluids correctly 4. Balance scale before assisting patient/resident onto scale 5. Have the patient/resident urinate before weighing 6. It is best to weigh patient/resident at the same time of day, using the same scale, and with the same linen or similar clothing 7. Know if patient/resident is to be weighed with or without shoes 8. Have at least one additional person helping when using mechanical lifts 9. Clean equipment and return it to appropriate location 10. Record findings on appropriate form(s) 11. Report any changes in findings to appropriate person 12. Be aware of how the patient/resident tolerates the procedure		
Objective 6 **Convert between standard time and military time (24-hour clock)** A. Systems of telling time 1. Standard a. A.M. = morning, midnight to noon b. P.M. = evening, noon to midnight B. Military (24-hour clock) 1. Four digits 2. No colons 3. Do not use A.M. or P.M. 4. Starts one minute after midnight (0001) and ends at midnight 24 hours later (2400) 5. 5. Noon is 1200	A. Lecture/Discussion B. Handout 7.6- Military/ (24 Hour Clock)	A. Written test B. Demonstrates correct use of military and standard time

Sample Test: Module 7- Weights and Measures

1. Match the correct household unit of measure to the correct metric units:

A. ounce	____	30 milliliters (ml)
B. inch	____	500 milliliters (ml)
C. pint	____	1000 milliliters (ml)
D. foot	____	30 centimeters (cm)
E. quart		

2. What would be the correct military time if the clock reads 3:00 p.m. in Greenwich time:
   A. 1200
   B. 1500
   C. 1600
   D. 0300

3. When measuring liquid volume with a graduated cylinder, the Nurse Assistant should do all of the following except:
   A. Pour liquid into the graduated cylinder
   B. Place graduated cylinder on a flat surface
   C. Read at eye level
   D. Read measurement at highest level of liquid surface

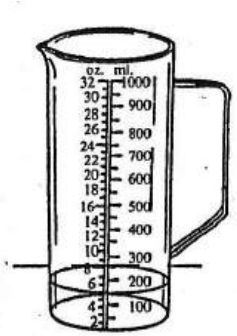
4. Match the correct military time to the correct Greenwich time:

A. 1945	___	7:45 A.M.
B. 1235	___	3:25 P.M.
C. 0745	____	12:35 P.M.
D. 1525	___	7:45 P.M.
E. 0035		

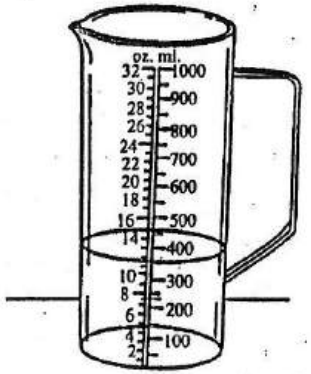
5. A patient/resident weighing 165 pounds is on a reduced calorie diet. The goal is to lose 2 pounds every week. Which of the following weights would meet the goal after one week?
   A. 167 pounds
   B. 165 pounds
   C. 164 pounds
   D. 163 pounds

6. If a person on I&O drinks 12 ounces of milk, the Nurse Assistant should mark on the client's record an intake of:
   A. 30 ml.
   B. 90 ml.
   C. 240 ml.
   D. 360 ml.

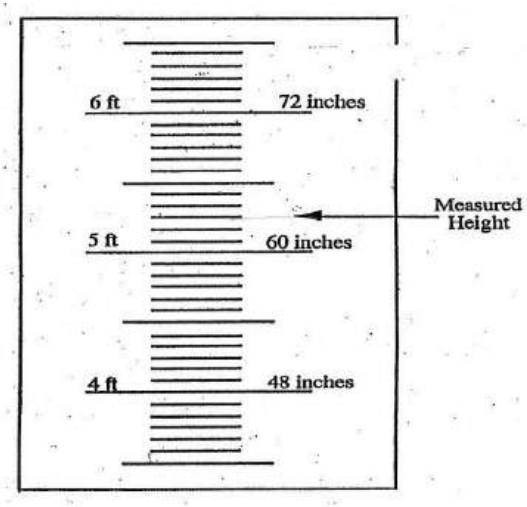
7. How many milliliters are in this graduate?
   A. 5
   B. 11
   C. 150
   D. 350



8. How many milliliters (ml) are in the graduate?
   A. 5
   B. 10
   C. 150
   D. 350



9. The Nurse Assistant measured the height of a patient/resident. Using drawing to the right, what is the patient's/resident's height?
    A. 60 inches
    B. 5 ½ feet
    C. 5 feet 3 inches
    D. 4 feet, 13 inches



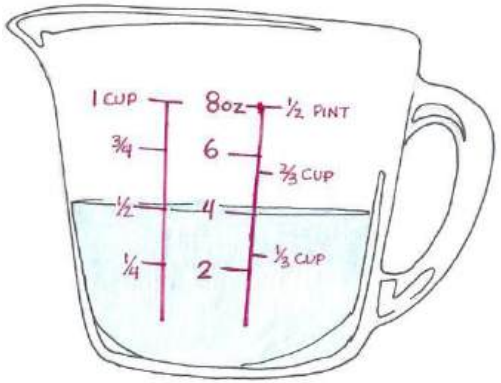
10. The Nurse Assistant is measuring intake and output for a patient/resident who drank 8 ounces of milk. What should the Nurse Assistant record?
    A. 500 ml.
    B. 120 ml.
    C. 240 ml.
    D. 250 ml.

11. A patient/resident is to be repositioned at 6:00 pm. Using military time, the Nurse Assistant repositions the patient/resident at:
    A. 0600
    B. 1200
    C. 1800
    D. 2100

12. Your patient/resident ate the following items for lunch: ½ cup string beans, 3 oz. fish, 6 oz. milk, 2 oz. Jello. What was his fluid intake?
    A. 120 ml.
    B. 240 ml.
    C. 300 ml.
    D. 330 ml.

13. The clock shows 10:32 am. In 24-hour clock time, this is:
    A. 10:32
    B. 1032
    C. 2232
    D. 10:32 am

14. How many milliliters (ml) of fluid are in the cup?
    A. 30 ml.
    B. 60 ml.
    C. 90 ml.
    D. 120 ml.



MANUAL SKILL: Measures and Records Weight of Ambulatory Client (using portable upright scale)
(see module 8)

EQUIPMENT:

Paper towel
Portable upright scale

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Assist the patient/resident to use the bathroom.
2. Take the patient/resident to the scale or bring the scale to the patient's/resident's room.
3. Provide for privacy.
4. Place a paper towel on the platform of the scale.
5. Balance the scale. When the weights are at zero, the balance bar's pointer should be floating at zero.
6. Assist the patient/resident to remove robe and slippers.
7. Assist the patient/resident to stand on center of the scale platform.
8. Move the large weight to the closest estimated patient/resident weight on the balance bar.
9. Move the small weight to the right until the balance bar's pointer hangs free halfway between the upper and lower bar guides (at the zero point).
10. Record the weight.
11. Assist the patient/resident off the platform.
12. Assist the patient/resident to put on robe and slippers.
13. Return equipment or return patient/resident to room as indicated.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

MANUAL SKILL: Weighing the Patient/resident in Bed

(see module 8)

EQUIPMENT:

Overbed scale

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Check scale sling for frayed area or poorly closing straps.
2. Take scale and mechanical lift to patient's/resident's bedside.
3. Set scale to zero.
4. Balance scale to include weight of sling, straps, and linen prior to positioning patient/resident in sling.
5. Provide for privacy.
6. Assist the patient/resident to use the bedpan.
7. Lock bed wheels.
8. Raise bed to comfortable working level for Nurse Assistant.
9. Lower side rail on Nurse Assistant's side. Make sure side rail on other side is up and locked.
10. Turn patient/resident away from the Nurse Assistant.
11. Place the sling folded lengthwise under the patient/resident.
12. Turn the patient/resident toward Nurse Assistant and position sling so that the patient/resident rests centered within the sling.
13. Turn and position patient/resident onto his or her back (supine position).
14. Attach suspension straps to sling. Check that all attachments are securely in place and hook points facing outward, away from patient's/resident's body.
15. Position frame over bed with base legs in the maximum open position.

16. Lock frame.
17. Attach suspension straps to frame.
18. Position patient's/resident's arms inside straps.
19. Slowly raise sling so patient's/resident's body is not touching the bed.
20. Adjust weights to balance scale.
21. Record weight.
22. Reposition sling over center of bed.
23. Slowly lower the patient/resident onto the bed.
24. Take off hooks and straps.
25. Turn patient/resident toward Nurse Assistant and remove sling.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Weighing the Patient/resident in a Wheelchair
(see module 8)

EQUIPMENT:

Overbed scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Weigh empty wheelchair.
2. Take wheel chair to patient/resident and assist patient/resident into wheel chair.
3. Take patient/resident to scale with wheel chair platform.
4. Provide for privacy.
5. Roll wheel chair with patient/resident onto platform.
6. Lock wheels of wheel chair.
7. Adjust weights to balance scale.
8. Record weight.
9. Return patient/resident to bed as necessary.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document after subtracting weight of wheelchair from total weight.
9. Report abnormal findings to licensed nurse.

M**ANUAL SKILL: Measuring the Height of Patient/resident Using an Upright Scale**

(see module 8)

EQUIPMENT:

Portable upright scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Take the patient/resident to the scale or bring the scale to the patient's/resident's room.
2. Provide for privacy.
3. Place a paper towel on the platform of the scale.
4. Assist the patient/resident to remove their slippers.
5. Raise the height rod.
6. Assist the patient/resident to stand on the scale platform, arms at side.
7. Have the patient/resident turn around and face away from the scale.
8. Lower the height measurement rod until it rests on the patient's/resident's head.
9. Record the height. The reading is made at the movable point of the ruler.
10. Assist the patient/resident off the platform.
11. Assist the patient/resident to put on their slippers.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Measuring the Height of a Patient/resident in Bed
(see module 8)

EQUIPMENT:

Pencil
Tape measure

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

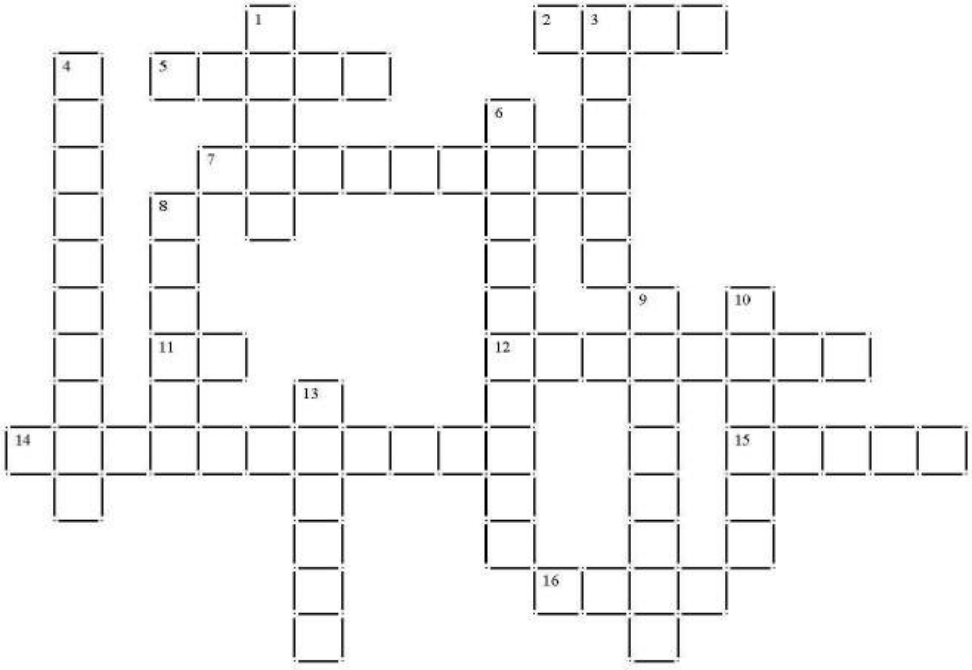
1. Lower side rail on your side.
2. Position patient/resident on his or her back (supine position) and remove pillow.
3. Draw a small pencil mark at the top of the patient's/resident's head on the sheet. If the patient/resident is stooped over or contracted, measure the patient's/resident's body in segments and total the measurements.
4. Make a second pencil mark even with the patient's/resident's heels.
5. Position the patient/resident on his/her side with his/her back toward the CNA.
6. Using the tape measure, measure the distance between the two marks.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Module 15: Weights and Measures

Weights and Measures Crossword



ACROSS

2 Two cups equal a ___.
5 Sixteen ounces equal one ___.
7 Traditional time.
11 Short for cubic centimeter.
12 System of telling time in which 1:00pm is 1300 hours.
14 The size of something.
15 Metric system measure that is about equal to one quart.
16 Basic unit of weight in the metric system.

DOWN

1 Two pints equal one ___.
3 Measurement; 12 ___ makes a foot.
4 A unit of measurement 1/100.
6 One thousandth of a liter.
8 Sixty cc's equals two ___.
9 Equal to 1000 grams.
10 Four quarts equal one ____.
13 The international system of measurement.

Lab Activity/Practice Worksheet:

Med cup #1 --	_____ml
	_____teaspoon
Med cup #2 --	_____tablespoon
	_____ml
Measuring cup -- Coffee cup	_____ounces
	_____ml
Urine cup --	_____ml
Plastic graduate	_____measure
	_____ounces
Urinal	_____ounces
	_____ml
Catheter drainage bag – measure in the bag itself, then empty and measure.	_____ml
	_____ml

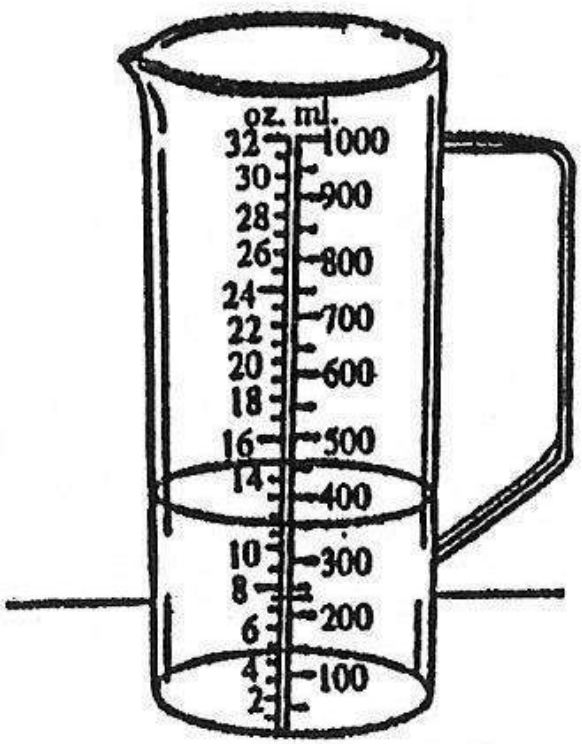
Fluid Measurement Handout:

Metric weight – 1 Kg = 2.2 lbs.
Metric height -- 1 cm = .39 inches.
1 inch = 2.5 cm

1cc = 1ml
1 ounce = 30 ml
1 teaspoon = 5 ml
1 tablespoon = 15 ml
1 cup = 8 ounces = 240ml
1 pint = 16 ounces = 500ml
1 quart = 32 ounces = 1000 ml
1 liter = 1000ml

a.m. = morning
p.m. = evening
wt. = weight
ht. = height
cc = cubic centimeter
Kg = kilogram
Lb. = pound
L = liter

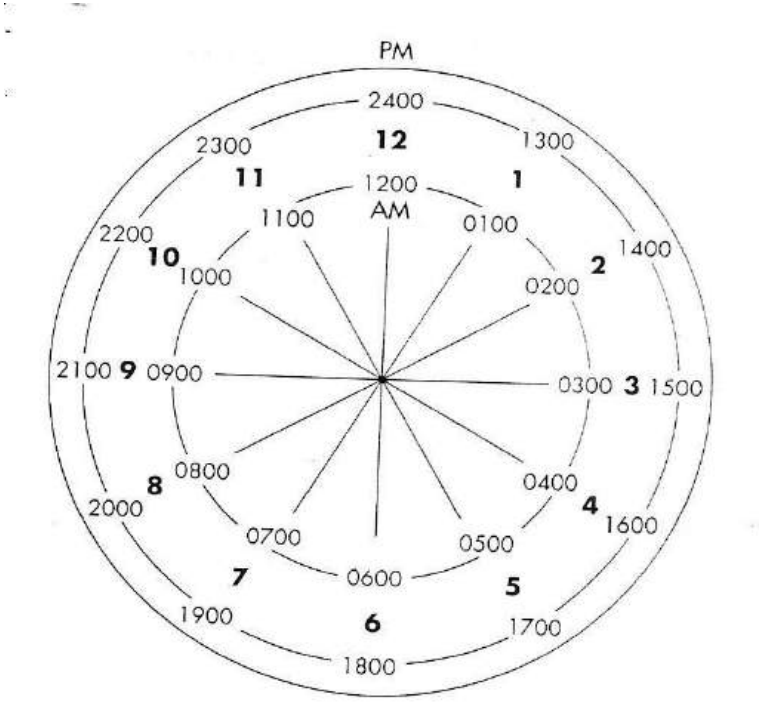
h.s. = hour of sleep
oz. = ounce
tbsp. = tablespoon
tsp. = teaspoon
amt. = amount
gtt = drop



MILTARY/24 HOUR TIME CLOCK

Using a different color pen show the time on the clock face. Then convert the regular time into military time (number 1 is shown as an example).

1. 8:20 a.m. = 0820 (example)
2. 11:47 a.m. = _____
3. _____= 1430
4. 5:15 p.m. = _____
5. 9:10 p.m. = _____
6. _____= 2400
7. _____= 1200



Correct answers should read:

1. 8.20 a.m.= 0820
2. 11:47 a.m.= 1147
3. 2:30 p.m.= 1430
4. 5:15 p.m.= 1715
5. 9:10 p.m.= 2110
6. Midnight (12 a.m.) = 2400
7. 12:00 p.m. (noon) = 1200

Module 8: Patient Care Skills
Minimum Number of Theory Hours: 14
Recommended Clinical Hours: 40

Statement of Purpose:
The purpose of this unit is to teach the students skills needed to support and/or assist the patient/resident in the areas of personal hygiene, an area of activities of daily living, and elimination. Personal hygiene or personal care is generally performed independently. The Nurse Assistant should assist with or perform personal care only when patients/residents are unable to perform a skill for themselves. Other activities included in this module are use of prosthetic devices, bowel and bladder retraining, and weighing and measuring height of the patient/resident.

Terminology:

1. Abrasion
2. Aspiration
3. Axilla
4. Catheter
5. Colostomy
6. Constipation
7. Cyanosis
8. Decubitus ulcer
9. Defecation
10. Dermis
11. Diarrhea
12. Elimination
13. Epidermis
14. Erythema
15. Eschar
16. Excoriation
17. Fecal
18. Feces
19. Flatulence
20. Hour of sleep (h.s.)
21. Ileostomy
22. Impaction
23. Incontinence
24. Jejunostomy
25. Neuropathy
26. Nits
27. Oral hygiene
28. Osteomyelitis
29. Ostomy
30. Perineum/Perineal
31. Pressure sore
32. Prosthesis
33. Stoma
34. Stool
35. Urinal
36. Urinary incontinence
37. Urination
38. Urine

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of fourteen (14) hours of class plus homework assignments and forty (40) hours of clinical experience, the learner will be able to:

1. Define key terminology
2. Identify and assist patients/residents with daily routine care, promoting independence and dignity

BATHING and FOOT CARE

3. Identify benefits of bathing and list five areas of body that require bathing daily
4. Describe the procedure for bathing patients/residents and safety guidelines

ORAL HYGIENE

5. List purposes and schedule for oral hygiene
6. Describe procedure of oral hygiene and denture care for a patient/resident needing assistance, and for the unconscious individual

NAIL CARE, HAIR CARE, SHAVING

7. Identify the Nurse Assistant role and responsibility for patient/resident nail care
8. Identify Nurse Assistant role and responsibility for caring for hair of patients/residents
9. Describe procedure for shaving a patient/resident

SKIN CARE

10. List ways to maintain healthy skin and identify at risk patients.
11. Describe causes, signs and symptoms, and staging of pressure sores.
12. Describe general nursing measures to prevent and treat pressure sores

DRESSING THE PATIENT/RESIDENT

13. Describe general guidelines for selecting and caring for patient's/resident's clothing
14. Discuss rationale for use of street clothes and guidelines for dressing or undressing a patient/resident

URINARY AND BOWEL ELIMINATION

15. Describe the usual frequency pattern for urination
16. List the observations to be made about urine
17. Describe urinary incontinence and the need for immediate care
18. Describe the purpose and general rules of care for urinary catheters
19. Describe the goals and methods for bowel and bladder training
20. Describe the normal pattern of bowel movements and reportable observations
21. Explain the purpose of an ostomy and the care of patients/residents with an ostomy

MEASURING HEIGHT AND WEIGHT

22. Describe the procedures for weighing and measuring height of the patient/resident

PROSTHETIC DEVICES

23. Describe common prosthetic devices and their care (artificial limbs, contact lenses, dentures, eyeglasses and hearing aids)
24. Describe the application, removal and care for "behind the ear" hearing aids

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define Key Terminology** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Handout 8.1a- Patient/resident Care Skills Crossword-1. E. Handout 8.1b- Patient/resident Care Skills Crossword-1- KEY F. Handout 8.1c- Patient/resident Care Skills Crossword-2 G. Handout 8.1d-	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Identify and assist patients/residents with daily routine care, promoting independence and dignity.** A. Each facility has specific policies and procedures related to AM care, PM care and h.s. care B. Early morning (AM) care 1. Offer bedpan/urinal or assist to bathroom, incontinence care, linen change	A. Lecture/Discussion B. Demonstration/return demonstration C. Role play Specific manual skills are listed under each objective	A. Written test B. Assists patients/residents with daily routine care

2. Wash face and hands 3. Offer oral hygiene 4. Assist with grooming 5. Straighten bed and unit 6. Position patient/resident for breakfast C. Morning care after breakfast 1. Oral hygiene 2. Offer bedpan/urinal or assist to bathroom 3. Bathing (includes foot care) 4. Shaving 5. Hair care 6. Dressing 7. Skin care 8. Assisting with activity (ROM, ambulation) 9. Linen change 10. Unit maintenance D. Afternoon care (prepare for meals - lunch and dinner) 1. Offer bedpan/urinal or assist to bathroom 2. Incontinence care/linen change 3. Wash hands/face 4. Straighten bed/unit 5. Position for meal/take to dining area E. Evening care (PM care, h.s. care) 1. Offer snack when applicable 2. Offer bedpan/urinal or assist to bathroom 3. Incontinence care/linen change 4. Wash hands/face 5. Oral hygiene 6. Back rub 7. Assist into sleepwear 8. Straighten bed/unit	E. Refer to Manual Skills procedure 8.2- Back rub	

Objective 3 **Identify benefits of bathing and list five areas of body that requires bathing daily.** A. Benefits of bathing 1. Cleanliness 2. Reduce bacteria and germs 3. Promote skin integrity 4. Stimulate circulation 5. Provide movement and exercise 6. Relaxation 7. Sense of well-being 8. Opportunity for communication and observation B. Body areas that require bathing 1. Face 2. Arms/underarms (axilla) 3. Hands 4. Legs/feet 5. Perineal area a. Genitals b. Anal area 6. Back 7. Any area where skin folds or creases, e.g., under breasts	A. Lecture/Discussion B. Specific manual skills listed under each objective	A. Written test B. Assists in bathing for patients/residents according to guidelines and facility policy
Objective 4 **Describe the procedure for bathing patients/residents and safety guidelines.** A. General steps for bed bath 1. Check with licensed nurse regarding type of bath a. Complete bed bath b. Partial bed bath 1) Done on days when complete bed bath not given 2) The partial bath consists of washing the patient's/resident's face, hands, axilla, back, buttocks, and genital area (perineal care)	A. Lecture/Discussion B. Demonstration/return demonstration C. Role play D. Refer to Manual Skills procedure 8.4a- Bed Bath E. Refer to Manual Skills	A. Written test B. Assists in bathing for patients/residents according to guidelines and facility policy

2. Gather equipment (bath blanket, basin, soap, water thermometer, wash cloths, bath towels) 3. Wash hands 4. Check patient's/resident's personal choices (water temperature, soap etc.) 5. Identify patient/resident 6. Identify yourself to patient/resident 7. Provide privacy a. Close door b. Pull curtain around patient/resident c. Only uncover area being washed d. Facility policy may vary 8. Follow standard precautions and blood borne pathogen standards 9. Assure adequate comfort, such as room temperature, freedom from drafts and adequately covered 10. Use comfortably warm water, change it when it becomes soapy, dirty or cold 11. Bathe areas soiled by fecal material or urine with soap and water 12. Wash from cleanest to dirtiest area 13. Rinse off all soap 14. Pat skin dry 15. Encourage patient/resident to help as much as possible B. Safety guidelines 1. Monitor correct water temperature 2. Use safety equipment, such as grab bars, nonskid surfaces, emergency call buttons and safety belts 3. Stay with patient/resident 4. Use correct body mechanics C. Reportable observations during bathing 1. Color of skin, whites of eyes, lips, nail beds 2. Rashes; locations and description	procedure 8.4b- Tub Bath F. Refer to Manual Skills Procedure 8.4c- Modified Bed Bath-For Testing G. Refer to Objective 17 for Perineal Care	

3. Dry skin, bruising or open areas 4. Pale or reddened areas 5. Drainage or bleeding 6. Swollen legs or feet 7. Complaints of pain or discomfort 8. Skin temperature		
Objective 5 **List purposes and schedule for oral hygiene.** A. Purpose 1. Cleanliness of mouth and teeth 2. Prevent mouth odor and infection 3. Prevent dental disease and tooth loss 4. Comfort 5. Pleasant taste 6. Improve taste of food B. When to perform oral hygiene 1. On awakening 2. After each meal 3. At bed time C. Special circumstances; when the patient/resident needs more frequent care 1. Unconscious – patient/resident should be side-lying to avoid choking and aspiration 2. Mouth breather 3. O2 4. NG tube or NPO 5. Elevated temperature	A. Lecture B. Discussion	A. Written test B. Performs or assists with oral hygiene and reports significant findings

Objective 6 **Describe procedure of oral hygiene and denture care for a patient/resident needing assistance, and for the unconscious individual.** A. Carry out procedure using standard precautions 1. Contact with mucous membranes 2. Gums may bleed 3. Pathogens may exist in the mouth B. Examine oral cavity and report findings 1. Dry, cracked, swollen or blistered lips 2. Redness, swelling, sores or white patches in the mouth or on the tongue 3. Redness, swelling or bleeding of gums 4. Loose broken or chipped teeth 5. Patient/resident complaints C. Dentures 1. Dentures are very costly and fragile 2. Handle with care at all times 3. Any observed damage to dentures	A. Lecture/Discussion B. Demonstration/return demonstration C. Role play D. Refer to Manual Skill procedure 8.6a- Providing Mouth Care E. Refer to Manual Skill procedure 8.6b- Assisting with Mouth Care F. Refer to Manual Skill procedure 8.6c- Mouth Care of the Unconscious Patient/resident G. Refer to Manual Skill procedure 8.6d- Providing Denture Care	A. Written test B. Performs or assists with oral hygiene and reports significant findings
Objective 7 **Identify the Nurse Assistant's role and responsibility for patient/resident nail care and foot care.** A. Performed to prevent infection, injury and odors. Guidelines: 1. Nails are easier to clean after soaking in warm, soapy water 2. Cut fingernails with clippers, not scissors (if facility allows) 3. File fingernails with emery board 4. When trimming fingernails, be cautious to prevent damage to tissues 5. Do not trim nails on patient/resident with diabetes or if on medication that affects blood clotting and circulatory problems 6. Do not cut or trim toenails	A. Lecture/Discussion B. Demonstration/return demonstration C. Role play D. Refer to Manual Skill procedure 8.7a- Fingernail Care E. Refer to Manual Skill Procedure 8.7b- Foot Care	A. Written test B. Performs nail care according to guidelines and reports observations as required

7. Report unusual conditions to licensed nurse such as redness or tenderness of finger tips, cuticles or toes 8. Follow facility procedure		
Objective 8 **Identify the Nurse Assistant's role and responsibility for caring for hair or patients/residents.** A. Hair care 1. Part of daily care 2. Important for identity and self-esteem 3. Accommodate patient/resident preferences for style, hair products 4. Shampoo Types a. Shower/tub b. Sink c. Bed 5. Medicinal shampoos are performed per facility policy B. Report observations 1. Scalp sores 2. Flaking 3. Presence of lice 4. Patches of hair loss 5. Very dry or oily hair 6. How procedure was tolerated	A. Lecture/Discussion B. Demonstration/return demonstration C. Role play D. Refer to Manual Skill Procedure 8.8a - Combing the Patient's/resident's Hair E. Refer to Manual Skill procedure 8.8b- Shampoo with Shower/Tub Bath F. Refer to Manual Skill procedure 8.8c- Shampoo of Bedridden Patient/resident	A. Written test B. Cares for patient's/resident's hair daily
Objective 9 **Describe procedure for shaving a patient/resident.** A. Important for feelings of comfort and self-esteem B. Guidelines 1. Use either electric razor or safety razor (patient/resident choice/facility policy) 2. If using an electric razor use appropriate safety precautions for electrical equipment 3. Safety razors can cause nicks or cuts; use standard precautions to prevent contact with blood	A. Lecture/Discussion B. Demonstration/return demonstration C. Role play D. Refer to Manual Skill Procedure 8.9- Shaving the Patient/resident	A. Written test B. Follows guidelines for shaving patients/residents

Objective 10 **List ways to maintain healthy skin and identify at risk patients.** A. Maintain skin health 1. Encourage well-balanced diet and fluids 2. Provide skin care a. Bathe as necessary b. Rinse off soap thoroughly c. Apply lotion as necessary d. Massage healthy skin e. Keep skin clean and dry 3. Observe high-risk patients/residents for potential problems 4. Give special attention to bony prominences a. Turn and position the patient/resident correctly b. Keep pressure off of reddened or irritated areas 5. Do not massage red, purple, or irritated areas 6. Only massage healthy tissue around the area 7. Keep bed free of small objects and linen free of wrinkles 8. Keep patient/resident clean & dry 9. Prevent shearing and friction 10. Report and record observations B. Factors that place patients/residents at high risk for skin breakdown 1. Mobility/sensory problems a. Paraplegic or quadriplegic b. CVA c. Peripheral vascular disease d. Bed rest or decreased mobility e. Decreased sensation f. COPD 1) Low oxygen level 2) Continuous high Fowlers 3) Medications g. Circulatory problems	A. Lecture B. Discussion C. Handout 8.10- High Risk Factors for Skin Breakdown and Interventions to Prevent	A. Written test B. Provides care to maintain skin health and prevent skin breakdown

1) Diabetes 2) Arterial disease with decreased sensation (neuropathy) 3) Poor circulation and healing 2. Elimination a. Incontinent of stool or urine b. Diarrhea c. Diaphoresis d. Dehydrated e. Leaking tubes or drainage 3. Fluid status a. Edema (swelling) b. Dehydration 4. Nutrition/body structure a. Obese b. Thin c. Poor appetite d. Nutritional lab values are low e. Poor fluid balance f. Poor nail care 5. Other predisposing factors a. Medications like Prednisone make the skin fragile and heal slower b. Cancer c. Splints/casts/prosthetic devices d. Anemia e. Age		
Objective 11 **Describe causes, signs and symptoms, and staging of pressure sores.** A. Common conditions which can lead to pressure sores 1. Pressure leads to decreased blood flow and nutrition of an area resulting in tissue loss	A. Lecture B. Discussion C. Handout 8.11- Staging for pressure sores	A. Written test

2. Excessively wet or dry skin 3. Moving patients/residents causing shearing force B. Stages; signs and symptoms 1. Stage 1 a. Skin is not broken. The epidermis and dermis are intact b. Erythema (redness) that does not resolve within 15-30 minutes 2. Stage 2 a. Skin not intact b. Partial skin loss of the inner and/or outer skin layer (epidermis is damaged and part of the dermis can be involved) c. Skin can be blistered, cracked, and open with erythema or appear as a shallow crater d. No necrotic or dead tissue is present e. Wound bed is moist, pink and painful 3. Stage 3 a. Full-thickness skin loss with both epidermis and dermis gone b. Damage extends to, but not through the tissue that covers the muscle c. Can have part of dermis left with necrotic tissue d. Possible drainage 4. Stage 4 a. Full skin loss with major destruction and tissue death b. Involves subcutaneous tissues – possible fatty tissue, muscle and/or bone c. Can see pink healthy cells, necrotic tissue and eschar d. Wound can tunnel or have undermining in skin surrounding wound e. Risk that bone may become infected (osteomyelitis)		

Objective 12 **Describe general nursing measures to prevent and treat pressure sores.** A. Nursing measures to prevent and treat pressure sores 1. Mobility/sensory a. Control pressure by pressure-reducing devices or special beds b. Turn every two hours at least c. Position with proper support of the body and limbs d. Promote active range of motion exercises or assist patient/resident with them e. Teach or assist patient/resident using a wheel chair to change position frequently f. Prevent shearing and friction during lifting, moving, transferring and repositioning procedures g. Keep bed linens clean, crumb free, and avoid wrinkles h. Watch tubing (like Foley Catheter) does not cause pressure i. Remove patients/residents from toilets and bedpans promptly j. Encourage circulation by gentle massage around red area; not over red area k. Check skin every eight hours l. Keep head of bed (H.O.B.) at 30 degrees as much as possible to avoid sacral pressure 2. Elimination a. Keep skin clean and dry; apply powder where skin touches skin. Watch diaphoretic (sweaty) patient/resident b. Check incontinent patient/resident every two hours and ensure dry and clean (even when using adult incontinence garment) c. Monitor incontinence garment– plastic edges near skin can cause irritation d. Avoid scrubbing or rubbing when bathing and drying e. Use blankets and pillows to prevent skin from being in contact with skin	A. Lecture/Discussion B. Show pictures of wounds in various stages C. Handout 8.12- Sitting on hand exercise: Sit on hands for 5 minutes Observe changes in color, sensation, etc. D. Share examples of how nursing assistants can be involved in QA/PI activities	A. Written test B. Uses techniques to prevent pressure sores C. Reports signs and symptoms of pressure sore formation to licensed nurse

3. Fluid status a. Elevate limb that has edema b. Monitor compression devices, such as anti-embolic stockings and ace bandages. Remove every eight hours, check skin and watch edges do not cut into skin c. Encourage fluids to 1500-2000ml/day or as per care plan 4. Nutrition status/body structure a. Encourage and assist with balanced diet b. Obese patient/resident; check skin folds c. Monitor bony prominences on thin patients/residents 5. Others; monitor casts, braces, and clothing items that may cause pressure against skin B. Use of pressure-reducing devices 1. Nothing replaces basic nursing care 2. Still must turn position and keep patient/resident clean and dry 3. Types of pressure reducing devices a. Bed cradle; keeps pressure off feet and lower legs b. Sheepskin c. Heel and elbow protectors – shearing effect d. Egg crate type pads/gel cushions e. Alternating pressure mattress f. Air fluidization bed (for example Clinitron or KinAir) g. Trochanter rolls h. Flotation pads or cushions C. Legal, Quality Assurance (QA) and Performance Improvement(PI) issues 1. Duty to keep patient/resident from harm and prevent sores 2. There are increased legal risks associated with patients/residents developing pressure sores when there are no preventive measures implemented 3. Utilization Review (UR) issues – huge increase cost to facility		

Objective 13 **Describe general guidelines for selecting and caring for patient's/resident's clothing.** A. Selecting clothing for the patient/resident 1. Fits well 2. Comfortable – including finding out whether the patient/resident is warm enough, but not too warm 3. Easy to get on and off 4. Neat - looks nice and attractive – respect the patient's/resident's own individual taste and choice of what clothing to wear 5. In good condition – has no wrinkles or holes, has snaps, fasteners, buckles and buttons, which function as they should B. Clothing is personal property 1. Label clothes with patient's/resident's name and write on personal belongings list 2. Avoid cutting or tearing 3. Do not discard 4. Store in the patient's/resident's unit 5. Fold neatly or hang on hangers in closet 6. Find out whether family or facility will clean soiled clothing and put into dirty clothes container 7. Assist patient/resident or family to choose clothing that meets physical needs and looks good 8. Do not use patient's/resident's clothing or personal items for another patient/resident	A. Lecture B. Discussion	A. Written test
Objective 14 **Discuss rationale for use of street clothes and guidelines for dressing or undressing a patient/resident.** A. Purpose of dressing in street clothes 1. How a patient/resident looks has an effect and influences their feelings of dignity and self-esteem as well as how others perceive them 2. It encourages patients/residents to be more independent about their activities in daily living (ADL's)	A. Lecture/Discussion B. Demonstration/return demonstration C. Role play	A. Written test B. Follows guidelines in dressing a dependent patient/resident and in assistant

B. Factors that limit a patient's/resident's ability to dress self 1. Limitation of body movement a. Brain impairment, as in dementia, mental retardation, injury, or coma b. Weakness c. Pain d. Fractures e. Contractures f. Amputation g. Paralysis 2. Other factors a. Special equipment, such as IV's, casts or braces b. Blindness c. Psychological factors, such as depression, fear of pain C. Guidelines for dressing/undressing patient/resident 1. Provide for privacy 2. Encourage the patient/resident to do as much as possible 3. Allow patients/residents to choose what to wear 4. While assisting the patient/resident, be gentle, while supporting all extremities 5. Follow patient's/resident's individual choices in use of makeup, jewelry, perfume, etc. D. Reportable observations 1. How much help is provided 2. How patient/resident tolerated procedure 3. Any complaint from patient/resident	D. Refer to Manual Skill Procedure 8.14a- Dressing and Undressing a Patient/resident E. Refer to Manual Skill Procedure 8.14b- Dressing a Patient/resident with an Affected (Weak) Right Arm	a partially dependent patient/resident
Objective 15 **Describe the usual frequency pattern for urination.** A. Frequency of urination depends on 1. Amount of fluid ingested 2. Personal habits 3. Availability of toilet facilities	A. Lecture/Discussion B. Demonstrate and return	A. Written test B. Assists patient/resident with

4. Physical activities 5. Illness/infection B. Frequency ranges from every 2-3 hours to every 8-12 hours 1. Each patient/resident has different urination needs 2. It is important to keep the patient's/resident's routine as normal as possible	demonstration of positioning bedpan C. Role Play D. Refer to Manual Skill Procedure 8.15- Assist with Use of Bedpan/Urinal	bedpan as needed C. Follows facility policy for bladder training
Objective 16 **List the observations to be made about urine.** A. Observations made about urine: 1. Color 2. Clarity 3. Odor 4. Amount B. Information that should be reported to the licensed nurse 1. Urine that appears abnormal a. Cloudy, stones, gravel, sediment b. Pinkish or reddish tint c. Dark color/concentration 2. Patient/resident complaints a. Urgency b. Burning on urination c. Difficulty in urinating d. Feeling of pressure in area of bladder e. Frequency f. Strong odor	A. Lecture/Discussion B. Refer to Manual Skill Procedure 8.16- Measures and Records Urinary Output	A. Written test B. Reports observations and patient/resident complaints according to policy
Objective 17 **Describe urinary incontinence and the need for immediate care.** A. Urinary incontinence 1. Inability to control the passage of urine from the bladder a. Constant leakage	A. Lecture/Discussion B. Demonstrate and return demonstration on manikin	A. Written test B. Performs hygiene measures in a safe manner while avoiding

b. Occasional leakage when laughs, coughs or sneezes c. No control 2. Causes a. Central nervous system problems b. Spinal cord injury c. Aging d. Confusion/disorientation e. Medications f. Weak pelvic muscles g. Urinary tract infection h. Prostate problems (male) i. Prolapse of uterus and bladder (female) j. Restraints k. Immobility l. Unanswered call lights m. Not having signal light within reach n. Urinary frequency/urgency o. Failure to toilet frequently 3. Signs of possible need to go to the bathroom a. Restlessness b. Fidgeting c. Pulling at clothes/undressing d. Holding or pointing at genitals e. Crying 4. Nursing measures a. Record incontinent episodes b. Answer call lights promptly c. Promote normal elimination B. Immediate care is important to prevent 1. Embarrassment, shame, anger, frustration, and depression 2. Development of odors 3. Patient/resident is uncomfortable	C. Refer to Manual Skill procedure 8.17- Perineal Care	embarrassment of the patient/resident

4. Skin breakdown a. Infection b. Irritation, redness or rashes 5. Disposable briefs are to be avoided as it may cause low self-esteem and skin irritation, and may encourage incontinence C. Nursing measures 1. Record voiding 2. Promote normal elimination 3. Follow elimination training programs 4. Encourage easy to remove clothing 5. Provide good skin care & perineal care 6. Dry garments and linens 7. Observe for skin breakdown 8. Use incontinent products as directed 9. Maintain clean, pleasant environment		
Objective 18 **Describe the purpose and general rules of care for urinary catheters.** A. Definition of urinary catheter 1. Plastic or rubber tube used to drain or inject fluid through a body opening 2. Most commonly used to drain the bladder 3. One end is placed in the bladder and the other end is attached by tubing to a drainage bag 4. Catheters are inserted by licensed personnel using sterile technique B. Types of indwelling catheters a. "Foley" b. Retention c. Suprapubic d. Straight catheter C. Purpose of urinary catheter	A. Lecture/Discussion B. Show equipment-urinary catheter and drainage system C. Demonstrate and return demonstration for emptying drainage bag D. Refer to Manual Skill Procedure 8.18a- Empty Urinary Drainage Bags E. Refer to Manual Skill Procedure 8.18b- Catheter Care for Female	A. Written test B. Follows guidelines when caring for urinary catheters and drainage systems

1. Complete loss of bladder control 2. Urinary retention (inability to urinate) 3. Before, during, and after surgical procedures 4. Too weak or disabled to use commode, bedpan or bathroom 5. Prevention of urine contamination on wounds and pressure ulcers 6. Not for convenience D. Complication resulting from catheters 1. Bladder infection 2. Blockage 3. General rules of catheter care a. Tubing should not be kinked or compressed (urine should flow without obstruction). Coil tubing on the bed b. Do not pull on catheter tubing c. Keep drainage bag below level of the bladder d. Drainage bag should be attached to the bed frame, not the side rail e. Never allow bag to touch the floor f. Catheter should be secured to the inner thigh g. Clean the perineal area and around the catheter, soapy water is adequate (use the procedure for catheter care preferred by facility) h. Drainage bag should be emptied and measured each shift (or more often if ordered/required) i. Report patient/resident complaints promptly to the licensed nurse j. Follow the rules of asepsis at all times, keep drainage systems closed k. Check for leaks and report status l. Use separate measuring containers for each patient/resident m. Encourage fluids E. Report observations		

2. Color, clarity, odor, presence of particles		
Objective 19 **Describe the goals and methods for bowel and bladder training.** A. General Guidelines 1. Goal is to regain voluntary control of bowels and bladder 2. Follow standard precautions 3. Follow bowel and bladder training schedule 4. Offer toileting per facility protocol 5. Explain schedule to patient/resident 6. Encourage proper diet 7. Answer call light immediately 8. Provide for privacy 9. Assist with perineal care to prevent skin breakdown 10. Keep accurate record of elimination pattern following facility protocol B. Bladder training 1. If having difficulty voiding a. Have patient/resident lean forward slightly b. Run water c. Never rush patient/resident 2. Follow facility policy for clamping of urinary catheter C. Bowel training 1. Suppository at a regular time 2. Increase fluids 3. Diet will affect regularity	A. Lecture/Discussion B. Share sample policy for bowel and bladder training C. Handout 8.19- Bowel and Bladder Assessment Program	A. Written test B. Follows facility policy for bowel and bladder training
Objective 20 **Describe the normal pattern of bowel movements and reportable observations**. A. Each person is different and has own pattern 1. Frequency – daily to every 2 to 3 days 2. Time of day – morning or evening 3. The Nurse Assistant should note and report stool shape, size,	A. Lecture/Discussion B. Refer to Manual Skill Procedure 8.20- Assisting Patient/resident to	A. Written test B. Assists patients/residents with elimination as needed

frequency, color, consistency, complaints of pain with defecation, etc. B. Notable observations 1. Stool shape 2. Size 3. Frequency 4. Color 5. Consistency 6. Amount 7. Complaints of pain with defecation C. Factors influencing bowel movements 1. Privacy – fear of others, hearing and/or smelling 2. Age – as patient/resident ages, more problems 3. Diet – need balanced diet with regular meals, food stimulates bowel movement 4. Fluids – need adequate fluid 5. Activity – stimulates 6. Medications – most tend to constipate 7. Personal habits 8. Disabilities D. General rules for maintaining normal elimination patterns 1. Promptly provide the bedpan, urinal, or commode, or help the patient/resident to the bathroom when the request is made 2. Assist the patient/resident to get into normal position (as much as is possible or safe) 3. Cover the patient/resident for privacy and warmth 4. Remain nearby if the person is weak or frail 5. Place the signal light and toilet tissue nearby 6. Allow the person time to carry out the elimination process 7. If patient/resident has difficulty, ask them what kinds of things they did at home to assist them, i.e., running water, reading or looking at a magazine	Commode/Toilet	

8. Provide perineal care if needed 9. Offer the opportunity to eliminate at regular intervals		
Objective 21 **Explain the purpose of an ostomy and the care of patients/residents with an ostomy.** A. Definition of ostomy 1. Surgical creation of an artificial opening most commonly into colon or small intestine 2. Some ostomies are for urinary drainage, i.e. nephrostomy, ureterostomy 3. Urine or feces and flatus pass through opening 4. Allow for healing of intestine after surgery or disease 5. Can be temporary or permanent B. Terms used with ostomy patients/residents 1. Stoma – a portion of the intestine brought to the surface of the abdomen to allow for drainage a. Pink and moist/red like mucous membrane b. Size and shape are different depending on area of intestine and patient/resident c. Can bleed when cleaned 2. Peristomal skin – the skin around the stoma; it should be clean, intact and dry 3. Appliance – the wafer and pouch or bag that protects the patient's/resident's skin and collects the drainage C. Ostomy types 1. Location depends on the disease or injury 2. Names according to location a. Colostomy 1) Ascending and transverse a) Stool is consistency of pureed liquid with slightly acidic content b) Must wear pouch all the time	A. Lecture/Discussion B. Show supplies for colostomy care C. Demonstrate/return demonstration on manikin for colostomy care D. Refer to Manual Skill procedure 8.21-Colostomy Care	A. Written test B. Follows guidelines when providing care for patient's/resident's with colostomy C. Follows guidelines when changing ostomy appliance D. Follows guidelines when emptying ostomy bag E. Provides skin care to patient/resident with an ostomy

c) Chew food well with a lot of fluids 2) Descending and sigmoid a) Stool formed and looks “normal” b) Pattern of stool drainage - every day or every other day c) May irrigate (enema) d) Regular diet e) May wear small patch, not pouch b. Ileostomy, small intestine (ileum) 1) Continuous liquid stool with large acidic content 2) About 1000-1500 ml output every day 3) Empty pouch every 2-4 hours or when one-third full 4) Watch skin for irritation if there is leakage 5) Very special diet 6) Fluid and electrolyte problems c. Jejunostomy, small intestine (jejunum) 1) Similar to ileostomy 2) Liquid output that drains 2000-3000 ml/ day 3) May attach to a Foley catheter bag to help drainage 4) Need IV nutrition to meet nutritional needs, as very little absorption takes place D. Ostomy care 1. Equipment a. Soap and water b. Bag or pouch c. Wafer d. Wash cloth or paper towels e. Gloves f. Many different types of appliances 1) One piece is a wafer and pouch together and cannot be reused 2) Two piece		

a) Wafer that lasts 5-7 days and cannot be reused b) Pouch can be taken off and emptied and cleansed and reused multiple times 2. Emptying of pouch a. Check pouch every 2-4 hours and do not let the pouch get more than one-third full b. If the pouch is reusable; empty and rinse over toilet with water, dry and reapply c. Make sure "seal" is tight d. Observe contents of bag - color, amount, consistency, and odor e. Report complaints of discomfort 3. Skin care a. Wash skin well with soap and water, and dry well b. Shave hair c. Observe skin around stoma for redness and irritation 4. Odor management a. Everyone's stool smells; ostomy patients/residents are no different b. There are sprays, tablets, etc. to reduce the odor E. Nurse Assistant's role 1. Assist with personal hygiene 2. Provide for privacy 3. Change appliances 4. Emptying ostomy bag 5. Provide skin care 6. Use standard precautions 7. Encourage patient/resident to assist in the care 8. Reinforce the teaching plan and material shared by the licensed nurse 9. Be aware of cultural differences in attitude about ostomies and their care a. Privacy		

b. Shame c. Body image		
Objective 22 **Describe the procedures for weighing and measuring height of the patient/resident (see module 7).** A. Measure height and weight on admission and as ordered B. Patient/resident wears gown or pajamas C. Should urinate before being weighed D. Do routine weights at the same time each day if physician ordered E. Most accurate weights completed during early morning care	A. Lecture/Discussion B. Refer to Manual Skill Procedures a. 8.22a- Measures and Records Weight of Ambulatory Patient/resident b. 8.22b- Weighing the Patient/resident in Bed c. 8.22c- Measuring Weight of Patient/resident in Wheel Chair d. 8.22d- Measuring the Patient's/resident's Height Using an Upright Scale	A. Written test B. Accurately measures patient/resident height and weight according to guidelines and facility policy, using standing scale, bed scale or wheel chair scale as appropriate
Objective 23 **Describe common prosthetic devices and their care (artificial limbs, hearing aids, contact lenses, eye glasses and dentures).** A. Types of prosthetic devices – cosmetic, adaptive and restorative 1. Artificial limbs; arms and legs a. Specially fitted to the individual patient/resident b. Nursing considerations 1) Ask charge nurse for guidelines 2) Observe patient's/resident's ability and/or assist	A. Lecture/Discussion B. Show pictures of various prosthetic devices C. Use internet resources	A. Written test B. Assists patients/residents with prosthetic devices

participate in ADLs and ambulation 3) Assist patient/resident to apply brace as ordered 4) Maintain body alignment when in chair or bed 5) Keep call bell and personal items within reach 6) Assist patient/resident with ROM to affected muscles 7) Assist patient/resident with aids to foster ADL and independence 8) Use pad brace, if necessary 9) Use stump sock to reduce swelling 10) Give constant praise for rehabilitative efforts 11) Provide skin care at pressure points of device to prevent skin breakdown 12) Observe for complaint of arm/leg pain or numbness, or weakness with use of prosthetic device 13) Encourage physical strengthening exercises for involved and non-involved extremities 2. Contact lenses a. Cleanse contact lenses as directed b. Special caution due to fragile nature of contact lenses c. Store according to package directions d. Easily lost e. Report the following 1) Redness or drainage from eyes 2) Complaints of eye pain or blurred vision 3. Eyeglasses a. Clean daily or as needed 1) Wash glass lenses with warm water, dry with soft tissue 2) Use special cleansing solution tissue and cloths on plastic lenses b. Check for intact parts, such as temples and screws c. Encourage patient/resident to wear eyeglasses as needed d. Store glasses carefully to protect from breakage and		

damage e. Check food trays and bed linens for misplaced eyeglasses f. Label eyeglasses with patient's/resident's name and room number 4. Dentures a. Refer to Mouth Care Objective 6 b. Label denture storage container with patient's/resident's name c. Label dentures with patient's/resident's identification d. Encourage patient/resident to wear dentures e. Examine dentures for rough surfaces, breaks or cracks f. Report findings to charge nurse g. Handle with care and clean thoroughly before storing h. Check food trays, bed linens, and wrapped up tissues or napkins for misplaced dentures B. Prosthetic devices help maintain independent functioning and patient/resident self-esteem		
Objective 24 **Explain the purpose of a hearing aid and the procedures for maintenance and care of the hearing aid.** A. Purposes of a hearing aid 1. Makes sound louder 2. Even the best hearing aid cannot restore full, normal hearing ability a. The patient/resident may still have trouble hearing b. Always face the patient/resident when talking to him/her and speak clearly B. Parts of a hearing aid 1. Microphone- changes sound waves into electric signals and transmits sound 2. Battery and Battery compartment 3. Amplifier uses battery energy to make the sound signals strong 4. Earmold channels the sound through the external ear canal to the ear drum (tympanic membrane)	A. Lecture/Discussion B. Refer to Manual Skill Procedure 8.24a- Applying a Behind-the-Ear Hearing Aid C. Refer to Manual Skill procedure 8.24b- Removing a Behind-the-Ear Hearing Aid	A. Written test B. Demonstrates proper care and storage of hearing aid

5. Cord- connects the amplifier to the earmold 6. On/off switch-turns hearing aid on/off and may control volume C. Care of Hearing aids 1. Caution: Never wash a hearing aid or immerse in water, as it will be ruined 2. Report to licensed nurse when the hearing aid needs cleaning or appears damaged 3. Check the battery periodically 4. Never drop the hearing aid 5. Do not attempt to repair hearing aids 6. Do not expose the hearing aid to heat 7. Do not let moisture get into the hearing aid 8. Do not use any kind of hair spray or medical spray on patients/residents while their hearing aids are in place the spray can clog the microphone opening 9. Check food trays and bed linens for misplaced hearing aids D. Storage of a hearing aid 1. Turn the hearing aid off when it is not in use 2. Store a hearing aid in a well-marked container labeled with patient's/resident's name and room number 3. Label hearing aids with patient's/resident's name E. Placement of the hearing aid 1. Turn down the volume before placing the hearing aid in the external ear canal. It should fit tightly but comfortably 2. After the hearing aid is in place, turn it on and adjust the volume so that patient/resident can hear in a normal tone. The patient/resident will tell you when he or she can hear comfortably 3. If the patient/resident complains of an unpleasant whistle or squeal, check the placement in the ear and for a crack or break in the earmold or wire F. Checking the batteries 1. Before applying a hearing aid, check the batteries		

2. Be sure they are the right size for the hearing aid 3. The battery case must close easily or something is wrong 4. To test the batteries, place the control switch to on and turn up the volume control. Cup your hand over the hearing aid and you should hear a whistle. If you do not hear the whistle, change the batteries 5. If the patient/resident complains that he or she cannot hear any sound, a. First check if hearing aid is turned on b. Remove the hearing aid and check the batteries for freshness c. Check to see if the hearing aid is broken d. Clean ear mold if necessary 6. If the patient/resident complains of hearing only intermittent		

Sample Test- Module 8: Patient Care Skills

1. A partial bath would include bathing the following body areas:
    A. Face, hands, underarms, back, buttocks and genital area
    B. Face, neck, chest, and arms
    C. Face, feet and legs
    D. Hands, feet, chest and back

2. A complete bed bath would be given to a patient/resident who:
    A. Has difficulty using his right hand
    B. Cannot step into a bath tub
    C. Is paralyzed on one side
    D. Is unconscious

3. A Nurse Assistant is bathing a patient/resident. Which of the following observations should be reported immediately to the nurse?
    A. Dry skin on the patient's/resident's legs
    B. A vein that curves and stands out
    C. An old bruise is turning yellow
    D. A bleeding skin tear

4. When bathing a patient/resident, the Nurse Assistant sees a swelling around the knee that is tender to touch. The Nurse Assistant should:
    A. Avoid washing the sensitive area during the bath
    B. Apply a warm wet washcloth to the knee
    C. Report this observation to the nurse
    D. Remind the patient/resident not to ambulate without assistance

5. In preparing the bath for the dependent patient/resident, the Nurse Assistant should:
    A. Fill the tub with no more than two inches of water
    B. Make sure that the water temperature is at least 120° F.
    C. Adjust the water temperature to 105° F.
    D. Position the patient/resident in the tub before adding water

6. When bathing a dependent patient/resident, the Nurse Assistant should:
    A. Leave the room at intervals to encourage the patient/resident to bathe on his own
    B. Rinse off all soap completely and dry the skin thoroughly
    C. Rub the skin vigorously to stimulate circulation
    D. Apply soap to all areas before rinsing with fresh water

7. When washing the face of a dependent patient/resident, the Nurse Assistant should:
    A. Use a separate washcloth for washing each eye
    B. Wipe the eyes from the outer edge to the center
    C. Use different corners of the washcloth when washing each eye
    D. Rinse the eyes by pouring a small amount of water on the forehead

8. In a complete bed bath, the water is changed:
    A. At the completion of the bath
    B. After each body area is washed
    C. After the front surfaces of the body are washed
    D. Whenever the water becomes soapy or cool

9. To assist Mrs. B a patient/resident, into a bathtub, the Nurse Assistant should:
    A. Stand at the side of the tub and have the patient/resident hold on to your shoulder as she steps into the tub
    B. Place a chair next to the tub and have the patient/resident hold on to the chair as she steps into the tub
    C. Have the patient/resident hold on to the grab bar in the tub enclosure as she steps into the tub
    D. Have the patient/resident sit on the side of the tub, pick up both legs and pivot them over the side and into the tub

10. Oral hygiene should be done:
    A. After each meal and at bedtime
    B. After breakfast and after last meal or snack of the day
    C. Before and after each meal
    D. Before and after meals or snacks

11. In what position should an unconscious patient/resident be placed when performing oral care?
    A. Lateral (side-lying, head to side) position
    B. Prone (on the stomach) position
    C. Supine (on the back) position
    D. Standing position

12. In assisting a patient/resident with oral hygiene:
    A. Offer a cup of mouthwash to the patient/resident before the toothbrush
    B. Warm the mouthwash in a basin of warm water before it is used
    C. Hold the emesis basin under the patient's/resident's chin when he/she needs to spit
    D. Let the patient/resident rinse his/her mouth with orange juice after brushing teeth

13. When the patient/resident takes his/her dentures out for the evening, the Nurse Assistant should:
    A. Send the dentures home with the family
    B. Store them in a labeled container filled with cool water inside the bedside table drawer
    C. Dry them and store in a plastic bag under the patient's/resident's pillow
    D. Store them in a clean container in the clean utility room

14. When cleaning dentures, the Nurse Assistant should:
    A. Use dental floss to clean between the teeth
    B. Soak the dentures in Lysol type disinfectant solution
    C. Brush only the teeth portion of the dentures
    D. Brush all surfaces of the dentures

15. When giving oral hygiene to an unconscious patient/resident, it is important for the Nurse Assistant to:
    A. Prevent the patient/resident from aspirating (breathing in) any fluid
    B. Hold the patient's/resident's mouth open with your fingers
    C. Use large amounts of mouthwash for rinsing the patient's/resident's mouth
    D. Wait at least 5 hours between each cleaning

16. As you brush Mrs. K's teeth, you notice that her gums are bleeding. The Nurse Assistant should:
    A. Brush harder to toughen up the gums
    B. Notify the charge nurse
    C. Stop brushing the teeth
    D. Increase fluids, because of the loss

17. A patient/resident asks a Nurse Assistant to cut his toenails because they are very thick and hurt when he wears shoes. The Nurse Assistant should:
    A. Soak his feet and then cut the nails using nail clippers
    B. Report his request to the nurse
    C. Give the patient/resident a nail clipper so that he may cut his nails himself
    D. Use a sharp scissor to trim the excess nail after a bath

18. To clean under the fingernails of the patient/resident, the Nurse Assistant should:
    A. Use an orange stick
    B. Use the blunt blade of a bandage scissors
    C. Use the point of fingernail scissors
    D. Trim and file the nails first

19. When performing hair care for a patient/resident, the Nurse Assistant should:
    A. Comb it into a new style each day
    B. Style it according to the patient's/resident's wishes
    C. Apply hair oil to reduce static
    D. Wait until family comes in

20. Before combing or brushing a patient's/resident's hair, the Nurse Assistant should:
    A. Put on gloves
    B. Wet the hair with a spray bottle
    C. Place a towel over the patient's/resident's shoulders
    D. Soak the patient's/resident's comb and brush in a disinfectant solution

21. The purpose of shampooing the hair of patients/residents is to:
    A. Remove tangles
    B. Lower body temperature
    C. Maintain cleanliness and well-being
    D. Be part of daily care of patient/resident

22. A bed shampoo will require:
    A. Shampoo tray, plastic sheet or bag, pitcher and basin
    B. Extra sheet, pillow, and pitcher
    C. Thermometer, graduate, bath basin, and several towels
    D. Spray bottle, emesis basin and washcloth

23. A medicinal shampoo generally requires:
    A. That the shampoo is left in the hair for a period of time before rinsing it out
    B. That the medicinal solution is left in the hair without rinsing it out
    C. Rinsing the hair with disinfectant solution
    D. That the nurse perform the procedure rather than a Nurse Assistant

24. To safely shave a patient/resident with a safety razor, the Nurse Assistant should:
    A. Apply an alcohol pre-shave solution
    B. Keep the skin taut in the area being shaved
    C. Move the razor in the opposite direction as the hair growth
    D. Rinse the razor in a disinfectant solution during shave

25. After shaving a patient/resident with his own electric razor, the Nurse Assistant should:
    A. Apply an oil based lotion to the skin
    B. Clean the blades of the razor with a cleaning brush
    C. Soak the razor in a disinfectant solution
    D. Report the action to the charge nurse

26. The Nurse Assistant is putting a pair of pants on a patient/resident who cannot sit up because of weakness. The Nurse Assistant should slip both feet into the legs of the pants and then:
    A. Ask the patient/resident to bend his knees and raise his buttocks as the Nurse Assistant pulls the pants up to his waist
    B. Attempt to sit the patient/resident on the side of the bed and pull pants up toward the waist
    C. Pull the top of the pants under the buttocks up the waist with the patient/resident flat on his back
    D. Assist the patient/resident to roll from side to side as the Nurse Assistant pulls the pants up to the waist

27. A general rule for dressing a patient/resident who is paralyzed or injured is:
    A. Dress the affected side first and undress it last
    B. Dress the affected side last and undress it first
    C. Have clothing split and snaps applied for easy dressing
    D. Avoid dressing the affected side

28. To accurately weigh the patient/resident, a general rule to follow is to:
    A. Weigh the patient/resident at different times each day
    B. Have the patient/resident be NPO before weighing
    C. Balance the scale before the patient/resident steps on it
    D. Weigh the patient/resident fully dressed

29. If a patient/resident is unable to stand up while being measured it is best to:
    A. Estimate the patient's/resident's height
    B. Measure the patient's/resident's height while lying in bed
    C. Ask the patient/resident how tall he was when ambulatory
    D. Chart that the measurement was not done because the patient/resident could not stand

30. A patient/resident was admitted to the nursing unit several days after surgery. To prevent problems, the Nurse Assistant should:
    A. Leave the patient/resident in bed at all times
    B. Tell the patient/resident to remain in the same position at all times
    C. Tell the patient/resident to cough and deep breathe every two hours
    D. Leave the patient/resident alone to rest all day

31. The Nurse Assistant is caring for a patient/resident who wants to shave with a safety razor. The patient/resident should not use the razor if the patient/resident is:
    A. Receiving oxygen
    B. Confused and disoriented
    C. Unable to ambulate to the bathroom
    D. Visiting with family

32. The Nurse Assistant is collecting supplies for colostomy care. Which of the following is NOT needed?
    A. A bedpan
    B. Toilet tissue
    C. Alcohol wipes
    D. Gloves

33. When changing a colostomy bag, the Nurse Assistant should know:
    A. The colostomy bag must be changed every two hours
    B. All colostomy patients/residents have liquid stools
    C. The colostomy bag needs to be changed when the bag is leaking
    D. A skin barrier will hold the bag in place without a belt

34. The Nurse Assistant is caring for a confused patient/resident who does not like to bathe. The Nurse Assistant should NOT:
    A. Prepare the patient/resident before bathing
    B. Give a sponge bath if patient/resident resists tub or shower
    C. Force the patient/resident into the shower or tub
    D. Schedule bathing when patient/resident is agitated

35. A patient/resident is to be weighed daily. The Nurse Assistant should:
    A. Weigh the patient/resident at the same time of day
    B. Hold the patient/resident on the scale, if unable to stand
    C. Not weigh the patient/resident who is unable to stand on scale
    D. Not allow the patient/resident to urinate before being weighed

36. When preparing to bathe a patient/resident, the Nurse Assistant should provide privacy curtains:
    A. Immediately after entering the room
    B. Before beginning the bath
    C. After washing the patient's/resident's face
    D. After completing the bath

37. The Nurse Assistant is checking the patient's/resident's body for signs of pressure sores. Which of the following areas are more likely to be affected?
    A. Bony areas such as shoulder blades, elbows, heels, and knees
    B. Thicker areas such as thighs and upper arms
    C. The abdomen and breasts
    D. The genital area

38. Which of the following foot care procedures is required for the patient/resident who is paralyzed from the waist down?
    A. Soak the feet in hot water after bathing
    B. Wrap the feet in hot towels, trim toenails if needed, and lubricate feet
    C. Wash and dry feet carefully and thoroughly, and check for any pressure signs
    D. Wash feet carefully, trim toenails and apply lubricant to keep area between toes moist

39. The Nurse Assistant should know that incontinent patients/residents:
    A. Cannot control their bladder or bowels
    B. Are lazy
    C. Are able to control the bladder or bowels
    D. Are confused

40. When putting in dentures, it is important to:
    A. Dry the dentures
    B. Wet the dentures
    C. Rinse with alcohol
    D. Dry the mouth

41. The Nurse Assistant should clean the patient's/resident's genital and anal areas:
    A. Every time the patient/resident uses the bathroom
    B. Only when the patient/resident is soiled
    C. Once a day and when the patient/resident is soiled
    D. Once during each shift

42. If the patient/resident is unable to clean up properly after using a bedside commode, the Nurse Assistant should:
    A. Assist the patient/resident to bed and return later to clean the patient/resident
    B. Give the patient/resident a washcloth and instruct him in proper cleaning techniques
    C. Provide the patient/resident with privacy and clean him gently and thoroughly
    D. Tell the patient/resident that he will be cleaned at bath time

43. Which of the following might the Nurse Assistant do to keep a patient/resident from being incontinent of urine?
    A. Offer the patient/resident the toilet, bedpan or urinal at regular intervals
    B. Tell the patient/resident that he will be assisted to the bathroom every four hours
    C. Leave a bedpan under the patient/resident
    D. Tell the patient/resident not to drink as much water

44. When caring for a patient/resident with dry skin, the Nurse Assistant should use:
    A. Soap
    B. Lotion
    C. Hot water
    D. Talcum powder

45. When providing a bedpan for a patient/resident, the Nurse Assistant should always:
    A. Use the same size bedpan for all patients/residents
    B. Wait until the patient/resident asks for a bedpan before giving one
    C. Place the open end of the bedpan toward the patient's/resident's back
    D. Allow privacy while the patient/resident is using the bedpan

46. When preparing to shave a patient/resident, the Nurse Assistant should soften the patient's/resident's facial hair by using:
    A. A cold towel
    B. A warm towel
    C. Lotion
    D. Alcohol

47. Which bathing method should the Nurse Assistant select for a patient/resident on bed rest who needs total assistance?
    A. A tub bath
    B. A shower
    C. A complete bed bath
    D. A partial bed bath

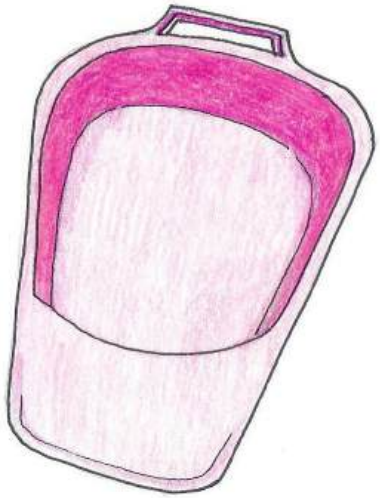
48. The Nurse Assistant should know that dentures should be cleaned at which of the following times?
    A. Before breakfast and at bedtime
    B. After breakfast and at bedtime
    C. After breakfast, lunch and supper
    D. Before breakfast, lunch, supper, and at bedtime

49. A patient/resident asks the Nurse Assistant to help her to the bathroom. The Nurse Assistant responds, "OK, but I'm really busy today. Bring your things with you so you can brush your teeth and fix your hair, too." By making these requests, the Nurse Assistant was:
    A. Lessening the number of decisions the patient/resident must make
    B. Denying the patient/resident the ability to make a personal choice about when her care would be done
    C. Showing the patient/resident who was the boss was on the unit
    D. Performing job duties as expected

50. When bathing a patient/resident, a Nurse Assistant should observe:
    A. Body size
    B. Body tone
    C. Skin condition
    D. Amount of body fat

51. The Nurse Assistant is caring for a resident who just received a new pair of glasses. The Nurse Assistant should:
    A. Tell the resident to wear the glasses only at mealtimes
    B. Clean the glasses with a disinfectant solution
    C. Put the glasses on the resident's bedside table when not in use
    D. Put the glasses in a labeled case when not in use

52. The bedpan shown below is a:
    A. Standard pan
    B. Fracture pan
    C. Curved pan
    D. Flat pan



MANUAL SKILL: Back Rub

EQUIPMENT:

Bath blanket
Bath towel
Lotion

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Raise side rail on opposite side of work area.
2. Raise bed to a comfortable position.
3. Position patient/resident in a prone or side-lying position with his or her back toward you.
4. Expose back, shoulders, upper arms, and buttocks. Cover rest of body with linens or bath blanket.
5. Lay towel on bed and tuck under edge of back.
6. Apply warm lotion to back (rub moderate amount of lotion in hands to warm it before applying to back or place lotion container in hot water).
7. Use long strokes; rub from buttocks to shoulders. Then stroke from shoulders over to upper arms and back down to buttocks. Use firm, gentle strokes. Keep hands in contact with patient's/resident's skin.
8. Repeat the process for at least three minutes.
9. Massage bony areas with a circular motion. (Do not massage bony areas that are reddened.)
10. Dry the patient's/resident's back by patting gently with the towel.
11. Close and retie the gown.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

Manual Skill: Bed Bath

EQUIPMENT:

Basin
Blanket or sheet
Soap
Washcloth and towel

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, and directly maintaining face to face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with curtain, screen or door.
8. Apply clean gloves prior to bathing patient/resident.

SKILL STEPS:

1. Offer patient/resident bedpan or urinal.
2. Cover patient/resident with bath blanket or sheet and fold top linen to bottom of bed.
3. Remove gown or pajamas.
4. Raise the bed to a level convenient for good body mechanics. Lower side rail on side where nurse will be working. Be sure opposite side rail is up and secure.
5. Lower head of bed to flat position.
6. Fill wash basin 2/3 full of warm water (105 degrees F). Check water for safe temperature and ask patient/resident to check water for comfort.
7. Assist patient/resident to move closer to you.
8. Lay towel across patient's/resident's chest and make a mitt with the washcloth.
9. Wash eyes without soap from nose to outside of face and use separate area of cloth for each eye. Wash inner aspect to outer aspect then proceed to wash face.
10. Wash face, ears, and neck, being careful to keep soap out of patient's/resident's eye.

11. Rinse and dry face by patting gently with towel.
12. Place towel lengthwise under arm farthest from you. Support arm with your hand under patient's/resident's elbow. Apply soap to wet washcloth. Wash shoulder, arm, underarm, and hand keeping rest of body covered. Use long, firm but gentle strokes. Move body gently and naturally avoiding force and over-extension of limbs and joints.
13. Rinse and dry well.
14. Place arm and hand under cover.
15. Repeat steps 12-14 with arm nearest you.
16. Fold sheet down to patient's/resident's abdomen keeping towel across chest.
17. Wash, rinse, and dry patient's/resident's chest. For female patients/residents, gently lift breasts to wash, rinse, and pat dry thoroughly.
18. Keeping chest covered with towel, fold sheet down to pubic area.
19. Wash, rinse, and dry patient's/resident's abdomen being careful to clean umbilicus and skin folds.
20. Pull sheet up over abdomen and chest and remove towel.
21. Empty wash basin and refill with clean water of proper temperature.
22. Fold sheet back from patient's/resident's leg farthest from you and place towel lengthwise under leg.
23. Bend the knee and wash, rinse, and dry the leg and foot. If patient/resident can bend knee easily, place basin on towel and place the patient's/resident's foot in the basin to wash.
24. Cover the patient's/resident's leg with sheet and remove towel.
25. Repeat steps 21-23 with leg nearest you.
26. Empty basin, rinse, and refill with water of proper temperature.
27. Assist patient/resident to turn on side so his/her back is toward you.
28. Place towel lengthwise on bed along patient's/resident's back.
29. Wash, rinse, and dry patient's/resident's back and buttocks.
30. Remove towel and assist patient/resident to turn onto back.
31. If patient/resident is able to wash own perineal area give him/her a soapy washcloth, then a clean, wet cloth to rinse, and a towel to dry.
32. Disposes linens without contaminating self.
33. If patient/resident is unable to wash own perineal area, assist by washing perineal area front to back to avoid infection. For female patients/residents, separate labia and wash from front to back. For uncircumcised males, retract foreskin and wash tip of penis and replace foreskin. Wear gloves when washing genital area.
34. Assist patient/resident into clean clothing.
35. Remove and remake bed with clean linen when necessary.
36. Lower bed, place side rails in up position, if applicable.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable
2. Remove gloves without contaminating self
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

MANUAL SKILL: Tub Bath

EQUIPMENT:

Clean clothing
Soap
Towel
Washcloth

BEGINNING STEPS:

1. Wash hands
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Fill tub half full of warm water (105 degrees F). Check water for safe temperature and ask patient/resident to check water for comfort.
2. Place towel or bath mat on floor beside tub.
3. Assist patient/resident to Tub Room.
4. Provide for privacy.
5. Assist patient/resident to remove clothing.
6. Assist patient/resident into tub.
7. Give patient/resident soap and washcloth and encourage to wash and rinse themselves as much as possible. Assist as necessary. **NEVER LEAVE PATIENT/RESIDENT ALONE IN THE TUB.
8. Assist patient/resident out of the tub encouraging use of grab bars.
9. Assist patient/resident in drying themselves thoroughly and dressing.
10. Return patient/resident to room.
11. Position patient/resident comfortably.

12. Place call light within reach.
13. Lower bed to safe position for the patient/resident.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Manual Skill: Modified Bed Bath (Face, One, Arm, Hand, and Underarm)-Testing Purposes Only

EQUIPMENT:

Basin
Blanket or sheet
Soap
Washcloth and towel

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, and directly maintaining face to face contact whenever possible.
6. Provide for privacy with curtain, screen or door.
7. Wash hands.
8. Lay towel across patient's/resident's chest and make a mitt with the washcloth.

SKILL STEPS:

1. Removes gown and places in soiled linen container, while avoiding over exposure of the client.
2. Before washing, check water temperature for safety and comfort and ask patient/resident to verify comfort of water.
3. Apply clean gloves prior to bathing patient/resident.
4. Beginning with eyes, washes eyes with wet washcloth (no soap) using a different area of the washcloth for each stroke, washing inner aspect to outer aspect then proceeds to wash face.
5. Dry face with towel.
6. Expose one arm and places towel underneath arm.
7. Applies soap to wet washcloth.
8. Wash arm, hand and underarm, keeping rest of body covered.
9. Rinse and dry arm, hand and underarm.
10. Moves body gently and naturally avoiding force and over-extension of limbs and joints.
11. Puts clean gown on client.
12. Empties, rinses, and dries basin.

13. After rinsing basin, place basin in designated dirty supply area.
14. Disposes of linen into soiled linen container.
15. Avoids contact between Nurse Assistant clothing and used linens.
16. After placing basin in designated dirty supply area, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Provides Mouth Care

EQUIPMENT:

Cup with water
Emesis basin
Gloves
Mouthwash (if desired)
Toothbrush
Toothpaste
Towel

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.
6. Explain procedure, speaking clearly, slowly, and directly, and maintaining face to face contact whenever possible.
7. Privacy is provided with curtain, screen or door.

SKILL STEPS:

1. Before providing mouth care, client is in upright, sitting position (75-90 degrees).
2. Puts on clean gloves before cleaning mouth.
3. Place clothing protector across chest before providing mouth care.
4. Secures cup of water and moistens toothbrush.
5. Before cleaning mouth, applies toothpaste to moistened toothbrush.
6. Clean mouth (including tongue and surfaces of teeth) using gentle motions.
7. Maintains clean technique with placement of toothbrush.
8. Candidate holds emesis basin to chin while client rinses mouth.
9. Candidate wipes mouth and removes clothing protector.
10. After rinsing toothbrush, empty, rinse and dry the basin and place used toothbrush in designated basin/container.

11. Places basin and toothbrush in designated dirty supply area.
12. Disposes of used linen into soiled linen container.
13. After placing basin and toothbrush in designated dirty supply area, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.
14. Signaling device is within reach and bed is in low position.

ENDING STEPS:

1. Position patient/resident comfortably.
2. Leave room neat.
3. Wash hands.
4. Document.
5. Report abnormal findings to licensed nurse.

MANUAL SKILL: Assisting with Mouth Care

EQUIPMENT:

Cup with water
Emesis basin
Gloves
Mouthwash (if desired)
Toothbrush
Toothpaste
Towel

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Position patient/resident sitting up comfortably (in bed or chair).
2. Place towel over patient's/resident's chest and under chin.
3. Place overbed table in front of the person. Adjust table height for the person.
4. Allow person to perform mouth care.
5. Rinse toothbrush and apply toothpaste.
6. Encourage patient/resident to brush own teeth if able. If unable, brush patient's/resident's teeth, using gentle massaging pressure, being sure to clean all tooth surfaces, including tongue.
7. Provide water, when finished or at any other time patient/resident requests, so that patient/resident can rinse mouth. Hold basin under patient's/resident's chin to catch water and give patient/resident tissue or cloth to wipe the mouth.

8. Clean and return equipment; placing toothbrush in a container that will avoid contamination and allow toothbrush to air dry.
9. Dispose of soiled linen in soiled linen container.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Mouth Care of the Unconscious Patient/resident

EQUIPMENT:

Gloves
Lemon and glycerin swabs (if ordered)
Solutions for cleansing and lubricating mouth
Sponge swabs (toothettes)
Tissues
Tongue blade, padded with gauze
Towel

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Raise bed to working height, lower side rail closest to Nurse Assistant.
2. Position patient/resident in side-lying position on the side towards you. Turn his/her head well to the side.
3. Place towel under patient's/resident's head and face and place kidney basin under the chin.
4. Position overbed table so you can reach it. Adjust height as needed.
5. Moisten toothettes with solution ordered.
6. Gently open mouth. If patient/resident resists, use padded tongue blade to hold mouth open. Separate upper and lower teeth with padded tongue blade. DO NOT USE TONGUE BLADE TO FORCE LIPS OR MOUTH OPEN.
7. Press excess solution from toothette and cleanse teeth, tongue, gums, roof of mouth, inside cheeks and lips with toothette.
8. Repeat process using lemon and glycerin swabs if needed.

9. Apply lubricant to lips if necessary.
10. Dry area around the mouth.
11. Remove the towel under the patient's/resident's head.
12. Repeat procedure every two hours or more often as needed.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Cleans Upper or Lower Denture

EQUIPMENT:

Denture cleanser/toothpaste
Denture cup
Emesis basin
Gloves
Mouthwash
Towel
Washcloth

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Provide for privacy with a curtain, door, or screen.
7. Wash hands.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Bottom of sink is lined and/or sink is partially filled with water before denture is held over sink.
2. Rinses denture in moderate temperature running water before brushing them.
3. Applies toothpaste to toothbrush.
4. Brushes surface of denture.
5. Rinses surface of denture under moderate temperature running water.
6. Before placing denture into cup, rinses denture cup and lid.
7. Places denture in denture cup with moderate temperature water/solution and places lid on cup.
8. Rinses toothbrush and places in designated toothbrush basin/container.
9. Maintains clean technique with placement of toothbrush and denture.
10. Sink liner is removed and disposed of appropriately and/or sink is drained.

11. After rinsing equipment and disposing of sink liner, removes and disposes of gloves (without contaminating self) into waste container and washes hands.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Fingernail Care

EQUIPMENT:

Bath basin 1/3 full of water (105 degree F)
Bath towel
Emery board
Kidney basin
Orangewood sticks
Lotion
Nail clippers
Paper towels

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Place towel (under patient's/resident's hand) over overbed table.
2. Place basin on towel with water in a comfortable position for patient/resident.
3. Before immersing fingernails, checks water temperature for safety and comfort and asks patient/resident to verify comfort of water.
4. Assist patient/resident to immerse fingertips in basin of water.
5. Clean under each fingernail with orangewood stick.
6. Wipe orangewood stick on towel after each nail.
7. Dry fingernail area.
8. Nurse Assistant feels each nail and files as needed (should be smooth).

9. Repeat steps on other hand.
10. Dispose of orangewood stick and emery board when finished.
11. Empty, rinse, and dry basin.
12. Place basin in designated dirty supply area.
13. Disposes of used linen into soiled linen container.
14. After cleaning nails and equipment, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container.
15. Wash hands.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Foot Care

EQUIPMENT:

2 Towels
Basin
Bath Mat
Gloves
Lotion
Soap
Wash Cloth

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Provide for privacy with a curtain, door, or screen.
7. Wash hands.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Before washing, check water temperature for safety and comfort and asks client to verify comfort of water.
2. Basin is in a comfortable position for client and on protective barrier.
3. Put on clean gloves before washing foot.
4. Client's bare foot is placed into the water.
5. Applies soap to wet washcloth.
6. Lifts foot from water and washes foot (including between the toes).
7. Foot is rinsed (including between the toes).
8. Dries foot (including between the toes).
9. Applies lotion to top and bottom of foot, removing excess (if any) with a towel.
10. Support foot and ankle during procedure.

11. Repeat steps 6-12 for other foot.
12. Empties, rinses, and dries basin then place basin in designated dirty supply area.
13. Disposes of used linen into soiled linen container.
14. After cleaning foot and equipment, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Provides Foot Care on One Foot (For Testing Purposes Only)

EQUIPMENT:

2 Towels
Basin
Bath Mat
Gloves
Lotion
Soap
Wash Cloth

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Wash hands
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.

SKILL STEPS:

1. Explains procedure, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.
2. Privacy is provided with a curtain, screen, or door.
3. Before washing, check water temperature for safety and comfort and asks client to verify comfort of water.
4. Basin is in a comfortable position for client and on protective barrier.
5. Put on clean gloves before washing foot.
6. Client's bare foot is placed into the water.
7. Applies soap to wet washcloth.
8. Lifts foot from water and washes foot (including between the toes).
9. Foot is rinsed (including between the toes).
10. Dries foot (including between the toes).
11. Applies lotion to top and bottom of foot, removing excess (if any) with a towel.
12. Support foot and ankle during procedure.
13. Empties, rinses, and dries basin then place basin in designated dirty supply area.

14. Disposes of used linen into soiled linen container.
15. After cleaning foot and equipment, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.
16. Signaling device is within reach.

ENDING STEPS:

1. Position patient/resident comfortably.
2. Lower bed to safe position for the patient/resident.
3. Leave room neat.
4. Document.
5. Report abnormal findings to licensed nurse.

MANUAL SKILL: Combing the Patient's/resident's Hair

EQUIPMENT:

Comb or hairbrush
Towel

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Raise head of bed to comfortable sitting position.
2. Place towel around patient's/resident's shoulders if sitting, or on pillow, if lying in bed.
3. Put hair into two sections, and then divide one side into two more sections.
4. Brush the hair. Start at scalp and brush little by little with downward motion moving towards the ends.
5. Comb or brush patient's/resident's hair into style patient/resident requests.
6. Remove towel and loose hair from the patient's/resident's shoulder.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Shampoo of Bedridden Patient/resident

EQUIPMENT:

Bath blanket
Bed protectors
Brush
Chair
Conditioner (optional)
Electric blow dryer (if allowed)
Large basin or pail
Patient's/resident's comb
Several containers of warm water
Several large bath towels
Shampoo
Shampoo tray
Tough or extra-large plastic garbage bag
Washcloth

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Lower side rail, raise bed to working position.
2. Place chair at bedside with basin or pail on chair.
3. Position patient/resident to edge of bed close to where you are standing.
4. Place bed protector on mattress under patient's/resident's head and shoulders.
5. Place trough under patient's/resident's head with open end in basin or pail and washcloth over eyes.
6. Wet hair by pouring warm water from pitcher over scalp.
7. Apply shampoo and lather hair well, massage scalp while shampooing.
8. Rinse hair well.
9. Repeat shampoo as necessary.
10. Remove trough from under patient/resident and set aside.
11. Dry hair by rubbing with towel, blow-dry if allowed.
12. Comb or brush hair in style agreeable to patient/resident.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Shampoo with Shower or Tub Bath

EQUIPMENT:

Conditioner
Shampoo
Supplies for tub bath or shower

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Follow steps for bathing procedure to place patient/resident in tub or shower.
2. Test temperature of water by running it over the inside of your wrist – should be 105° F (40-45°C) warm but not hot.
3. Give patient/resident dry washcloth and/or assist patient/resident to hold over the eyes. Encourage patient/resident to tilt head backward, if possible.
4. Wet patient's/resident's hair.
5. Apply shampoo, rubbing into scalp with fingertips. Start at hairline and work toward the back.
6. Massage the scalp with your fingertips. Do not scratch the scalp.
7. Rinse with water until all shampoo is gone. Avoid getting water in patient's/resident's face, ears.
8. If conditioner is used, pour into palm of your hand, work through the hair, and allow to remain 2-3 minutes. Rinse with clear warm water.
9. Wrap towel around patient's/resident's head and complete bath according to bath procedure.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Shaving

EQUIPMENT:

Aftershave lotion (if desired)
Basin of warm water (105 degree F)
Gloves
Safety razor
Shaving cream
Tissues
Towel & wash cloth

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Raise head of bed to comfortable sitting position. Semi-fowler's position, if allowed.
2. Position overbed table within easy reach and at a comfortable height.
3. Place towel under patient's/resident's chin and across chest.
4. Hold wash cloth, wrung out of warm water for a minute on facial area to be shaved.
5. Check for safe water temperature and ask patient/resident to verify water for comfort.

Safety Razor:

6. Rub shaving cream into beard to soften.
7. Pull skin tight above area to be shaved; shave gently using short, even strokes and rinsing razor frequently.

8. Shave in the direction of hair growth.
9. Lather neck area and stroke upward in a similar manner.
10. Dispose of safety razor in sharps container

Electric Razor:

11. Check equipment for damaged cord or mechanisms.
12. Pull the skin tight above area to be shaved.
13. Shave in the direction of hair growth when shaving male face and female underarms.
14. Shave upward, starting at the ankle, when shaving legs.
15. Apply direct pressure to any nicks and cuts.
16. Wash shaved area with clean cool water and dry gently.
17. Apply aftershave lotion to male face if desired.
18. Remove towel.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Dressing and Undressing the Patient/resident

EQUIPMENT:

Encourage patient/resident to select clean clothing of choice

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. After asking what clothing items he/she would like to wear, arrange clothing items in the order of dressing and open buttons, zippers, and fasteners.
2. Assist patient/resident to a comfortable sitting position while assisting. Be gentle and pay attention to how you hold the patient/resident.
3. Avoid overexposure and assist patient/resident with clothing on upper body first (if patient/resident has a weak side, apply clothing to weak side first).
4. While putting on clothing items, move body gently and naturally avoiding force and over-extension of limbs and joints.
5. Place arm in sleeve. (Do not pull on arm).
6. Gather shirt, blouse, or dress to neck opening and slip over head or around shoulders as appropriate to garment and place other arm in sleeve.
7. Position sleeves comfortably at shoulders. Adjust clothing to cover upper body.
8. Smooth and ease clothing over body by pulling it down. (If unable to sit up, assist patient/resident to roll side to side while adjusting clothing).
9. Assist patient/resident in buttoning, fastening garments if patient/resident is unable.
10. To apply clothing to lower extremities put weaker foot into pants first followed by stronger foot, working them up the legs by pulling one side then the other.

11. If patient/resident is able, ask that he/she raise the hips while you pull the pants up to the waist. If patient/resident cannot assist, turn onto the weak side, pulling the clothing up the stronger side.
12. Turn patient/resident onto stronger side and finish pulling up the pants.
13. Assist with buttons or zippers as necessary.
14. To undress, reverse steps of the procedure.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Dresses Patient/resident with Affected (Weak) Right Arm

EQUIPMENT:

Clean clothing of patient's/resident's choice

BEGINNING STEPS:

1. Knock and pause before entering the patient's/resident's room.
2. Introduce self.
3. Identify patient/resident.
4. Gather equipment, if applicable.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Privacy is provided with a curtain, screen, or door.

SKILL STEPS:

1. Ask patient/resident which shirt he/she would like to wear and dresses them in their shirt of choice.
2. While avoiding overexposure of patient/resident, removes gown from the unaffected side first, then removes gown from affected side and disposes of gown into soiled linen container.
3. Assist patient/resident to put the right (affected/weak) arm through the right sleeve of the top before placing garment on the left (unaffected) arm.
4. While putting on shirt, moves body gently and naturally avoiding force and over-extension of limbs and joints.
5. Finish with clothing in place.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Signaling device is within reach and bed is in low position.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

MANUAL SKILL: Assist in the Use of Bedpan

EQUIPMENT:

Basin of warm water
Bedpan and cover, or fracture bedpan and cover
Disposable gloves (two pairs)
Toilet tissue
Urinal
Washcloth, soap, towel
Hand wipes

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Wash hands.
6. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
7. Privacy is provided with a curtain, screen or door.

SKILL STEPS:

1. Lower head of the bed.
2. Puts on clean gloves before handling bedpan.
3. Places bedpan correctly under client's buttocks.
4. Removes and disposes of gloves (without contaminating self) into waste container and washes hands.
5. After positioning client on bedpan and removing gloves, raises head of bed.
6. Toilet tissue is within reach.
7. Hand wipe is within reach and client is instructed to clean hands with hand wipe when finished.
8. Signaling device within reach and client is asked to signal when finished.
9. Puts on clean gloves before removing bedpan.
10. Head of bed is lowered before bedpan is removed.
11. Avoids overexposure of client.
12. Empties and rinses bedpan and pours rinse into toilet.

13. After rinsing bedpan, place bedpan in designated dirty supply area.
14. After placing bedpan in designated dirty supply area, removes and disposes of gloves (without contaminating self) into waste container and wash hands.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Signaling device is within reach and bed is in low position.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

NOTE: The above information lists the required performance steps in testing the skill.
The following provides additional helpful information regarding Assisting with Bedpan or Urinal.

1. Before placing bedpan or urinal, fold back the top sheets so that they are out of the way.
2. Raise the patient's/resident's gown, but keep the lower part of the body covered.
3. Ask the patient/resident to assist by bending the knees and placing the feet flat on the mattress. Ask patient/resident to raise hips. Assist as necessary by slipping your hand under the lower back and lifting slightly. Place the bedpan in position evenly under the buttocks. The narrow end of pan should point toward the foot of the bed.
4. Fracture pan: narrow end of pan points toward head of bed, under patient's/resident's lower back; handle should point toward foot of bed
5. If the patient/resident is unable to assist, turn the patient/resident to one side and place the bedpan against the buttocks, push downward on the bedpan into the mattress as you carefully turn the patient/resident back onto the bedpan.
6. Replace the sheet over the patient/resident.
7. Elevate the head of the bed and the knees slightly to a modified sitting position.
8. Put the call light or signal, warm, wet washcloth or hand wipe and toilet paper within easy reach of the patient/resident, raise side rail.
9. Ask the patient/resident to signal when finished, leave patient/resident alone unless contraindicated in the nursing care plan. Check on patient/resident every 2-5 minutes.
10. Discard gloves, wash hands.
11. When the patient/resident signals, return to the room. If the patient/resident is unable to signal, check frequently. Never leave a patient/resident sitting on a bedpan for a prolonged period, or with the urinal positioned where skin pressure can be created.
12. Put on your gloves and answer the patient's/resident's signal immediately.

13. Fill the basin with warm water; assemble soap, washcloth, and towel.
14. To remove bedpan from under patient/resident, ask the patient/resident to flex knees and rest weight on heels.
15. Place one hand under the small of the back and lift gently to help raise the buttocks or roll the patient/resident off the bedpan to the side and remove the pan (be sure to hold bedpan from tipping while rolling the resident). Lift and move carefully. Hold pan firmly with one hand. Cover bedpan after removing.
16. Many residents have difficulty cleaning adequately after using the bedpan. Assist the resident to clean and wipe as necessary. Check the anal area, clean with soap and warm water while resident is on his or her side (always clean from front to back).
17. Remove bedpan or urinal to bathroom.
18. If specimen is required, collect it at this time. Measure urine if resident is on Intake and Output.
19. Check the stool or urine for abnormal appearance.
20. Empty the bedpan or urinal into the toilet and flush.
21. Rinse bedpan/urinal in cold water and disinfect; rinse and dry or follow facility procedure for cleaning equipment.
22. Discard gloves, wash hands.
23. Put clean bedpan or urinal inside resident's bedside table.
24. Assist resident with hand washing.

MANUAL SKILL: Measures and Records Urinary Output

(see module 7)

EQUIPMENT:

Disposable gloves
Graduate

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Provide for privacy with a curtain, door, or screen.
7. Wash hands.

SKILL STEPS:

1. Puts on clean gloves before handling bedpan.
2. Pours contents of the bedpan into measuring container without spilling or splashing urine outside of container.
3. Measures amount of urine at eye level with container on flat surface.
4. After measuring urine, empties contents of measuring container into toilet.
5. Rinses measuring container and pours rinse into toilet.
6. After rinsing equipment, and before recording output, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
7. Records contents of container within plus or minus 25 ml of evaluator's reading.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse

MANUAL SKILL: Perineal Care for Female

EQUIPMENT:

Basin of warm water and soap or perineal wash
Bath blanket
Bedpan
Gloves
Towels
Washcloths
Waterproof protector for bed

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Privacy is provided with a curtain, screen or door.

SKILL STEPS:

1. Before washing checks water temperature for safety and comfort and asks patient/resident to verify comfort of water.
2. Puts on clean gloves.
3. Place pad/linen protector under perineal area before washing.
4. Exposes perineal area while avoiding overexposure of client.
5. Applies soap to wet washcloth.
6. Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke.
7. Using a clean washcloth, rinses soap from genital area, moving from front to back, while using a clean area of the washcloth for each stroke.
8. Dries genital area moving from front to back with towel.
9. After washing genital area, turns to side, then washed and rinses rectal area moving from front to back using a clean area of the washcloth with each stroke. Dries with towel.
10. Reposition client.
11. Empties, rinses, and dries basin.
12. After rinsing basin, places basin in designated dirty supply area.

13. Disposes of used linen into soiled linen container and disposes of linen protector appropriately.
14. Avoids contact between nurse candidates clothing and used linen.
15. After disposing of used linen, and placing used equipment in designated dirty supply area, remove and dispose of gloves(without contaminating self) into waste container and wash hands.

ENDING STEPS:

1. Position patient/resident comfortably.
2. Signaling device is within reach and bed is in low position.
3. Leave room neat.
4. Wash hands.
5. Document.
6. Report abnormal findings to licensed nurse.

NOTE: The above information lists the required performance steps in testing the skill.
The following provides additional helpful information regarding Perineal Care.

1. Raise the bed to a level convenient for good body mechanics.
2. Lower side rail on side where Nurse Assistant will be working. Be sure opposite side rail is up and secure.
3. Remove bedspread and blanket. Fold and place on back of chair.
4. Turn patient/resident on back, cover with drape, sheet or bath blanket and have patient/resident hold top of drape or sheet while you pull out top sheet.
5. Instruct patient/resident to raise hips while bed protector is placed underneath patient/resident.
6. Offer bedpan to patient/resident.
7. Position drape, sheet or bath blanket so only the area between the legs is exposed.
8. Female perineal care:
    a. Ask patient/resident to separate her legs and flex knees.
    b. If she is unable to spread legs and flex knees, the perineal area can be washed with the patient/resident on the side with legs flexed.
9. Put on disposable gloves.
10. Wet washcloth, make mitt and apply soap or periwash.
11. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back.
12. Rinse and pat dry with towel.
13. Male perineal care:
    a. Form a mitten with washcloth and apply soap.
    b. Gently wash pubis and penis. If uncircumcised, pull back foreskin and wash.

c. Carefully dry and return foreskin to normal position. Make sure shaft of penis is dry.
d. Ask patient/resident to bend and separate knees. Help patient/resident if required. Wash scrotum carefully. Rinse and pat dry.

14. Turn patient/resident away from you. Use a new washcloth and wash around anus. Rinse area and dry.
15. Help position patient/resident onto back.
16. Remove protective pad under buttocks and remove gloves.
17. Put top sheet over patient/resident and have patient/resident hold it at top while you remove the drape, sheet or bath blanket.
18. Replace blanket and spread.

MANUAL SKILL: Empty Urinary Drainage Bags

(see module 7)

EQUIPMENT:

Antiseptic wipe
Disposable gloves
Graduate
Paper towel

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Place paper towel on floor with graduate on it so that urine can be collected when drain is open.
2. Open the clamp on the bottom of the drainage bag.
3. Let all urine drain into the graduate. Do not let the drain touch the graduate.
4. Close the clamp and clean with antiseptic wipe, then replace the clamped drain in the holder bag.
5. Measure the amount of urinary output. See Manual Skill 8.16 Records and Measures Urinary Output.
6. Discard paper towel and antiseptic wipe.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. After placing used equipment in designated dirty supply area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Catheter Care for Female (not Tested in California)

EQUIPMENT:

Basin of warm water and soap or perineal wash
Bath blanket or sheet for privacy
Bedpan
Gloves
Towels
Washcloths
Waterproof protector for bed

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Before washing check water temperature for safety and comfort and ask patient/resident to verify comfort of water.
2. Place pad/linen protector under perineal area before washing and cover with bath blanket.
3. Expose area surrounding catheter while avoiding over exposure of patient/resident.
4. Apply soap or perineal wash to wet washcloth.
5. While holding catheter near meatus without tugging, clean at least four inches of catheter nearest meatus, moving in only one direction, away from meatus, using a clean area of the cloth for each stroke.
6. While holding catheter near meatus without tugging, rinse at least four inches of catheter nearest meatus, moving in only one direction, away from meatus, using a clean area of the cloth for each stroke.

7. While holding catheter near meatus without tugging, dry at least four inches of catheter nearest meatus, moving in only one direction, away from meatus, using a clean area of the cloth for each stroke.
8. Empty, rinse, and dry basin.
9. After rinsing basin, place basin in designated dirty supply area.
10. Dispose of used linen into soiled linen container and disposes of linen protector appropriately.
11. Avoid contact between Nurse Assistant's clothing and used linen.
12. After disposing of used linen and placing used equipment in designated dirty supply area, remove and dispose of gloves(without contaminating self) into waste container and wash hands.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Place call light within reach.
4. Lower bed to safe position for the patient/resident.
5. Leave room neat.
6. Wash hands.
7. Document.
8. Report abnormal findings to licensed nurse.

MANUAL SKILL: Assisting Patient/resident to Commode/Toilet

EQUIPMENT:

Basin
Commode/toilet
Disposable gloves
Toilet paper
Towel, water and soap (or hand wipe)

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. For commode:
    a. Place next to bed.
    b. Position for patient's/resident's convenience.
    c. Lock wheels.
    d. Remove cover, be sure bedpan or other receptacle is present in commode.
2. Position bed at lowest point, lower side rails nearest commode.
3. Assist patient/resident to sitting position on side of bed with feet flat on floor.
4. Before assisting to stand, patient/resident is wearing non-skid footwear.
5. Assist patient/resident to standing position.
6. For commode, pivot patient/resident and lower to commode. For toilet, assist patient/resident to ambulate to bathroom, and lower to toilet. Use of gait belt is per facility protocol.
7. Leave call bell and toilet tissue within reach.

8. Maintain privacy, but do not leave patient/resident unattended.
9. When patient/resident signals, return promptly.
10. Put on gloves and assist patient/resident to clean anus and perineum.
11. Allow patient/resident to wash and dry hands.
12. Assist patient/resident back to bed.

ENDING STEPS:

1. Position patient/resident comfortably.
2. Place call light within reach.
3. Lower bed to safe position for the patient/resident.
4. Put cover on commode and remove to bathroom, noting contents and measuring if required.
5. Empty and clean per facility policy.
6. Measure output. See Manual Skill 8.16 Measures and Records Urinary Output.
7. Return clean commode to proper place.
8. After cleaning equipment and placing used equipment in designated area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
9. Leave room neat.
10. Wash hands.
11. Document output.
12. Report abnormal findings to licensed nurse.

MANUAL SKILL: Colostomy Care

EQUIPMENT:

Bedpan
Clean colostomy appliance prepared to fit stoma
Cleansing agent or soap (cleansing agent is ordered by team leader)
Disposable bed protector
Gloves
Skin barrier as ordered by team leader
Toilet tissue
Washbasin
Washcloth and towel

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Raise bed to working position.
2. Lower side rails.
3. Place disposable bed protector under patient/resident.
4. Fill washbasin half full of warm water.
5. Gently remove soiled stoma bag and place in bedpan.
6. Wipe area around stoma with toilet tissue to remove feces or mucus.
7. Place dirty tissue in bedpan.

8. Clean skin around stoma with water or prescribed cleaning agent.
   a. If medicated agent is used, must be applied by licensed nurse.
   b. Note any evidence of skin breakdown or redness.
9. Rinse entire area well to remove any residue.
10. Pat area dry with towel gently but thoroughly.
11. Apply skin barrier if ordered.
12. Remove adhesive backing on appliance.
13. Center appliance over stoma; apply gentle pressure to adhesive surface from stoma outward.
14. If used, connect belt to appliance.
15. Cover bedpan and take it to the bathroom, maintain patient/resident safety and privacy.
16. Measure as directed; empty pouch and bedpan; note color, amount, consistency, and odor.
17. Put pouch in disposable bag.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Measures and Records Weight of Ambulatory Patient/resident

EQUIPMENT:

Paper towel
Portable upright scale

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.
6. Explains procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
7. Provide for privacy with a curtain, door, or screen.

SKILL STEPS:

1. Make sure client has shoes on before walking to scale.
2. Before patient/resident steps onto scale, candidate sets scale to zero then obtains client's weight.
3. While client steps onto scale, candidate stands next to scale and assists client, if needed, onto center of scale.
4. While client steps off scale, candidate stands next to scale and assists patient/resident, if needed, off the scale before recording weight.
5. Before recording, washes hands.
6. Records weight based on indicator on scale. Weight is within plus or minus 2 lbs. of evaluator's reading. If weight recorded in kg weight is within plus or minus 0.9 kg of evaluator's reading.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Weighing the Patient/resident in Bed

(see module 7)

EQUIPMENT:

Overbed scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Check scale sling for frayed area or poorly closing straps.
2. Take scale and mechanical lift to patient's/resident's bedside.
3. Set scale to zero.
4. Balance scale to include weight of sling, straps, and linen prior to positioning patient/resident in sling.
5. Provide for privacy.
6. Assist the patient/resident to use the bedpan.
7. Lock bed wheels.
8. Raise bed to comfortable working level for Nurse Assistant.
9. Lower side rail on Nurse Assistant's side. Make sure side rail on other side is up and locked.
10. Turn patient/resident away from the Nurse Assistant.
11. Place the sling folded lengthwise under the patient/resident.
12. Turn the patient/resident toward Nurse Assistant and position sling so that the patient/resident rests centered within the sling.
13. Turn and position patient/resident onto his or her back (supine position).
14. Attach suspension straps to sling. Check that all attachments are securely in place and hook points facing outward, away from patient's/resident's body.
15. Position frame over bed with base legs in the maximum open position.

16. Lock frame.
17. Attach suspension straps to frame.
18. Position patient's/resident's arms inside straps.
19. Slowly raise sling so patient's/resident's body is not touching the bed.
20. Adjust weights to balance scale.
21. Record weight.
22. Reposition sling over center of bed.
23. Slowly lower the patient/resident onto the bed.
24. Take off hooks and straps.
25. Turn patient/resident toward Nurse Assistant and remove sling.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Weighing the Patient/resident in a Wheelchair

(see module 7)

EQUIPMENT:

Wheelchair scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Weigh empty wheelchair and all miscellaneous linens and clothing.
2. Take wheel chair to patient/resident and assist patient/resident into wheel chair.
3. Take patient/resident to scale with wheel chair platform.
4. Provide for privacy.
5. Roll wheel chair with patient/resident onto platform.
6. Lock wheels of wheel chair.
7. Adjust weights to balance scale.
8. Record weight.
9. Return patient/resident to bed as necessary.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Measuring the Height of Patient/resident Using an Upright Scale

(see module 7)

EQUIPMENT:

Portable upright scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Assures patient/resident has shoes/nonskid slippers on before walking to scale
2. Take the patient/resident to the scale or bring the scale to the patient's/resident's room.
3. Provide for privacy.
4. Place a paper towel on the platform of the scale.
5. Assist the patient/resident to remove their slippers.
6. Raise the height rod.
7. Assist the patient/resident to stand on the scale platform, arms at side.
8. Have the patient/resident turn around and face away from the scale.
9. Lower the height measurement rod until it rests on the patient's/resident's head.
10. Record the height. The reading is made at the movable point of the ruler.
11. Assist the patient/resident off the platform.
12. Assist the patient/resident to put on their slippers.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Measuring the Height of a Patient/resident in Bed

` (see module 7)

EQUIPMENT:

Pencil
Tape measure

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

SUPINE POSITION

1. Lower side rail on your side.
2. Position patient/resident on his or her back (supine position).
3. Draw a small pencil mark at the top of the patient's/resident's head on the sheet. If the patient/resident is stooped over or contracted, measure the patient's/resident's body in segments and total the measurements. (See below).
4. Make a second pencil mark even with the patient's/resident's heels.
5. Position the patient/resident on his/her side with his/her back toward the Nurse Assistant.
6. Using the tape measure, measure the distance between the two marks.

CONTRACTED PATIENT/RESIDENT

1. Measure from crown to hip.
2. Measure from hip to knee.
3. Measure from knee to heel.
4. Add total of three measurements.
5. Record and report.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Applying a Behind-the Ear Hearing Aid

EQUIPMENT:

Fresh battery (if required)
Hearing aid

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Check the hearing aid to be sure batteries are working and tubing is not cracked.
2. Check to be sure hearing aid is turned off or volume is turned to lowest level.
3. Look into the patient's/resident's ear to check for wax buildup or other problems such as sores.
4. Handle the hearing aid carefully. Do not drop it nor get it wet.
5. Hand the hearing aid to the patient/resident so that you can assist the patient/resident if necessary as he/she inserts the hearing aid ear mold into the ear canal.

Alternative actions:

1. Grasp the ear mold and gently insert the tapered end into the ear canal.
2. Gently twist the ear mold into the curve of the ear while gently pulling the earlobe with the other hand. The hearing aid should fit snugly, but comfortably, flush with the ear.
3. Turn on the control switch.
4. Adjust the volume while talking to the patient/resident. Stop when the patient/resident can hear you.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove and dispose of gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Removing a Behind-the Ear Hearing Aid

EQUIPMENT:

Hearing aid
Hearing aid storage container

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

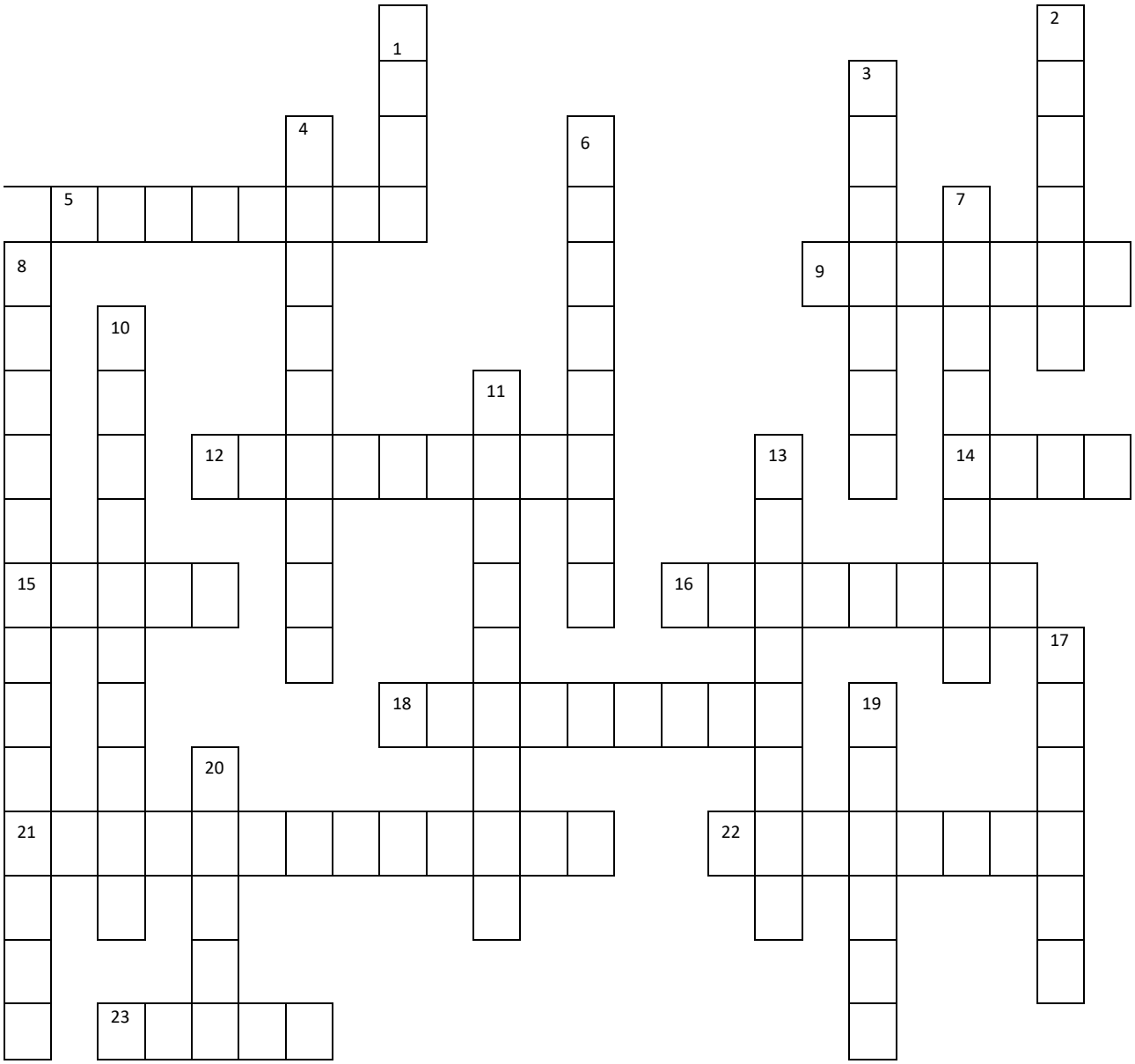
1. Turn off the hearing aid.
2. Loosen the outer portion of the hearing aid mold by GENTLY pulling on the upper part of the ear.
3. Lift the ear mold upward and outward.
4. Make sure on-off switch is in off position.
5. Remove battery if necessary.
6. Store hearing aid in a container marked with the patient's/resident's name.
7. Place it in the bedside stand or other safe place as facility policy states.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove and dispose of gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Module 8: Patient/resident Care Skills Handout 8.1a-Crossword #1

Patient/resident Care Skills Crossword #1



Across

5 A spot where skin or mucous membrane has been scraped off.
9 A way of tucking linens under the mattress to keep the linens straight and smooth at the corner.
12 A small sheet placed over the middle of the bottom sheet.
14 Mouth.

15 An open sore.
16 Bluish discoloration of the skin.
18 Outer layer of the skin.
21 The head of the bed is lowered and the foot of the bed is raised.
22 Area of the genitalia and anus.

23 Part on the bed that allows the head or foot of the bed to be raised or lowered.

Down

1 A bed where the top linens are folder to the foot of the bed indicates that it is_____.
2 A bed where the top linens are not folder back indicates that it is_____.

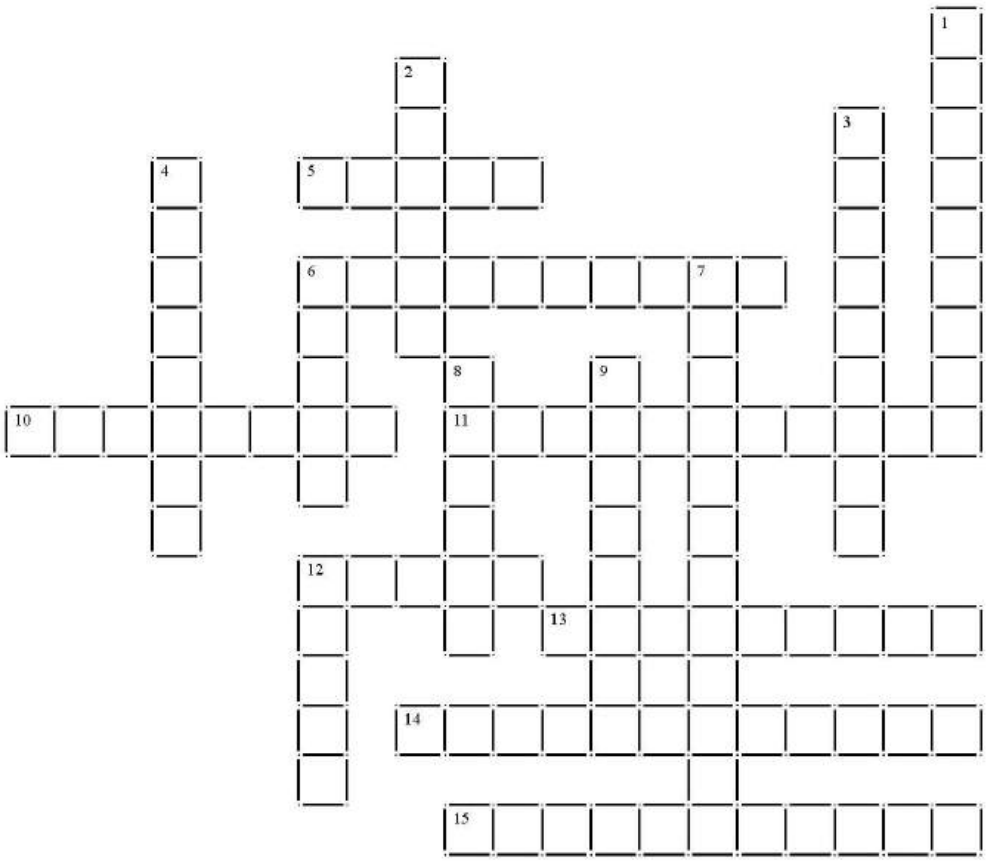
3 Referring to health and cleanliness.

4 Official departure of a patient/resident from a facility or nursing unit.
6 Itching.
7 The death of a group of cells.
8 Skin.
10 A bed with no one in it.

11 Referring to a particular type of skin breakdown, and a recumbent position.
13 Moving a patient/resident from one room, nursing unit, or facility to another.
17 Inner layer of skin.
19 Space under the upper arm.
20 Official entry of a person into a facility or nursing unit.

Module 8: Resident Care Skills[Type text] Handout 8.1c- Crossword #2

Resident Care Skills Crossword #2



Across

5 Fluid excreted by the kidneys.

6 Excessive gas in the stomach and intestines.

10 A tube used to drain or inject fluid through a body opening.

Down

1 An artificial opening between the large intestine and the abdominal surface.

2 Used by men for urination.

3 The surgical creation of an opening between the ileum (small intestine) and the abdomen.

Module 8: Patient/resident Care Skills Handout 8.1Cc-Crossword #2

11 A cone-shaped solid medication that is inserted into a body opening.
12 An opening.
13 A buildup of hard feces in the rectum.
14 The inability to control the passage of urine or feces.
15 Excretion of wastes.

4 The frequent passage of liquid stools.

6 The excretions of the bowels.
7 Passage of a hard, dry stool.
8 The surgical creation of an artificial opening.
9 A sample of something.
12 Feces that have been excreted.

High Risk Factors for Skin Breakdown and Interventions to Prevent

High Risk Factors	Interventions
1. Mobility/Sensory: Paraplegic Quadriplegic CVA Peripheral Vascular Disease Bed rest Diabetic COPD Decreased sensation	Control pressure-egg crate; air bed ROM at least every 4 hours. Turn every two hours, even air bed. Proper position with pillows. Avoid friction, or shear by using draw sheet, trapeze. Specific pressure relief devices-booties, elbow, wheel chair pad. Assesses skin every 8 hours. Keep HOB below 30 degrees as much as possible.
2. Elimination: Incontinence stool/urine Diaphoresis Dehydrated Leaking tubes	Keep dry-fecal incontinence bag, rectal tube, Foley cath, texas cath. Caution with “diapers”. Use briefs. Check diaphoretic patient. Change diet or stool routine. R/O UTI and other causes. Adjust meds-watch for yeast. No plastic near skin-watch “Attends”. Cleanse-do not “scrub” pat dry well.
3. Edema/Fluid status: Edema/swelling Dehydration	Elevate limb and change position. Use compression devices-TEDS. Ace wrap BUT remove every 8 hours and check skin; check that device does not cut in on the edges.

High Risk Factors for Skin Breakdown and Interventions to Prevent

High Risk Factors	**Interventions**
	Force fluids 2000 day if low. Check skin every 8 hours. Lotion skin frequently-especially dry skin.
4. Nutrition/Body structure: Obese Thin Poor appetite Nutritional lab values low	Dietary consult. Medicate for N&V (nausea & vomiting); diarrhea Supplement diet-need protein, vitamins, and minerals. Use semi-fowlers position for tube feeders
5. Other Predisposing Factors: COPD Diabetes Medications-Prednisone Cancer Splints/casts Prosthetic devices Anemic	Licensed nurse check labs-anemia, protein, oxygen saturation, albumin Steroids-slow healing, mask infection, fragile skin. Check oxygen sat. Possible oxygen. Keep track of patient's blood sugars. Realize some patients will break down no matter what. Close watch on high risk areas of feet and coccyx.

Staging of Pressure Sores

Stage I

- The skin has not been broken.
- The epidermis and dermis are intact.
- Has erythema that does not resolve within 30 minutes.

Goal:

- Prevent skin breakdown
- Heal in 48 hours with pressure relief.

Stage II

- The skin is open.
- There is damage to the epidermis and PART of the dermis can be involved.
- The skin can be cracked, blistered, broken open, and reddened.
- No necrotic tissue is present.
- Wound bed is moist, pink and painful.

Goal:

- Re-epithelialization
- Heal in 5-7 days

Stage III

- Have a full thickness loss (epidermis and dermis gone) or partial dermis left but has necrotic tissue is present in wound.
- May or may not have necrotic tissue in deeper full lose wounds.
- May not be painful.

Goal:

- Granulation, contraction, re-epithelialization.
- Takes weeks to months to heal.

Stage IV

- Involves deep tissue including possible fat, muscle, and bone.
- Can have granulated tissue, necrotic tissue, and eschar.
- Some wounds have tunneling or undermining.
- Osteomyelitis of the bone is a threat.

Goal:

- Granulation, contraction, and re-epithelialization.
- Long term healing process – months.
- May need skin graft or flap to heal.

A licensed nurse assesses and "Stages" wounds. A wound is not "staged" until the eschar is gone and wound bed can be visualized and assessed. Wounds are reassessed at every dressing change or every eight hours if possible. Wounds may continue to deteriorate within the first 5-7 days of treatment and may even look worse. The wound care is not to blame; it is just the wound declaring the true amount of damage that was done, now that it is in a "good" environment.

"Sitting on Hand" Activity

Purpose - To help student understand the principles of pressure on the skin and how their patient/resident may feel this pressure

Timing - At beginning of skin lecture

1. Ask students to take their non-dominant hand and place entirely under their buttocks while sitting.
2. Instruct student that they may not move/shift positions or remove hand until you tell them they can in five minutes.
3. Observe students while lecturing and note shifting and moving – remind them not to do so.
4. After five minutes have students remove hand from under buttock and note: red, pain and numbness.
5. Reinforce patients/residents may not be able to move and they only get moved every two hours.

Bowel & Bladder Assessment Program

Date																						
Date Started	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	
7 am																						
8 am																						
9 am																						
10 am																						
11 am																						
12 noon																						
1 pm																						
2 pm																						
3 pm																						
4 pm																						
5 pm																						
6 pm																						
7 pm																						
8 pm																						
9 pm																						
10 pm																						
11 pm																						
12 Midnight																						
1 am																						
2 am																						
3 am																						
4 am																						
5 am																						
6 am																						
Signature 7-3																						
3-11																						
11-7																						

S- Suppository Inserted
BM-Bowel Movement

Licensed Nurses Instructions: _____

_____

_____

Name- Last First Middle	Room No.	Attending Physician	Hosp. No.

Bowel & Bladder Retraining Program

Form 609 Briggs, Des Moines, Iowa 50306

Module 9: Patient Care Procedures
Minimum Number of Theory Hours: 7
Recommended Clinical Hours: 20

Statement of Purpose:
The purpose of this unit is to provide learning experiences that will prepare the Nurse Assistant to safely carry out procedures that support the patient/resident in meeting physical care needs that cannot be performed independently.

Terminology:

1. Admission
2. Anti-embolic stockings
3. Bandage
4. Binders
5. Clean catch
6. Defecate
7. Discharge
8. Draw sheet
9. Edema
10. Elastic bandage
11. Electric bed
12. Evacuation
13. Excoriated
14. Expectorate
15. Fanfold
16. Fluid
17. Gastrostomy tube
18. Hives
19. Intake
20. Integumentary system
21. Intravenous (IV)
22. Lesions
23. Manual bed
24. Mitered corner
25. Mucous
26. Nasogastric tube (NGT)
27. Non-prescription
28. Occupied bed
29. Ointment
30. Output
31. Percutaneous Endoscopic Gastrostomy (PEG)
32. Pruritus
33. Reflux
34. Reverse Trendelenburg
35. Scaly
36. Semi-Fowler's position
37. Side rails
38. Specimen
39. Suppository
40. Transfer
41. Trendelenburg
42. Unoccupied bed

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of seven (7) hours of class plus assignments and twenty (20) hours of clinical experience, the learner will be able to:

1. Define key terminology

COLLECTION of SPECIMENS

2. Describe the Nurse Assistant's role in collecting specimens (sputum, urine, and/or stool)

BED CARE

3. Discuss procedures for bed making and maintaining proper body mechanics
4. Discuss types of beds and bed positions
5. Discuss ways to maintain the patient's/resident's environment

BOWEL CARE

6. Describe the Nurse Assistant's role in administering an enema
7. Describe the Nurse Assistant's role in giving a suppository

TUBES

8. List the types and uses of gastrointestinal (GI) tubes
9. Describe major nursing care activities for patients/residents with feeding tube (nasogastric or gastrostomy)
10. Describe nursing care activities for a patient/resident receiving intravenous (I.V.) therapy

INTAKE AND OUTPUT

11. Describe the Nursing Assistant's role in assisting the patient/resident to maintain fluid balance
12. Describe the purpose and procedure for measuring the amount of fluid taken in and fluids excreted by the patient/resident

BANDAGES AND DRESSINGS

13. Discuss the Nursing's Assistant role in the use of bandages, binders and dressings
14. Describe the use and method of applying anti-embolic hose/elastic stockings

OINTMENTS, POWDERS, and LOTIONS

15. Identify the Nurse Assistant's role in the care of patients/residents' skin conditions and the use of non-prescription ointments, lotions, or powders

ADMISSION, TRANSFER and DISCHARGE

16. Explain the role of the Nurse Assistant in the admission of a patient/resident to the facility
17. Explain the role of the Nurse Assistant in transferring a patient/resident from one area to another within the facility
18. Explain the role of the Nurse Assistant in the discharge of a patient/resident

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes	A. Ask students to select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Describe the Nurse Assistant's role in collecting specimens (sputum, urine, and/or stool).** A. Sputum Specimens 1. Purpose a. Respiratory disorders cause the secretion of mucus from lungs, bronchi and trachea b. Mucous secretion is called sputum (not related to saliva) c. Expectorated from upper airways d. Sputum is studied for blood, microorganisms, and abnormal cells 2. Assisting the patient/resident in raising sputum for a specimen a. Secretions are more easily coughed up after the patient/resident wakes up in early a.m. b. Allow the patient/resident to rinse their mouth with water, as this reduces the amount of saliva in the mouth and removes food particles	A. Lecture/Discussion B. Ask students to role play what to tell patient/resident specifically. It is not enough to have them say "I'll explain it to the patient/resident". Each skill has requirement to "Explain procedure, speaking clearly, slowly, and directly. Maintain face to face contact whenever possible." They need to practice what to say	A. Written test B. Uses correct techniques to collect, label, and document obtaining a specimens

c. Do not use mouthwash, as this may destroy some of the organisms d. Coughing up sputum may be embarrassing to the patient/resident, and may nauseate others nearby e. The specimen itself may be perceived as unpleasant Keep container covered and place in bag f. Privacy is important g. Use standard precautions 3. Specimen needs to be labeled a. Patients/residents full name b. Room and bed number c. Time and date the specimen was collected 4. Observations a. Color b. Odor c. Consistency d. Blood 5. Document specimen obtained and where taken B. Urine Specimens 1. Purpose a. Urine is collected for a laboratory examination or testing in the unit to help the physician diagnose a problem or evaluate treatment 2. Methods for collecting urine specimens a. Mid-stream b. Clean catheter urine specimen c. 24-hour urine specimen 3. Rules to follow in collecting urine specimen a. Wash hands before and after collecting a specimen b. Use standard precautions c. Use the correct and clean container for each specimen	C. Demonstrate and return demonstration using vanilla pudding D. Manual Skills 9.2a-Collecting and Identifying Specimens-Sputum E. Demonstration and return demonstration of urine collection using colored water F. Manual Skills 9.2b-Collecting and Identifying Specimens-Urine G. Demonstration and return demonstration of stool specimen collection using “play dough” or clay H. Manual Skills 9.2c-Collecting and Identifying Specimens-Stool	

d. Label the container accurately 1) Patient's name 2) Room and bed number 3) Date and time specimen was collected e. Collect specimen directly into container at time specified f. Do not touch the inside of the container or lid g. Ask the patient/resident not to have a bowel movement while the specimen is being collected h. Ask the patient/resident to place toilet tissue in the toilet or wastebasket i. Take the specimen and the requisition slip to the designated lab pick-up station j. Document that the specimen was obtained and where it was taken in the patient/resident record 4. Observations a. Difficulty obtaining specimen b. Color, clarity and odor c. Particles d. Complaints of discomfort and/or urgency C. Stool Specimens 1. Stool is collected for a laboratory test to check for the presence of blood, fat, micro-organisms, worms (parasites), and any abnormal contents 2. General rules for collection a. Maintain patient's/resident's privacy b. Use standard precautions c. Use clean container d. Give the patient/resident clear instruction on how to defecate for the specimen; must not contaminate with urine or toilet tissue e. Label the container accurately 1) Patient's/resident's name 2) Room and bed number 3) Date 4) Time specimen was collected		

f. Clarify if the specimen must be kept at room temperature, or refrigerated (check on specific lab test) g. Take specimen and requisition slip to the designated area 3. Observations a. Difficulty in obtaining specimen b. Color, amount, consistency, and where taken c. Complaints of pain or discomfort 4. Document specimen obtained and where taken		
Objective 3 **Discuss procedures for bed making and maintaining proper body mechanics**. A. Bed making is an important part of the Nurse Assistant role 1. A clean, dry, neat bed makes the patient/resident more comfortable 2. The body exerts uneven points of pressure over bony prominences (elbow, sacrum), etc., when against the mattress for extended periods. Use a mattress pad, if ordered 3. Bed linen must be wrinkle-free to prevent it from becoming an irritant to skin 4. The state of mind of the patient/resident is affected by the condition of the bed. To create and maintain a positive attitude, the bed should be kept a. In good repair b. Clean bedframe by damp dusting daily c. Well-made, wrinkle-free d. Attractive with use of bedspread 5. Keep call bell in place, clipped to linen 6. Keep the patient/resident reality-oriented by use of patient's/resident's personal pillow, afghan, etc. (familiar objects)	A. Lecture/Discussion B. Demonstrate and return demonstration C. Manual Skills 9.3a-Occupied Bed Making D. Manual Skills 9.3b-Unoccupied Bed Making	A. Written test B. Demonstrates proper bed making in clinical setting C. Uses proper body mechanics during bed making in clinical setting

B. Bed linen can act as an irritant to patient/resident skin 1. Use sheets to separate the blanket from the patient's/resident's skin, thus preventing blanket fibers from causing irritation 2. Keep bottom linens tucked in and wrinkle-free 3. Cover plastic draw sheet with cotton draw sheet 4. Straighten and tighten loose sheets, blankets and bedspreads whenever necessary 5. Strong laundry soaps may cause skin irritation; observe for patient/resident skin problems and report C. Aseptic technique is important when handling bed linen; follow standard precautions 1. Wash hands. Germs spread by cross-contamination 2. Hold and carry linen away from uniform a. Dirty linen is dirtier than the uniform and could transfer micro-organisms to the uniform b. Clean linen is cleaner than the uniform 3. Shaking linens or fluffing them in the air is avoided during bed making since this practice will spread dust and germs 4. Keep linen off the floor or off the overbed table, as soiled linen can transfer germs to these areas 5. Soiled linen should be immediately placed in a linen hamper or rolled tightly and tucked at the foot of the bed between the mattress and frame until it can be carried to the linen hamper 6. Soiled-linen hampers should be kept covered to prevent spread of infection and odors D. Body Mechanics 1. Proper body mechanics is required to make a bed to prevent injury and fatigue 2. Know your limitations. Don't try to lift, turn, or move a patient alone if you have any doubts about your ability to do so 3. Get close to sides of bed; don't make beds from the head of bed or foot positions		

4. Keep back straight and knees bent 5. Keep feet apart to give a broader support base 6. Move feet to turn in the direction wanted and avoid twisting your back 7. Face in the direction you are working at the side of the bed 8. Raise bed to comfortable height 9. Make one side of bed before beginning other side		
Objective 4 **Discuss types of beds and bed positions** A. Functions and structures of a hospital bed 1. Manually operated beds have hand cranks at the foot of the bed which raise or lower the head, foot, or total bed. Cranks are to be kept down when not in use 2. Electric beds have electric controls located on the side or foot of the bed for the patient/resident and staff use 3. Side rails a. Uses 1) Prevent patient/resident from falling out of bed 2) Provide security 3) Give patient/resident support to hold or grasp when moving or turning while in bed b. Regulations regarding use 1) Considered restraints 2) Must have consent to use 3) Need for use must be noted in patient's/resident's record and care plan 4) Patient/resident must be checked frequently if side rails are ordered B. Bed Positions 1. High position encourages the staff to use good body mechanics when giving care to patients/residents, moving patients/residents to stretchers, or when making the bed	A. Lecture/Discussion B. Demonstrate and return demonstration of bed functions	A. Written test B. Demonstrates safe operation of beds in clinical setting C. Raises and lowers bed to accommodate patient's/resident's needs

2. Low position is used to encourage the ambulatory patient/resident to get in and out of bed with ease and safety 3. Fowler's position (backrest raised 45° to 90°) is used for patient/resident comfort to eat meals and to breathe more easily in certain respiratory and cardiac conditions 4. Semi-Fowler's position (backrest 45° with knees raised 15°) is used for comfort and to keep the patient/resident from sliding down in bed 5. Trendelenburg position is when the head of the bed is lowered and the foot of the bed is raised. This position requires a doctor's order 6. Reverse Trendelenburg position is when the head of the bed is raised and the foot of the bed is lowered. This position requires a doctor's order		
Objective 5 **Discuss ways to maintain the patient's/resident's environment.** A. Patients/residents spend a lot of time in their rooms 1. Rooms should be comfortable. Control temperature, ventilation, noise, light, and odor 2. Rooms should be safe a. Maintain furniture and equipment for communicating in a safe and effective manner b. Patient's/resident's rights to privacy should be considered when furnishing a room. Allow the patient/resident choices and selection of own furniture from home to the extent of facility policies c. Make sure bed wheels are locked when giving care or transferring patients/residents B. General rules for maintaining the patient's/resident's unit 1. Make sure patient/resident can reach bedside stand and overbed table 2. Arrange personal belongings the way the patient/resident prefers, with patient/resident safety in mind and within easy reach	A. Lecture/Discussion B. Ask students to think of creative ways to make the patient's/resident's room safe and comfortable as well as promote independence	A. Written test B. Maintains safe and comfortable room environment for patient/resident

3. Keep call bell within patient's/resident's reach 4. Make sure patient/resident can reach telephone, television controls, and light controls 5. Provide the patient/resident with tissues, toilet paper and a waste container 6. Adjust lighting and temperature for patient's/resident's comfort 7. Respect patient's/resident's belongings 8. Keep environment clean 9. Straighten bed linens as needed		
Objective 6 **Describe the Nurse Assistant role in administering an enema.** A. An enema is the introduction of fluids into the rectum and lower colon; ordered by a doctor B. The purpose of a enema is to 1. Stimulate a bowel movement 2. Relieve constipation or fecal impaction 3. Cleanse bowel of feces prior to surgery and diagnostic procedures 4. Remove flatus (gas) C. Types of enemas 1. Cleansing enemas to remove feces from colon and rectum a. Tap water b. Soap suds 2. Oil retention enema; given for constipation or fecal impaction for lubrication of feces 3. Commercial mixtures; given for constipation (i.e., Fleet's) D. General rules to follow when giving an enema 1. Before Nursing Assistant administers enema, make sure: a. State governing board allows Nursing Assistants to give enemas b. Procedure is in job description c. Have obtained the necessary education and training d. There is a nurse available to supervise the procedure	A. Lecture/Discussion B. Demonstrate and return demonstration on manikin C. Manual Skills 9.6a- Administering a Soap Suds Enema D. Manual Skills 9.6b- Administering the Commercially Prepared Enema and Cleansing Enema	A. Written test B. Administers enema according to policy

2. Temperature of solution should be 105° F. 3. Amount of solution is 500-1000 ml for adults 4. Patient/resident positioned in left Sim's position 5. Height of enema bag is no more than 18" above the mattress 6. Depth of tube insertion is about 2" to 4" into rectum and tube must be lubricated 7. Administer solution slowly over ten to fifteen minutes (Solution is usually held in rectum for a variable length of time until urge to defecate occurs) 8. Hold enema tube in place while administering 9. Make sure toilet facility is nearby and available 10. Observe the results of the enema 11. Use standard precautions		
Objective 7 **Describe the Nurse Assistant's role in giving a suppository.** A. A rectal suppository is used to 1. Stimulate to empty the bowel 2. Lubricate the stool to ease evacuation B. Nurse Assistant role 1. Facility policy dictates if the Nurse Assistant may insert a suppository 2. General rules to follow when inserting a suppository a. Nurse Assistants may not administer medicated suppositories b. Identify the patient/resident by checking the arm band c. Remove wrapper from the suppository (if wrapped) d. Place suppository 1 to 1-1/2 inches past anal sphincter using gloved hand and index finger f. Instruct the patient/resident to hold the suppository in the rectum as long as possible g. Observe for results of the suppository e. Report the results to the licensed nurse	A. Lecture/Discussion B. Demonstrate and return demonstration on manikin C. Manual Skills 9.7- Rectal Suppository-Laxative	A. Written test B. Administers suppository according to policy

Objective 8 **List types and uses of gastrointestinal (GI) tubes.** A. Nasogastric tube 1. Inserted through nose into stomach or intestine to a. Drain the GI tract by means of suction to prevent post-operative vomiting, obstruction, or gas formation b. Diagnose a disease c. Wash out stomach content d. Provide a route for feeding one who is unable to take food by mouth B. Gastrostomy tube/PEG 1. Surgically inserted through abdominal wall into the stomach 2. Purpose of tube is for feeding the patient/resident	A. Lecture/Discussion B. Show students examples of nasogastric and gastrostomy tubes or if unavailable, show pictures of tubes	A. Written test B. Correctly identifies types of GI tubes
Objective 9 **Describe major nursing care activities for patients/residents with feeding tubes (nasogastric or gastrostomy).** A. Care of patient/resident with nasogastric tube 1. Give frequent oral hygiene and keep the lips and mouth moist. The mouth becomes very dry and may have a bad taste 2. Nose and nostrils need to be cleaned frequently 3. Increase freedom of movement by securing tubing with clamp or tape to the patient's/resident's clothing to permit maximum activity 4. Check to see that the patient/resident does not sit or lie on tubing (tubing must be free of kinks) 5. Check to see if the suction machine is operating satisfactorily and reporting at once if it is not working (if suction is ordered) 6. Permitting the patient/resident (if allowed) to suck on ice chips, throat lozenges, or hard candy to keep throat slightly moist. Patient/resident is usually NPO (nothing by mouth) Positioning the patient/resident with head of bed elevated at 45 degrees during the feeding and for 30-60 minutes afterward, and then 30 degrees after the feeding	A. Lecture/Discussion B. Ask students to discuss what it would feel like to not be able to eat normal food	A. Written test B. Maintains patient NPO/ice chips as ordered C. Provides safe care for patient/resident with feeding tube D. Uses nursing measures to provide comfort to patient/resident with a feeding tube E. Reports unusual signs or symptoms to licensed nurse

B. Care of patient/resident with gastrostomy tube 1. Give frequent oral hygiene and keep the lips and mouth moist The mouth becomes very dry and may have a bad taste 2. Increase freedom of movement by securing the gastrostomy tube with clamp or tape to the patient's/resident's clothing to permit maximum activity 3. Check to see that the patient/resident does not sit or lie on tubing (tubing must be free of kinks) 4. Permit the patient/resident (if allowed) to suck on ice chips, throat lozenges, or hard candy to keep throat, as well as tube, slightly moist 5. Position the patient/resident with head of bed elevated at all times 20 degrees to 30 degrees, to prevent reflux 6. Removing dressing from G-tube; clean and dry area; replace according to care plan 7. Reporting any unusual conditions observed during procedure a. Same as nasogastric tube b. Redness, swelling, drainage, odor or pain at the ostomy site C. Nursing care is provided to maintain a patient's/resident's mental and emotional comfort by: 1. Keeping the environment clean, tidy, and well-ventilated, as the patient/resident is often very sensitive to odors which can cause nausea and vomiting 2. Answering call lights promptly 3. Checking frequently and giving emotional support 4. Giving an extra back rub 5. Straightening or changing bed linen prn 6. Asking patient/resident to express concerns about the tube 7. Encouraging the patient/resident to be up, dress in day clothes, and join in activities as tolerated 8. Assist patient/resident to attend family and group activities		

D. Observe, report, and record routine care and any unusual events 1. Nausea, vomiting, diarrhea 2. Discomfort 3. Distended abdomen 4. Coughing 5. Care of indigestion or heartburn 6. Elevated temperature 7. Signs and symptoms of respiratory distress 8. Increased pulse rate 9. Care of flatulence		
Objective 10 **Describe nursing care activities for a patient/resident receiving intravenous (I.V.) therapy.** A. Reasons for using I.V. therapy 1. I.V. therapy provides the body with needed elements that can't be given as rapidly or efficiently by other means 2. I.V. may contain a. Blood, plasma b. Nutritional requirements for water, salt, sugar, etc. c. Medications 3. Rate of I.V. flow is often controlled by an infusion pump B. Nursing Assistant responsibilities include observing for flow from I.V. 1. Keeping tubing free of twisting or kinking 2. Observing position of tubing and condition of injection site for any infiltration a. An infiltrated I.V. is one in which the needle has come out of the vein and the I.V. leaks into the tissue, causing swelling b. Report this condition immediately to the charge nurse	A. Lecture/Discussion B. Manual Skills 9.10- Changing Clothing of Patient/resident with an I.V.	A. Written test B. Uses proper procedures for bathing and dressing patient/resident with an I.V. C. Uses nursing measures to provide comfort to patient/resident with an I.V.

3. Checking restraints or soft protective devices to be sure that they are not blocking the vein. Follow your agency's policy regarding restraints and soft protective measure C. Nursing Assistant responsibilities 1. Maintain a patient's/resident's physical comfort 2. Bathe the patient/resident according to daily routine a. Wash gently around the area where needle is inserted b. Do not loosen the tape that holds needle in place c. When drying, do not rub over area, pat gently to avoid dislodging the needle 3. Assist the patient/resident with eating by cutting food, preparing liquids, and arranging utensils conveniently 4. Assist the patient/resident with feeding as little as possible to encourage self-care 5. Assist the patient/resident to ambulate a. Provide a portable I.V. stand b. Assist out of bed c. Observe closely for weakness d. Support the I.V. arm to ensure continuous flow; a sling may be used to rest the arm e. Patients/residents may grasp the I.V. pole for support (with I.V. hand). This provides support for the arm and lets them move at their own pace, leaving other hand free for balance by holding onto railings		
Objective 11 **Describe the Nursing Assistant role in assisting the patient/resident to maintain fluid balance.** A. Importance of maintaining fluid balance 1. Next to oxygen, water is the most important physical need 2. Death can result from taking in inadequate fluids, from losing too much fluid or too much fluid intake a. Water enters body through food and fluid b. Water is lost through urine, sweat, feces, and lungs	A. Lecture B. Discuss creative ways to encourage increase in fluid intake	A. Written test B. Follows instructions for patient/resident fluid intake

3. Balance between amount of fluid taken in and the amount of fluid lost is necessary to maintain health a. Amount of fluid taken in and the amount of fluid lost must be equal b. An adult needs about 2000 ml of fluid a day c. Edema; fluid intake exceeds fluid output, tissues swell with water d. Dehydration; fluid output exceeds fluid intake, decrease in the amount of fluid in tissues 4. Patients/residents depend on nursing personnel to meet part or all of their food and fluid needs B. Encouraging increase in fluid intake 1. Forcing Fluids a. When physician orders "force fluids" it means to have the patient/resident drink an increased amount of fluid b. May order specific amount of fluid for 24-hour period c. Maintains fluid balance d. May be for general or specific amount of fluid 2. Nurse Assistant's responsibility to encourage fluid intake a. Keep record of amount taken in b. Provide variety of fluids c. Place within patient's/resident's reach d. Offer fluids frequently to patients/residents who cannot feed themselves C. Restricting fluid intake 1. When physician orders "restrict fluids" it means fluids are restricted to a specific amount 2. Nurse Assistant's responsibility a. A sign posted above the bed b. Water is offered in small amounts c. Keep water pitcher out of sight, or removed from room d. Keep accurate intake and output record e. Be aware of shift fluid requirements f. Provide patient/resident with frequent oral hygiene		

g. Explain to the patient/resident and family the reason for limiting fluid, removing water pitcher, etc. D. Nothing by mouth (NPO) 1. Ordered a. Before and after surgery b. Before certain lab tests and x-rays c. In the treatment of some illnesses 2. Nurse Assistant's responsibility for NPO patient/resident a. NPO sign above bed b. Remove water pitcher and glass c. Offer frequent oral hygiene d. No swallowing of any fluid		
Objective 12 **Describe the purpose and procedure for measuring the amount of fluid taken in and fluids excreted by the patient/resident (see module 7).** A. Purpose of "intake and output" (I & O) measurement 1. The doctor or nurse may want to keep track of a patient's/resident's fluid intake and output to evaluate a. Fluid balance b. Kidney function c. Response to medical treatment 2. Accurate measurement is needed and documented on the I & O record B. Measurement of patient's/resident's intake 1. Measured in milliliters (ml) 2. Determine the fluid capacity of bowls, dishes, cups, pitchers, glasses, and other containers used to serve fluids 3. Count as intake a. Water, milk, coffee, juice, soup, etc. b. All food in liquid form when eaten or those that later revert to liquid, i.e., Jell-O, ice cream 4. A conversion table is provided on the intake and output record used to chart intake	A. Lecture/Discussion B. Review metric and household systems of measurement in Module 15- Fluid Measurement Handout 15.5 C. Provide exercises for students to practice intake and output measurement D. Manual Skills 9.12- Measuring Oral Intake E. Refer to Module 8 Manual Skill: 8.16- Measuring Urinary Output	A. Written test B. Records accurate intake and output according to facility policy

5. A container called a graduated cylinder is used to measure fluid C. Measurement of patient's/resident's output 1. Measure all fluids excreted by patient/resident done in ml. 2. All liquid output will be measured including urine, vomitus, liquid stool, drains and suctions 3. Plastic urinals and emesis basins may be calibrated 4. Use standard precautions when measuring output D. Recording intake and output 1. I & O record at bedside, document amounts when fluid is taken in or excreted 2. Amounts are totaled at end of shift and entered in the patient's record 3. Other special forms as required by facility E. Reporting intake and output: 1. Report any unusual occurrences 2. Refusing to drink fluid, special fluid likes or dislikes, and blood in urine		
Objective 13 **Discuss the Nursing Assistant role in the use of bandages, binders and dressings.** A. Purpose of bandages and binders 1. Apply pressure (compression) in order to stop bleeding or swelling, and to assist in absorbing tissue fluids 2. Provide for immobilization of an injured part; a fractured (broken) arm 3. Hold dressings in place 4. Protect open wounds from contaminants	A. Lecture/Discussion B. Demonstrate and return demonstration of dressing and bandage application	A. Written test B. Follows instructions of licensed nurse for application and removal of bandages and dressings

5. Apply warmth to a joint, as for persons suffering from painful joints due to arthritis 6. Provide support and aid in venous (return blood flow) circulation, as when bandaging the leg of a patient/resident suffering from varicose veins or limited circulation in the extremities (arms or legs) B. Dressings are ordered by the physician and initially applied by the licensed nurse C. Nurse Assistant role 1. Apply simple, dry, non-sterile dressings to uncomplicated wounds 2. Assist the licensed nurse with complex wounds D. The licensed nurse will inform the Nurse Assistant when to change a dressing and what supplies to use E. Materials used for dressings and bandages 1. Dressings are made from a variety of materials, mainly gauze which comes in 2 inch, 3 inch, and 4 inch squares. The size depends on the area of the body involved and the purpose of the dressing 2. Bandages and binders are made from muslin, gauze, flannel, rubber, and elastic fiber 3. Dressings are held in place with hypoallergenic tape, plastic tape, elastic tape, paper tape, silk tape, adhesive tape, and binders or bandages. The type depends on the purpose and the patient/resident F. Principles of bandaging 1. Apply bandage so pressure is evenly distributed to area a. If joint is involved in bandaging, support it in a comfortable position with a slight flexion of the joint b. Attach bandage securely to avoid friction and rubbing of underlying tissue which could cause irritation c. Start at the lower (distal) part of extremity d. Work upward to the top (proximal) part		

G. Rationale for removing elastic bandages 1. Elastic bandages should be removed every eight hours, unless ordered more frequently, to allow for inspection of underlying skin 2. Replace a moist or soiled bandage 3. Reapply a loose or wrinkled bandage H. Observation and reporting to licensed nurse 1. Swelling 2. Pain 3. Change in color 4. Decrease or increase of temperature 5. Drainage: color, consistency, amount 6. Odor		
Objective 14 **Describe the use and method of applying anti-embolic hose/elastic stockings.** A. Anti-embolic hose/elastic stockings are used to increase circulation by improving venous return from the legs to the heart B. Key points when applying elastic stockings 1. Always apply before patient/resident gets out of bed 2. Check for wrinkles 3. Check skin color and temperature 4. Check popliteal pulse **C.** Anti-embolic hose/elastic stockings are to be removed every 8 hrs. or according to facility policy	A. Lecture/Discussion B. Demonstrate and return demonstration in applying anti-embolic hose/elastic stockings C. Manual Skill 9.14- Anti-embolic Hose/Elastic Stockings	A. Written test B. Applies Anti-embolic hose/elastic stockings according to procedure C. Removes Anti-embolic hose/elastic stockings according to facility policy
Objective 15 **Identify the Nurse Assistant's role in the care of patient's/resident's skin conditions and the use of non-prescription ointments, lotions, or powders.** A. The Nurse Assistant can provide care to patients/residents with the following intact skin conditions 1. Foot care 2. Dandruff 3. Dry Skin	A. Lecture/Discussion B. Demonstrate and return demonstration of foot care with lotion application	A. Written test B. Applies non-prescription ointments, lotions and

B. The Nurse Assistant must reports the following existing skin conditions to the licensed nurse 1. Acne 2. Minor burn 3. Rash 4. Excoriation, abrasions, skin tears 5. Eczema or psoriasis 6. Poison ivy or poison oak 7. Minor wounds 8. Insect bites or stings C. The Nurse Assistant can apply over-the-counter ointments, lotions, or powders to intact skin surface only D. The Nurse Assistant does not apply ointments, lotions, or powders to irritated skin surfaces OR open lesions E. Over-the-counter ointments, lotions, or powders that the Nurse Assistant may apply to intact skin 1. Zinc oxide 2. A and D ointment 3. Clearasil 4. Stri-dex medicated pads 5. Selsun Blue 6. Keri Lotion 7. Corn Huskers 8. Johnson's Medicated Powder 9. Tinactin Foot Powder F. General rules for application of ointment, lotion, or powder 1. Prepare the patient/resident 2. Position the patient/resident 3. Cleanse the skin 4. Protect the surrounding skin	C. Refer to Module 8 Manual Skill 8.7b- Foot Care	powders according to facility policy

4. Applying ointments, lotions, or powders a. Apply as directed, wear gloves b. Creams or liniments are rubbed in by hand c. Lotions are patted on with a cotton ball d. Ointments are applied with a wooden tongue blade or a cotton swab e. Sprinkle powder onto hand or cloth, and then apply to patient/resident 5. Chart and report observations a. Make a note of the appearance of the skin b. Describe any changes in the appearance c. Identify any signs of irritation		
Objective 16 **Explain the role of the Nurse Assistant in the admission of a patient/resident to the facility.** A. Admission to a long-term facility is stressful to both the patient/resident and family 1. First impressions of the facility are important for the adjustment of the patient/resident to the facility 2. The new patient/resident may have many feelings of loss a. Home b. Possessions c. Independence d. Family e. Freedom f. Privacy g. Control over one's life B. Welcome the patient/resident 1. Greet patient/resident by name 2. Introduce yourself 3. Explain what you will be doing	A. Lecture B. Discussion	A. Written test B. Follows admission procedures of facility

4. Convey a warm welcome through tone of voice and facial expression C. Collect base line information about the patient/resident 1. Measure patient's/resident's height and weight 2. Measure patient's/resident's vital signs 3. Observe the patient's/resident's a. Grooming b. Condition of hair and nails c. Condition of skin d. Mental alertness e. Sight and hearing f. Presence of any prosthesis g. Ability to move around D. Report all questions and concerns of the patient/resident or family to the licensed nurse E. Orient the patient/resident and family to the facility 1. Review facility routine 2. Introduce patient/resident to roommate and staff 3. Tour the facility 4. Explain the operation of bed controls, TV controls, and nurse call system F. Care for personal belongings 1. Patients/residents must know they have control over their possessions and can decide where to put item 2. Fill out the facility list of possessions a. Encourage patient/resident to send valuables home with family b. Objectively describe valuables kept at facility 3. Label items with patients/residents' name		
Objective 17 **Explain the role of the Nurse Assistant in transferring a patient/resident from one area to another within the facility.** A. Tell the patient/resident in advance about the transfer, and explain	A. Lecture	A. Written test

the reason for moving B. Collect all the patient's/resident's belongings and take them to the new room 1. Be careful not to lose any items 2. Check all drawers and closets for personal items C. Introduce patient/resident to new roommates 1. New surroundings may cause confusion; orient patient/resident to new room 2. Continue to remind patient/resident of new room	B. Discussion	B. Follows transfer procedures of facility
Objective 18 **Explain the role of the Nurse Assistant in the discharge of a patient/resident.** A. Collect base line information about the patient/resident: 1. Measure patient's/resident's height and weight 2. Measure patient's/resident's vital signs 3. Observe the patient's/resident's: a. Grooming b. Condition of hair and nails c. Condition of skin d. Mental alertness e. Sight and hearing f. Presence of any prosthesis g. Ability to move around B. Collect all personal belongings of the patient/resident: 1. Check all drawers and closets for personal items 2. Review facility list of possessions for items that might be in the safe or locked cabinet or the laundry C. Assist the patient/resident to his or her vehicle or designated mode of transportation after checking with licensed nurse. Patient/resident usually leaves by wheelchair	A. Lecture B. Discussion	A. Written test B. Follows discharge procedures of facility

Sample Test: Module 9- Patient Care Procedures

1. A patient/resident has diarrhea. You know that liquid feces and frequent wiping can lead to?
    A. Skin breakdown
    B. Dehydration
    C. Oliguria
    D. Death

2. What is the preferred position for giving an enema?
    A. Fowler's or semi-fowlers position
    B. Sims' or left side lying position
    C. Prone or supine position
    D. Supine or right side-lying position

3. Water temperature for an enema solution for adults usually is
    A. 100^{o}
    B. 105^{o}
    C. 110^{o}
    D. Body temperature

4. A patient/resident finished urinating. The person cannot clean her genital area. You need to do the following **EXCEPT**
    A. Wipe her from back to front
    B. Use fresh tissue for each wipe
    C. Provide perineal care if necessary
    D. Wear gloves

5. A male patient/resident is not circumcised. When giving perineal care, which is correct?
    A. Retract the foreskin
    B. Separate the labia
    C. Start at the rectum
    D. Use firm, upward strokes

6. Which linens must be tight and wrinkle-free?
    A. Bottom linens
    B. The blanket
    C. The bedspread
    D. The pillowcase

7. The nurse asks you to collect a random urine specimen. Which is correct?
    A. No special measures are needed
    B. The perineal area is cleaned before collecting the specimen
    C. The first voiding is discarded
    D. The person voids twice

8. The nurse asks you to strain a person's urine. To do this, you need
    A. A midstream urine specimen
    B. A 24-hour urine specimen
    C. A strainer or gauze
    D. Elastic tape

9. Mucus from the respiratory system that is expelled through the mouth is
    A. Phlegm
    B. Saliva
    C. Sputum
    D. Ketone

10. Oral care before collecting a sputum specimen involves
    A. Brushing the teeth
    B. Using mouthwash
    C. Flossing
    D. Rinsing with clear water

11. The nurse asks you to collect a stool specimen from a patient/resident. Which is **INCORRECT**?
    A. Explain what the person needs to do
    B. Explain what you will do
    C. Ask if the person understands what to do
    D. Stay with the person until the person has a bowel movement

12. When collecting a sputum specimen, the person coughs up sputum from the
    A. Mouth
    B. Throat
    C. Upper airway
    D. Bronchi and trachea

13. Normal urine has
    A. A faint odor
    B. A strong odor
    C. A sweet odor
    D. An ammonia odor

14. Which of the following is a characteristic of normal urine?
    A. Pale-yellow urine
    B. Straw-colored urine
    C. Red-colored urine
    D. Clear urine

15. A clean, neat, wrinkle-free bed does the following except
    A. Increase the person's comfort
    B. Help prevent skin breakdown
    C. Help prevent pressure ulcers
    D. Prevent incontinence

16. A patient/resident is up all day. What kind of bed should you make?
    A. Closed bed
    B. Open bed
    C. Occupied bed
    D. Surgical bed

17. Which is **not** a safety measure for making beds?
    A. Raise the bed for body mechanics
    B. Wear gloves when removing linen from the person's bed
    C. After making a bed, lower the bed to its lowest position
    D. After making an occupied bed, always raise the bed rails

18. Linens are held
    A. With forceps
    B. Close to your body and uniform
    C. Away from your body and uniform
    D. With gloves on

19. A patient/resident brought a pillow from home. Which statement is correct?
    A. The person needs to bring a pillowcase, too
    B. The person must use a pillow provided by the nursing center
    C. The person has the right to use the pillow
    D. The pillow must have a safety check by the maintenance department

20. You brought 2 pillowcases into a patient's/resident's room. The person uses 1 pillow. What should you do with the other pillowcase?
    A. Return it to the linen supply
    B. Leave it in the person's room for another time
    C. Take it to another patient's/resident's room
    D. Put it with the dirty laundry

21. You are going to make a bed. For good body mechanics, the bed is
    A. Fowler's position
    B. Raised
    C. Locked into position
    D. Moved so you can reach it with ease

22. Your patient/resident is right-handed. The bedside stand and call signal should be:
    A. On her right side
    B. On her left side
    C. Wherever the facility wants it
    D. Where it will be convenient for you

23. Wet, damp, or soiled linens are changed
    A. Right away
    B. After meals
    C. After the shower or bath
    D. Each shift

24. The bottom sheet is placed on the bed correctly if
    A. The hem-stitching is down
    B. The hem-stitching faces outward
    C. The top edge is even with bottom of the mattress
    D. It completely covers the plastic draw sheet

25. You are removing dirty linens from a person's bed. Which is correct?
    A. Remove all dirty linens at once
    B. Roll each piece away from you
    C. Keep the side that touched the person outside the roll
    D. Place dirty linen on the floor

26. Which is **not** a rule for collecting specimens?
    A. Use a clean container for each specimen
    B. Use the correct container
    C. Label the container accurately
    D. Collect the specimen as soon as you have time

27. A patient/resident has fecal incontinence. You know that
    A. Good skin care is required
    B. A bowel training program will cure the person's incontinence
    C. The condition is permanent
    D. The person has dementia

28. Keeping the person's room clean, neat, safe, and comfortable is the responsibility of
    A. Housekeeping staff
    B. Everyone involved in the person's care
    C. Maintenance staff
    D. The person and family

29. The loss of urine in response to a sudden need to void is called:
    A. Overflow incontinence
    B. Mixed incontinence
    C. Functional incontinence
    D. Urge incontinence

30. You are admitting a new patient/resident. Which is **incorrect**?
    A. Discuss the person's diagnoses and medical history
    B. Complete the clothing list
    C. Orient the person to the room
    D. Orient the person to the nursing unit and the facility

31. The nurse asks you to assist with the admission of a new patient/resident. What can the nurse delegate to you?
    A. Transporting the person to his or her room
    B. Having the person sign admitting papers
    C. Having the person sign a general consent for treatment
    D. Explaining patients/residents rights to the person

32. An infected wound is
    A. A contaminated wound
    B. An open wound
    C. A dirty wound
    D. A full-thickness wound

33. These statements are about skin tears. Which is **incorrect?**
    A. Skin tears can occur during bathing, dressing, repositioning, or transfers
    B. Skin tears are painful
    C. Infection can develop in a skin tear
    D. Skin tears usually occur over a bony area

34. Drainage that is thick green, yellow, or brown is
    A. Purulent drainage
    B. Serosanguineous drainage
    C. Serous drainage
    D. Sanguineous drainage

35. Which will help prevent skin tears?
    A. Keep your fingernails short and smoothly filed
    B. Wear simple earrings
    C. Wear gloves
    D. Practice hand hygiene before and after giving care

36. A patient/resident is going to be discharged. What must occur before the person can leave?
    A. Give the person prescriptions written by the doctor
    B. The person must be transported to the exit area by wheelchair or stretcher
    C. The person must pay the bill
    D. The person must sign a consent form

37. Which is not a guideline for measuring weight and height?
    A. No footwear is worn
    B. The person voids after being weighed
    C. Weigh the person at the same time of day
    D. Use the same scale for daily, weekly, and monthly weights

38. An elastic bandage is applied from the
    A. Lower part to the top part
    B. Top part to the lower part
    C. Back to front
    D. Front to back

39. Elastic stockings also are called
    A. Anti-embolism stockings
    B. Support Hose
    C. Elastic bandages
    D. Montgomery bandages

40. A patient/resident objects to a transfer or a discharge. An ombudsman makes sure that the person's best interests are considered.
    A. True
    B. False

41. When removing dirty linens, roll each piece toward you.
    A. True
    B. False

42. Wet, damp and soiled linens are changed at the end of your shift.
    A. True
    B. False

43. When using a fracture pan, the larger end is placed under the buttocks.
    A. True
    B. False

44. When collecting specimens, you must not touch the inside of the container lid.
    A. True
    B. False

45. Linen can be transferred from one patient's/resident's room to another patient's/resident's room.
    A. True
    B. False

Matching

A. Oliguria
B. Enema
C. Open bed
D. Pressure Ulcer
E. Constipation

46. The passage of a hard, dry stool
47. A type of bed ready for a patient/resident arriving on a stretcher.
48. Scant amount of urine.
49. Open wound on the heel of a patient/resident.
50. The introduction of fluid into the rectum.

MANUAL SKILL: Collecting and Identifying Specimens: Sputum

EQUIPMENT:

Completed label
Completed laboratory requisition
Emesis basin
Gloves
Mask
Paper or plastic bag
Sputum specimen container with cover
Tissue

BEGINNING STEPS:

1. Gather equipment .
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce yourself (name and title).
5. Identify patient/resident. Use two identifiers (name, DOB).
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
7. Put on mask and gloves. (If patient/resident has known or suspected TB, wear the proper mask).

SKILL STEPS:

1. If the patient/resident has eaten recently, ask the patient/resident to rinse her mouth with water. Assist as necessary. Use emesis basin to spit water out.
2. Ask the patient/resident to cough deeply, so that sputum comes up from the lungs. To prevent the spread of infection ask the patient/resident to cover the nose and mouth with a tissue while coughing.
3. Have the patient/resident spit the sputum directly into the specimen container. (Collect 1-2 teaspoons).
4. Wipe any sputum of the outside of the container with tissues (only the outside of the container should be touched) cover the container tightly.
5. Discard the tissues.

ENDING STEPS:

1. Place container into bag.
2. Remove and dispose of gloves and mask properly (without contaminating self).
3. Leave call light within patient's/resident's reach.
4. Wash hands.
5. Report any changes in the patient/resident to nurse.
6. Document procedure using facility guidelines.
7. Take specimen container and lab slip to designated place promptly.

MANUAL SKILL: Collecting and Identifying Specimens: Urine

EQUIPMENT:

Bedpan
Bedside commode
Completed lab requisition
Gloves
Graduate measure
Labeled specimen container and lid
Paper or plastic bag
Specimen pan for toilet
Urinal

BEGINNING STEPS:

1. Gather equipment.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self (name and title).
5. Identify patient/resident. (Name and DOB).
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
7. Provide privacy (curtain and/or door).
8. Apply clean gloves.

SKILL STEPS:

1. Under optimal conditions the specimen should be collected directly into the container or use clean/unused bedpan urinal or specimen pan.
2. Assist the patient/resident to a comfortable position to urinate.
3. Ask the patient/resident to urinate into a clean bedpan, urinal or specimen pan.
4. Instruct the patient/resident not to put toilet tissue in bedpan, urinal or specimen pan, put in plastic bag or wastebasket.
5. Cover the bedpan or urinal and take it to the bathroom.
6. If patient/resident is on intake and output. Pour urine into new or unused graduate and measure.

7. Pour the urine into specimen container, filling it three fourths full if possible.
8. Place lid on container. Put container in plastic bag.
9. Pour leftover urine into toilet and flush.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove and dispose of gloves (without contaminating self) into waste container.
3. Wash hands.
4. Assist patient/resident to wash hands, if applicable.
5. Position patient/resident comfortably.
6. Place call light within reach.
7. Lower bed to safe position, if applicable.
8. Wash hands.
9. Report any abnormal findings to licensed nurse.
10. Document.
11. Take the labeled specimen and lab requisition to the appropriate storage or pick-up station.

MANUAL SKILL: Collecting and Identifying Specimens: Stool

EQUIPMENT:

Bedpan
Bedside commode
Completed lab requisition
Gloves
Labeled specimen container and lid
Paper or plastic bag
Specimen pan for toilet
Toilet tissue
Tongue blade
Urinal

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self (name and title).
4. Identify patient/resident. (Name and DOB).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy.
8. Wash hands.

SKILL STEPS:

1. Practice good body mechanics. Adjust bed to safe working level, (waist high) if using a bedpan. Lock the wheels.
2. Lower the side rail (if it is not already lowered) on the side nearest you.
3. Apply clean gloves.
4. Assist the patient/resident with toileting. Use a clean or unused bedpan, bedside commode or specimen pan.
5. Ask the patient/resident not to urinate at the same time.

6. Ask the patient/resident not to put the toilet paper in with the sample. Provide a plastic bag or wastebasket.
7. Provide privacy; make sure call light is within reach.
8. After the bowel movement, help as necessary with perineal care. Help the patient/resident wash hands.
9. Make patient/resident comfortable.
10. Using the tongue blades, take about two tablespoons of stool and put it in the container.
11. Cover the container tightly and bag the specimen.
12. Wrap the tongue blades in toilet paper and throw them away in proper container.
13. Empty bedpan or container into the toilet and flush.

ENDING STEPS:

1. Clean equipment and store in proper place.
2. Remove and dispose of gloves (without contaminating self) into waste container.
3. Wash hands.
4. Return bed to low position if raised. Ensure patient's/resident's safety. Return side rails as ordered.
5. Leave call light within reach.
6. Wash hands.
7. Report any changes in the patient/resident to the licensed nurse.
8. Document procedure using facility guidelines.
9. Take specimen to designated place promptly.

MANUAL SKILL: Occupied Bed Making

EQUIPMENT:

Bedspread
Blanket
Bottom Sheet
Drawsheet or plastic pad
Mattress Pad (if used)
Pillow case
Top Sheet

BEGINNING STEPS:

1. Wash Hands.
2. Collect clean linens (always carry away from uniform).
3. Knock and pause before entering, identify self by name and title.
4. Identify patient/resident. (Name and DOB).
5. Place linen on a clean surface (may use overbed table, bed side dresser, may cover with towel).
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
7. Provide Privacy, draw curtain and/or close door.

SKILLS STEPS:

1. Lower head of bed before moving patient/resident.
2. Keep patient/resident covered while linens are changed.
3. Loosens top linen from end of the bed.
4. Raise side rail on side to which patient/resident will move and patient/resident moves toward raised side rail.
5. Raise the bed to comfortable working height.
6. Loosens bottom used linen on working side and moves bottom linen toward center of bed.
7. Places and tucks in clean bottom linen or fitted bottom sheet on working side and tucks under patient/resident.
8. Before going to other side, client moves back onto clean bottom linen.
9. Raise side rail then goes to other side of bed.
10. Remove used bottom sheet.
11. Pulls and tucks in clean bottom linen, finishing with bottom sheet free of wrinkles.

12. Patient/resident is covered with clean top sheet and bath blanket/used top sheet has been removed.
13. Change pillowcase.
14. Linen is centered and tucked in at foot of bed.
15. Avoid contact between Nurse Assistant's clothing and used linen.
16. Dispose of used linen into soiled linen container and avoid putting linen on floor.

ENDING STEPS:

1. Return bed to the lowest position.
2. Make sure call light is within reach.
3. Wash hands.

Note: Above steps are minimal requirements for testing purposes. See below for additional steps that may be useful for this skill.

Additional Skill Steps

1. If bedspread and blanket are to be reused, remove from bed and fanfold on back of chair or foot board of bed.
2. Lower the side rail on the side of the bed nearest you and raise side rail on side where patient/resident will turn.
3. Loosen the top and bottom linen at the foot of the bed.
4. Drape patient/resident with a bath blanket
    a. Unfold the bath blanket over the top sheet.
    b. Ask patient/resident to hold top of the bath blanket.
    c. Roll the top sheet under bath blanket to the foot of the bed.
5. Assist patient/resident to roll away from you towards the side rail (adjust pillow for patient/resident comfort).
6. Roll the bottom linen toward the patient/resident and tuck under the patients/residents body.
7. Put the mattress pad on the bed (if used).
8. Place the bottom sheet on the bed.
    a. If using a fitted sheet, pull the fitted corner over the top and bottom of the mattress.
    b. If using a flat sheet, put narrow hem at the bottom of the bed, tuck the sheet under the top of the mattress, and make a mitered corner, then tuck the sheet under the mattress along the side.
9. If using a draw sheet, place it on top of the sheet about 12" to 14" from head of bed.
10. Fold the clean linen toward the patient/resident next to the used linen; this will create a "hump" of linen next to the patient/resident.
11. Assist patient/resident to roll towards you over the hump of linen and immediately raise the side rail for support (adjust pillow for patient/resident comfort).

12. Go to the opposite side of bed and lower the side rail.
13. Remove soiled linen by rolling edges towards side with soiled side inward and place in linen hamper, or plastic bag. AVOID HOLDING SOILED LINEN AGAINST UNIFORM.
14. Unfold clean bottom linen from beneath the patient/resident, pulling it snug and removing wrinkles.
15. Assist the patient/resident to a comfortable position, making sure bath blanket does not get caught under patient/resident.
16. Place top sheet with wide hem toward head of bed with centerfold at center of bed, over bath blanket and unfold with as little movement as possible.
17. Place blanket (if used) over top sheet with centerfold at center of bed, about 6-8" below the top edge of top sheet and fold top sheet over to form a cuff.
18. Ask patient/resident to hold the top linen. Roll bath blanket from head to foot of bed and remove.
19. Tuck top linen under bottom of the mattress and make a mitered corner.
    a. With hand closest to foot of bed, pick up edge of sheet at side of bed about 18" from foot of bed.
    b. Place this section of sheet and blanket on bed.
    c. Tuck the hanging part of the sheet under the mattress.
    d. Pick up the part of the linens resting on the bed at the point, fold back over side of the bed.
20. Make a toe pleat.
21. Remove pillow and replace pillowcase.
    a. Grasp the clean pillowcase at the center of the seamed end.
    b. Turn the pillowcase back over your hand.
    c. Grasp the pillow at the center with the hand that is inside the pillowcase.
    d. Pull the pillowcase down over the pillow with your free hand.
    e. Line up seam of the pillowcase with the edges of pillow making sure corners of the pillow are in the corners of the pillowcase.
    f. Fold extra material of the pillowcase over and under the pillow.
22. Place pillow under the patients/residents head with the open edge facing away from the door.
23. Make sure patient/resident is comfortable in proper body alignment, bedside table is within reach.
24. Return side rails per care plan.
25. Open curtains, window drapes and door (per patients/residents preference).
26. Dispose of soiled linens.
27. Document.
28. Report any abnormal findings to the licensed nurse.

MANUAL SKILL: Unoccupied Bed Making

EQUIPMENT:

Bed Spread
Blanket
Bottom Sheet
Draw Sheet (chuck)
Mattress pad (if used)
Pillowcase
Top sheet

SKILLSTEPS:

1. Wash hands.
2. Collect clean linens.
3. Carry linens away from uniform.
4. Place linen on clean surface (bedside table, overbed table; a towel may be used to create a clean surface).
5. Lower the head of bed to flat position, raise bed to comfortable working height, lower side rails.
6. Remove pillowcase and set pillow aside on clean surface.
7. Remove soiled linen, loosen all linen, and roll from edges to center with soiled side inward, place directly into linen hamper. **NEVER PLACE LINEN ON FLOOR.**
8. Wash Hands.
9. If used, place mattress pad on the mattress.
10. Place bottom sheet on mattress in the center, with the center fold at the center from head to foot. **DO NOT SHAKE.**
    a. If using a fitted sheet pull the fitted corners over the top and bottom of the mattress on one side.
    b. If using a flat sheet
        1) Put narrow hem at bottom of bed.
        2) Tuck the sheet under the mattress at the top.
        3) Make a mitered corner.
        4) Tuck sheet under mattress along side.
11. Place draw sheet on top of bottom sheet about 12 – 14” from top edge of mattress.
12. Place top sheet with centerfold at center of bed from head to foot.
13. Center the top sheet with the wide hem even with the top of the mattress and the stitched side or seemed side up.
14. Unfold the sheet so that it hangs evenly on both sides of the mattress. **DO NOT SHAKE.**
15. Place the blanket over the top sheet.
    a. The top edge of the blanket should be 6 – 8” below the top edge of the top sheet.

   b. Fold the top sheet down over the top of the blanket to make a cuff.
16. Tuck the top sheet and blanket under the foot of the mattress. Make a mitered corner.
17. Move to the other side of the bed.
18. *Complete one side of bed before going to the other side of bed to save time and energy (*Repeat step 10 – 16).
19. Loosen end of linens or make a toe pleat for comfort.
20. Place pillowcase on pillow.
    a. Grasp the clean pillowcase at the center of the seamed end.
    b. Turn the pillow case back over hand.
    c. Grasp the pillow at the center with the hand that is inside the pillowcase.
    d. Pull the pillowcase down over the pillow with your free hand.
    e. Line up the seams of the pillowcase with the edges of the pillow making sure that the corners of the pillow are in the corners of the pillowcase.
    f. Tuck the extra material of the pillowcase inside and under pillow.
21. Place the Pillow on the bed so that the open edge is facing away from the door.
22. Lower the bed.
23. Ensure room is neat and clean, call light on bed, bedside table straightened and placed by bed.
24. Wash hands.

Closed Bed- Place the bed spread over the blanket and the pillow.

Open Bed- Fanfold the top linen toward the foot of the bed. Be certain that the cuff edge is closest to the head of the bed.

MANUAL SKILL: Administrating a Soap Suds Enema:

EQUIPMENT:

Bed protector
Bedpan or commode
Enema bag/bucket, tubing with clamp
Enema solution (soapsuds, tap water, or normal saline as ordered by physician)
Gloves
Toilet tissue
Water-soluble lubricant

BEGINNINGSTEPS:

1. Gather equipment.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room, introduce self by name and title.
4. Identify patient/resident (use name band and date of birth).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Provide for privacy (close privacy curtains, window shades and/or door).
7. Apply clean gloves.

Skill Steps:

1. In the bathroom or utility room prepare enema.
    a. Make sure that the tubing is connected to bag/bucket.
    b. Close clamp on tubing and fill bag/bucket with accurate amount of solution.
    c. Test temperature of solution to ensure that it is not neither too hot or too cold.
    d. Open clamp and allow solution to fill the tubing to remove air and then close clamp.
2. Raise side rails, and raise bed to a comfortable working height.
3. Lower the side rail nearest you.
4. Assist patient/resident to left Sims' position.
5. Place bed protector under the patient's/resident's buttocks.
6. Have a bedpan within reach.

7. Keep patient/resident covered and expose only the buttocks.
8. Apply lubricant to tip of tubing 2-4“.
9. Raise right buttocks so you can visualize the anus.
10. Gently and slowly insert tip of tubing 2-4” using a gentle rotating movement. ***Never push against resistance because you may injure your patient/resident, stop procedure and call supervising nurse.***
11. Open clamp and raise enema bag/bucket 18 inches above the mattress.
12. Allow the solution to flow slowly into anus.
13. If patient/resident complains of discomfort clamp tubing and wait a minute or so before continuing the flow.
14. When the solution is almost gone, clamp tube and slowly remove the tubing.
15. Place tubing into the enema bag/bucket and do not allow the tip to come in contact with the bed, floor or uniform (may wrap tip of tubing in a paper towel).
16. Encourage patient/resident to hold solution as long as possible.
17. When patient/resident is ready to expel enema, assist patient/resident onto bedpan. If allowed raise head of bed.
18. If patient/resident is allowed bathroom privileges, assist to bathroom and stay near in case patient/resident needs help.
19. Place toilet tissue and signal cord within reach.
20. Check on patient/resident every few minutes.
21. Discard disposable equipment.
22. Remove bedpan, remove bed protector and any soiled linens and replace, cleanse patient/resident as necessary or cleanse patient/resident and assist back to bed.
23. Assist patient/resident to wash hands.
24. Check contents of bedpan or toilet for color, consistency, amount, unusual material then empty and flush.

ENDING STEPS:

1. Remove and dispose of gloves (without contaminating self) into waste container.
2. Wash hands.
3. Position patient/resident comfortably.
4. Lower the bed to a safe position.
5. Ensure call light is within reach.
6. Wash hands.
7. Document.
8. Report any abnormal findings to licensed nurse.

MANUAL SKILL: Administering the Commercially Prepared Enema (Cleansing and/or Oil Retention)

EQUIPMENT:

Bed protector
Bedpan
Commercially prepared enema (cleansing and/or Oil Retention)
Lubricating jelly
Toilet tissue

BEGINNING STEPS:

1. Gather Equipment.
2. Knock on door and pause before entering, introduce self by name and title.
3. Wash hands.
4. Identify patient/resident (name band and date of birth).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Provide privacy, close privacy curtains, window shades and/or door.
7. Raise the bed to a comfortable working height.
8. Lower the side rail nearest you.
9. Apply clean gloves.

SKILL STEPS:

1. Cover patient/resident with a blanket or sheet, fold remaining linen to the foot of the bed.
2. Position the patient/resident in the left Sims' position.
3. Place bed protector under buttocks.
4. Have bedpan within reach.
5. Expose buttocks by raising edge of blanket, keep patient/resident covered.
6. Raise right buttocks to visualize the anus.
7. Remove cap from enema.
8. Lubricate the tip 2 to 4 inches with lubricating jelly.
9. Gently insert tip of enema 2" through anus into rectum.
10. Squeeze and roll the plastic bottle gently until all the solution enters the rectum. Stop if patient/resident complains of pain or if you feel resistance, or if bleeding occurs.
11. Remove tube from patient's/resident's anus and place bottle in box for disposal.

   a. For oil retention – encourage patient/resident to hold solution for 20 minutes (or time ordered) before placing on bedpan or assisting patient/resident to toilet.
   b. For cleansing enema – assist patient/resident onto bedpan or to toilet. Encourage patient/resident to retain enema until urge to defecate is felt.
12. Remove gloves.
13. Wash hands.
14. Provide toilet tissue and make sure call bell is within reach, provide privacy.
15. Discard disposable enema equipment.
16. Monitor patient/resident every few minutes or when patient/resident signals.
17. Apply gloves.
18. Remove bedpan.
19. Assist patient/resident to clean perineal area.
20. Remove bed protector.
21. Check contents of bedpan or toilet for color, consistency, amount, unusual material then empty.

ENDING STEPS:

1. Remove and replace any soiled linen.
2. Remove and dispose of gloves (without contaminating self) into waste container. Wash hands.
3. Provide material for patient/resident to wash hands.
4. Position patient/resident for comfort.
5. Lower bed to safe position.
6. Ensure call light is within reach.
7. Wash hands.
8. Document.
9. Report any abnormal findings to licensed nurse.

MANUAL SKILL: Rectal Suppository-Laxative

EQUIPMENT:

Bedpan with cover
Disposable gloves
Suppository as ordered for bowel evacuation
Toilet tissue
Water-soluble lubricant

BEGINNING STEPS:

1. Wash hands.
2. Gather equipment.
3. Knock on door and pause, introduces self by name and title.
4. Identify patient/resident (use name and date of birth).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Provide privacy, close privacy current and/or door.

SKILL STEPS:

1. Raise bed to a comfortable working level.
2. Position the patient/resident or ask the patient/resident to turn on left side and raise one knee toward the chest. Assist as necessary.
3. Apply clean gloves.
4. Lift the sheet and expose the buttocks.
5. Unwrap the suppository.
6. Lubricate suppository as needed.
7. Spread buttocks to expose anal area.
8. Insert the suppository, using index finger. Ask the patient/resident to take deep breaths, as this will help relax the patient and retain the suppository Place the suppository past the rectal sphincter against the wall of the colon.
9. Withdraw the finger and hold toilet tissues against the anus briefly.
10. Remove the gloves by turning them inside out; dispose according to facility policy.
11. Wash hands.
12. Reposition the patient/resident in a comfortable position, and ask patient/resident to retain the suppository as long as possible (15-20 minutes).

13. Provide a bedpan for use, if necessary, or assist to the bathroom.
14. Adjust bedding, helping patient to assume a comfortable position.
15. Place a call bell near the patient's/resident's hand, but check every few minutes.
16. Provide privacy.
17. Once patient/resident is finished, assist with hygiene if necessary.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove and dispose of gloves (without contaminating self) into waste container. Wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Changing Clothing of Patient/resident with an I.V.

I.V. without pump

EQUIPMENT:

Gown or clothing of patient's/resident's choice, non-skid footwear

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment.
7. Provide for privacy.
8. Apply gloves, if necessary.

SKILL STEPS:

1. Ask patient/resident what she/he would like to wear.
2. Raise bed to a comfortable working level.
3. Lower the side rail near you.
4. Cover the patient/resident with a bath blanket. Fanfold linens to the foot of the bed.
5. Untie the gown and free parts of the gown that the person is lying on.
6. Remove gown/shirt/blouse from arm without I.V. first.
7. Gather up the sleeve of the arm with the I.V. Slide it over the I.V. site and tubing. Remove the arm and hand from the sleeve.
8. Keep the sleeve gathered. Slide your arm along the tubing to the bag.
9. Remove the I.V. bag from the pole. Slide the bag and tubing through the sleeve. Do not pull on the tubing. **DO NOT LOWER THE BOTTLE OR BAG BELOW THE LEVEL OF THE PATIENT'S/RESIDENT'S ARM.**
10. Replace the I.V. bag on the pole.
11. Gather the sleeve of the clean gown that will go on the arm with the I.V. bag.
12. Remove the I.V. bag from the pole. Slip the sleeve over the bag at the shoulder part of the gown. Replace the bag on the pole.

13. Slide the gathered sleeve over the tubing, arm, hand, and I.V. site and over the arm.
14. Replace IV bag on pole.
15. Put the other side of the gown on. Fasten the back.
16. Cover the person. Remove bath blanket.

ENDING STEPS:

1. Clean and return equipment and supplies.
2. Remove gloves, if wearing.
3. Position the patient/resident comfortable.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Thank the patient/resident, leave room neat.
7. Wash hands.
8. Document.
9. Report any abnormal findings to licensed nurse.

I.V. INFUSING VIA PUMP

EQUIPMENT:

I.V. Gown or patients/residents clothing choice (gown with snaps at shoulder)

BEGINNING STEPS:

1. Wash hands.
2. Gather equipment.
3. Knock and pause at door before entering the patient's/resident's room.
4. Introduce self, using name and title.
5. Identify patient/resident using name and date of birth.
6. Explain procedure.
7. Provide privacy.
8. Apply gloves if necessary.

SKILL STEPS:

1. Raise bed to comfortable working level.
2. Lower side rail nearest you.
3. Cover patient/resident with a bath blanket, fanfold top linens to foot of bed.
4. Untie gown and free any part of the gown patient/resident is lying on. (If in personnel clothes STOP and get licensed nurse to disconnect I.V.)
5. Remove the sleeve from the arm without the I.V. first.
6. Unsnap the closure at the shoulder of the gown with the I.V. and remove.
7. With the new gown unsnap the closure on the side with the I.V.
8. Put on the gown on the side without the I.V. first, and then snap the closure at the shoulder on the I.V. side fasten back.
9. Cover the patient/resident, remove the bath blanket.

ENDING STEPS:

1. Clean and remove equipment.
2. Remove and dispose of gloves (without contaminating self) into waste container.
3. Wash hands.
4. Position the patient/resident comfortably.
5. Place call light within reach.
6. Lower bed to safe position for the patient/resident.
7. Thank the patient/resident, leave room neat.
8. Wash hands.
9. Document.
10. Report any abnormal findings, if patient/resident was disconnected from the pump inform licensed nurse to restart.

MANUAL SKILL: Measuring Oral Intake
(see module 7)

EQUIPMENT:

Graduated measuring container (graduate)
Intake and output record
Pen/pencil

BEGINNING STEPS:

9. Wash hands.
10. Knock and pause before entering the patient's/resident's room.
11. Introduce self.
12. Identify patient/resident.
13. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
14. Gather equipment, if applicable.
15. Provide for privacy with a curtain, door, or screen.
16. Apply gloves (standard precautions).

SKILL STEPS:

1. Gather equipment.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.
6. Explain procedure.
7. Provide for privacy.
8. Apply gloves, if necessary.
9. Pour the liquid remaining in the container into the graduate.
10. Measure the amount at eye level. Keep the container level.
11. Check the amount of the serving on the I & O record.
12. Subtract the remaining amount from the full serving amount. Note the amount.
13. Repeat steps 9 – 12 for each liquid.
14. Add the amounts from each liquid together.

15. Immediately record the time and amount on the I & O record.
16. Clean and return equipment and supplies.
17. Remove gloves, if wearing.
18. Position patient/resident comfortably.
19. Place call light within reach.
20. Lower bed to safe position for the patient/resident.
21. Leave room neat.
22. Wash hands.
23. Report abnormal findings to licensed nurse.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. After placing used equipment in designated dirty supply area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Applies One Knee-High Elastic Stocking

EQUIPMENT:

Anti-embolic/elastic stockings

BEGINNING STEPS:

1. Gather equipment.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self by name and title.
5. Identify patient/resident (name and date of birth).
6. Explain procedure, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.
7. Privacy is provided with a curtain, screen or door.

SKILL STEPS:

1. Client is in supine position (lying down in bed) while stocking is applied.
2. Turns stocking inside out, at least to the heel.
3. Places foot of the stocking over the toes, foot and heel.
4. Pulls top of stocking over foot, heel, and leg (It turns right side out as it is pulled up).
5. Moves foot and leg gently and naturally, avoiding force and over-extension of limb and joints.
6. Finishes procedure with no twists or wrinkles and heel of stocking, if present, is over heel and opening in toe area (if present) is either over or under toe area.

ENDING STEPS:

1. Position patient/resident comfortably.
2. Signaling device is within reach and bed is in low position.
3. After completing skill, wash hands.
4. Leave room neat.
5. Document.
6. Report abnormal findings to licensed nurse.

Module 10: Vital Signs
Minimum Number of Theory Hours: 3
Recommended Clinical Hours: 6

Statement of Purpose:
The purpose of this unit is to prepare students to know how, when and why vital signs are taken and how to report and chart these procedures. Students will learn the correct procedure for measuring temperature, pulse, respirations, and blood pressure. They will learn to recognize and report normal and abnormal findings.

Terminology:

Temperature:	**Blood Pressure**	**Pulse**	**Respiration**	**Pain** (effects on Vital signs)
1. Afebrile 2. Axilla 3. Celsius 4. Fahrenheit 5. Febrile 6. Metabolism 7. Mucosa 8. Pyrexia 9. Tympanic	10. Aneroid manometer 11. Bell 12. Diaphragm 13. Diastolic 14. Hypertension 15. Hypotension 16. Orthostatic hypotension 17. Pre-hypertension 18. Pulse pressure 19. Sphygmomanometer 20. Stethoscope 21. Systolic	22. Apical 23. Arrhythmia 24. Bounding 25. Brachial 26. Bradycardia 27. Carotid 28. Pulse deficit 29. Radial 30. Rhythm 31. Thready 32. Tachycardia	33. Abdominal respirations 34. Apnea 35. Bradypnea 36. Cheyne-Stokes 37. Cyanosis 38. Diaphragm 39. Dyspnea 40. Labored respiration 41. Orthopnea 42. Shallow respiration 43. Stertorous 44. Tachypnea 45. Temperature, Pulse, Respiration (TPR)	46. Acute pain 47. Chronic pain 48. Phantom pain 49. Pain scales

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of three (3) hours of class plus homework assignments and six (6) hours of clinical experience, the student will be able to:

1. Define key terminology
2. Describe what is meant by vital signs, their purpose, and observations made while performing the procedures
3. Discuss the use of temperature as an indicator of body function
4. Describe nursing measures to raise and lower the temperature of the body
5. Describe the circulatory system as it relates to pulse, and identify the pulse sites
6. Describe factors that increase and decrease pulse, and the qualities to observe in taking a pulse
7. Define and describe respiration and factors that affect respiratory rate
8. Describe observations to be made when measuring respirations
9. Describe abnormal breathing patterns
10. Describe the process for taking TPR as a combined procedure
11. Describe what happens in the circulatory system to produce blood pressure
12. Identify factors that increase or decrease blood pressure
13. Identify parts of the blood pressure equipment
14. Discuss the procedure for taking a blood pressure reading
15. Discuss observation and reporting of patient's/resident's pain
16. Record vital signs on chart, graph, and Nursing Assistant notes

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes E. Handout 10.1a- Vital Signs Crossword F. Handout 10.1b- Vital Signs Crossword KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Describe what is meant by vital signs, their purpose, and observations made while performing the procedures.** A. Vital signs refer to the temperature, pulse, respirations, and blood pressure B. Pain, previously considered the 5th vital sign, has measurable effects on vital signs depending on the type of pain 1. Acute pain 2. Chronic pain 3. Phantom pain 4. Pain scales C. Vital signs are indicators of body function 1. Assess body systems 2. Signify changes that are occurring in the body D. Observations when taking vital signs include 1. Color and temperature of the skin	A. Lecture/Discussion B. Demonstration and return demonstration C. Handout 10.2- Vital Signs Chart	A. Observe student measuring vital signs B. Ask students what changes they would note in patient's/resident's skin color, temperature, and behavior

Objective 3 **Discuss the use of temperature as an indication of body function.** A. Temperature 1. Balance between heat gained and heat lost 2. The hypothalamus in the brain is the temperature regulation center B. Heat production. Heat is produced in our bodies by cellular activity, food metabolism, muscle activity, and hormones 1. Infection elevates temperature 2. Brain injury can alter the temperature regulating center to either increase or decrease temperature 3. External factors can cause temperature elevation, such as, hot drinks, hot air, warm clothing and exercise 4. Internal factors such as dehydration C. Heat loss. Heat is normally lost from the body through: 1. Skin – sweating or perspiration and increased blood flow to skin surface 2. Lungs – increased respiratory rate 3. Elimination – urine and feces D. Heat conservation. Heat is conserved by the body through 1. Reducing perspiration 2. Decreasing the flow of blood to the skin 3. Shivering (which increases muscular activity to produce heat) E. Four main sites for temperature measurement (Note contraindications on Skills Procedures pages) 1. Oral (most common) 2. Rectal a. Most accurate b. Not used as often as in past Caution: The vagus nerve may be stimulated when taking a rectal temperature, which may temporarily decrease the patient's/resident's heart rate and blood pressure 3. Tympanic 4. Axillary 5. Temporal	A. Lecture/Discussion B. Display all types of thermometers C. Ask students to identify types D. Demonstration and return demonstration with all types of thermometers as well as contraindications E. Manual Skills10.3a- Oral Temperature F. Manual Skills 10.3b- Axillary Temperature G. Manual Skills 10.3c- Tympanic Temperature H. Manual Skills 10.3d- Rectal Temperature I. Use visual aid for temperature reading in the ear J. Manual Skills 10.3e- Electronic temperature	A. Written test B. Demonstrates accurate measurement of temperature by oral, axillary, temporal, and rectal routes C. Demonstrates use of mercury-free glass thermometer, electronic, digital, tympanic, and temporal artery thermometers D. Reports abnormal temperature to nurse

F. Types of Thermometers 1. Glass a. Clinical thermometer b. Mercury free; mercury glass thermometers are no longer used by many facilities, as the mercury is toxic c. Oral or Axillary thermometer has long narrow bulb and blue or green color coding d. Rectal thermometer has short stubby bulb and is color coded red e. All glass thermometers require the use of a disposable plastic sheath 2. Digital a. Used for oral, rectal or axillary measurement b. Battery operated c. Takes approximately 60 seconds to display the temperature d. Will flash or beep when the temperature has been registered e. Requires the use of a disposable plastic sheath 3. Electronic a. Used for oral, rectal or axillary measurement b. Registers temperature in 2-60 seconds c. Flashes or makes a sound when temperature is displayed d. Probes are color coded (red-rectal, blue/green-oral or axillary) e. Requires the use of a disposable plastic probe cover f. Stored in a re-charging unit when not in use 4. Disposable a. Used for oral or axillary measurement b. Single use, usually used for patients/residents in isolation c. Does not require the use of a disposable cover		

5. Tympanic a. Used to measure temperature reading in the ear b. Requires a disposable probe cover c. Incorrect positioning or ear wax may cause inaccurate reading d. Hearing Aids need to be removed e. Stored in a re-charging base when not in use 6. Temporal Artery a. Infrared thermometer that measures the temperature of temporal artery b. Device for forehead measurement G. Normal ranges for temperature 1. Normal resting range in adult (97° F – 99° F) or (36° C – 37.5° C) 2. Oral 98.6° F 3. Rectal 99.6 °F – one degree higher than oral 4. Axillary 97.6 °F – one degree lower than oral 5. Tympanic or temporal 98.6° F		
Objective 4 **Describe nursing measures to raise and lower temperature of the body.** A. Measures to raise the temperature 1. Increase the temperature in the room 2. Add coverings to the body 3. Provide hot liquids to drink 4. Give warm baths or soaks B. Measures to lower the temperature 1. Decrease the temperature in the room 2. Remove coverings from the body 3. Offer cool liquids to drink 4. Provide cool bath or sponging	A. Lecture B. Discussion	A. Written test B. Observation in clinical setting

Objective 5 **Describe the circulatory system as it relates to pulse and identify the pulse sites.** A. Pulse 1. Each time the heart contracts, blood is forced into the arterial system. The arterial walls expand to accept the increase in pressure; this expansion is called the pulse 2. By counting each palpated expansion of the arterial wall, the pulse rate can be determined 3. The average (adult heart beat) pulse is 60 to100 beats/minute B. Major pulse sites 1. Carotid – neck 2. Apical – left chest (taken with stethoscope) 3. Brachial – inner part of elbow 4. Radial – thumb side of wrist 5. Femoral – groin 6. Popliteal – behind the knee 7. Dorsalis pedis – (pedal) top of the foot	A. Lecture/Discussion B. Use visual aid for demonstrating pulse sites C. Role play D. Advanced activity: Ask students to research procedure for pulse deficit measurement and report/demonstrate to the class	A. Written test B. Locates major pulse sites
Objective 6 **Describe the factors that increase and decrease pulse, and the qualities to observe in taking a pulse.** A. Factors that increase pulse 1. Exercise 2. Fever 3. Hemorrhage 4. Pain 5. Shock 6. Strong emotions (anger, fear, laughter, excitement) 7. Over 100 beats/min – tachycardia	A. Lecture/Discussion B. Demonstration and return demonstration of radial and apical pulse measurement for full minute C. Role play D. Manual Skills 10.6a-Radial Pulse E. Manual Skills 10.6b-Apical Pulse	A. Written test B. Demonstrates accurate measurement for radial and brachial pulse for one full minute C. Reports abnormal pulse to nurse

B. Factors that decrease the pulse 1. Sleep/rest 2. Depression 3. Drugs (digitalis, morphine) 4. Athletes in good physical condition have a lower pulse, probably below 60 beats/min 5. Below 60 beats/min – bradycardia C. Qualities of pulse 1. Rate – number of beats per minute 2. Rhythm a. Refers to regularity of pulse beats b. Report irregular heart rhythm even if rate is normal 3. Strength; force (volume) — weak (thready) or bounding		
Objective 7 **Define and describe respiration and factors affecting respiratory rate.** A. Definition 1. Respiration is defined as the exchange of oxygen and carbon dioxide in lungs 2. Breathing refers to inhalation and exhalation of air 3. Regulated in the brain by the medulla B. Normal rate in adult is 12 to 20/minute C. Normal breathing is quiet, effortless, and regular in rhythm D. Factor that increase respiratory rate 1. Exercise 2. Strong emotion 3. Infection 4. Increased body temperature 5. Increased metabolism 6. Pain E. Factors that decrease respiratory rate 1. Rest/sleep 2. Depression 3. Drugs/medications 4. Meditation	A. Lecture B. Discussion	A. Written test

Objective 8 **Describe observations to be made when measuring respirations.** A. Rate 1. Number of respirations per minute 2. Normal adult 12-20/minute B. Rhythm; regularity of respirations C. Depth; shallow, normal, deep D. Symmetry E. Effort it involves F. Discomfort it causes G. Position patient/resident adopts H. Sounds that accompany it I. Color of skin and mucous membranes, nail beds (cyanosis) J. Changes in patient's/resident's behavior	A. Lecture/Discussion B. Manual Skills 10.8-Respirations C. Demonstration and return demonstration for measuring respiratory rate D. Role play	A. Written test B. Demonstrates accurate measurement of respirations C. Reports immediately to nurse if patient's/resident's respiratory rate is above or below normal
Objective 9 **Describe abnormal breathing patterns.** A. Labored; the patient/resident struggles or works hard to breathe B. Orthopnea; breathing possible only when person sits or stands C. Stertorous; patient/resident makes snoring sounds while breathing (indicates partial airway obstruction) D. Abdominal; breathing using mostly the abdominal muscles E. Shallow; breathing with only the upper part of the lungs F. Dyspnea; painful or difficult breathing G. Tachypnea; respiratory rate above 24/minute H. Bradypnea; respiratory rate less than 10/minute I. Apnea; absence of breathing J. Cheyne-stokes respirations gradually increase in rate and depth and then become shallow and slow, then a period of apnea	A. Lecture B. Discussion	A. Written test B. Reports abnormal breathing pattern or change in patient's/resident's appearance or behavior to licensed nurse

Objective 10 **Describe the process for taking temperature, pulse and respiration (TPR) as a combined procedure.** A. The temperature is taken first, then the pulse, followed by respirations B. Be sure to remember the pulse rate while counting the respirations so they can be documented together C. Try not to stop to record the pulse before counting the respirations	A. Lecture/Discussion B. Demonstration/return demonstration of TPR measurement C. Role play	A. Demonstrates accurate measurement of TPR in one process B. Reports abnormal to licensed nurse
Objective 11 **Describe what happens in the circulatory system to produce blood pressure.** A. Circulatory system and blood pressure 1. Blood Pressure is the force (pressure) of the blood pushing against the walls of arteries 2. Systolic pressure (first number of reading) a. Heart contracts forcing blood into the artery b. Pressure at highest in arteries 3. Diastolic pressure (second number of reading) a. Heart at rest b. Pressure at lowest in arteries; arteries completely open 4. Thumping sounds a. Produced as blood flows through the arteries b. Heard in large arteries of limbs 5. Sounds correspond to numbers a. Represents millimeters of mercury (mm Hg), seen on sphygmomanometer b. First sound heard when taking blood pressure is systolic pressure 1) Contraction of heart muscle 2) Closure of the mitral and tricuspid valves c. Last sound heard when taking the blood pressure is diastolic pressure	A. Lecture/Discussion B. Ask students to research pulse pressure reading and disorders where this would be indicated	A. Written test

1) Relaxation of heart muscle 2) Closure of aortic and pulmonic valves d. Recorded as an improper fraction—systolic *over* diastolic B. Blood pressure – normal and abnormal ranges 1. Normal adult a. 120/80 mm Hg. b. 90 - 140 range for systolic c. Systolic reading of 139 is classified as pre-hypertensive d. 60-90 range for diastolic e. Diastolic reading of 89 is classified as pre-hypertensive 2. Abnormal blood pressures a. Hypertension; persistent measurements above normal range 1) 140 and above – systolic 2) 90 and above – diastolic b. Hypotension; persistent measurements below normal range 1) 90 and below – systolic 2) 60 and below – diastolic 3. Pulse pressure a. The difference between systolic and diastolic pressures b. May provide information concerning health of blood vessels (arteries) c. Average range is 30-50 mmHg.		
Objective 12 **Identify factors that increase or decrease blood pressure.** A. Factors that raise blood pressure 1. Strong emotion 2. Exercise 3. Standing or sitting 4. Excitement 5. Pain	A. Lecture B. Discussion	A. Written test

6. Decrease of blood vessel size 7. Digestion 8. Improperly placed cuff B. Factors that lower blood pressure 1. Rest/sleep 2. Lying down 3. Depression 4. Shock 5. Hemorrhage		
Objective 13 **Identify parts of the blood pressure equipment.** A. Manual sphygmomanometer a. Cuff b. Bulb c. Manometer (aneroid or mercury column) 2. Stethoscope B. Electronic (automated) sphygmomanometer 1. Cuff is attached to patient 2. Cuff automatically inflates and deflates 3. Blood pressure displayed digitally 4. Stethoscope not required C. Some facilities may use a monitoring device that measures other vital signs such as pulse rate, temperature and blood oxygen levels as well as blood pressure	A. Lecture/Discussion B. Show equipment	A. Written test
Objective 14 **Discuss the procedure for taking a blood pressure reading.** A. Guidelines 1. Blood pressure commonly is measured at the brachial artery 2. The popliteal artery (behind the knee) may also be used 3. Blood pressure measurements at a site other than the brachial artery must be ordered by a doctor 4. Patient/resident should be at rest; check position order (LSS-lying,	A. Lecture/Discussion B. Manual Skills 10.14a-Blood Pressure-One step C. Manual Skills 10.14b-Blood Pressure-Two	A. Written test B. Demonstrates accurate measurement of blood pressure C. Reports abnormal blood pressure to licensed nurse

sitting, standing) 5. Make sure manometer is properly calibrated (reads "0" when no air is in cuff) 6. Use appropriate sized cuff for the limb being used to measure blood pressure a. Cuff that is too narrow or small gives a false high reading b. Cuff below the level of the heart will give a false high reading c. Improperly placed cuff or too loose cuff gives a false low reading d. Alternative sizes of blood pressure cuffs such as wide, large, and/or thigh cuffs 7. Do not take the blood pressure on an arm or side with injury or medical equipment present such as a. IV line b. Burns or injuries c. Paralysis due to stroke d. Amputation e. Cast f. Recent trauma g. Site used for dialysis h. Mastectomy or surgery on the breast 8. Position the patient's/resident's arm level with the heart 9. Apply blood pressure cuff to bare arm (not over clothing) 10. Position the sphygmomanometer at the Nursing Assistant's eye level 11. Measurement techniques a. One step; no estimation of systolic pressure before measurement b. Two step; estimation of systolic pressure before measurement	step D. Display equipment and have students identify parts E. Demonstration and return demonstration of blood pressure measurement F. Role play	
Objective 15 **Discuss observation and reporting of patient's/resident's pain.** A. Pain was known as the 5th vital sign, but has measurable effects on vital signs	A. Lecture/Discussion	A. Written test

1. Pain is not a normal part of aging 2. Pain is a warning or distress signal by the body that something is wrong 3. Nursing Assistants may be the first to notice that patient/resident is in pain 4. Nursing Assistant must use skills of observation, as some patients/residents may not verbally indicate they have pain 5. Each person's response to pain may be different 6. Culture may play an important part on a patient's/resident's reaction to having pain 7. Pain may cause or increase anxiety and or stress 8. Take complaints of pain seriously, avoid judging 9. Types of pain: a. Acute pain b. Chronic pain c. Phantom pain B. Signs of Pain 1. Increased pulse, respirations, blood pressure 2. Sighing, moaning, groaning, or crying 3. Nausea, vomiting 4. Sweating 5. Squeezing eyes shut, tightening jaw, grinding teeth, holding a body part tightly 6. Increased restlessness, agitation or tension 7. Difficulty moving, positioning or walking C. Guidelines for observation and reporting of pain 1. Ask patient/resident if they are in any pain. 2. Use pain scale 3. Ask patient/resident to describe the pain • Location • Frequency (continuous, off and on) • Duration (how long pain lasts) • Pain quality (nature and type of pain) 4. Observe facial expression, movement, respiration 5. Ask patient/resident level of pain using facility method 6. Report complaints of pain to licensed nurse	B. Handout 10.15- Pain Scale C. Role play use of pain scale D. Ask students to share possible barriers related to pain management	B. Observation in clinical

D. Nurse Assistant comfort measures 1. Check on patient/resident often and ask if the pain has been relieved 2. Tell patient what you plan to do and how you will do it 3. Avoid sudden, jerking movement when repositioning 4. Offer backrubs (if indicated) 5. Listen to patient/resident concerns, provide emotional support 6. Maintain a clean, comfortable, quiet environment 7. Eliminate unpleasant sounds, sights, odors from the environment		
Objective 16 **Record vital signs on chart, graph and Nursing Assistant notes.** A. Charting temperature, pulse, respiration (TPR) 1. Report normal and abnormal TPR to licensed nurse 2. Record on hospital flow sheets, graphic records, and Nursing Assistant notes according to facility policies. Record in the order of TPR 3. Record temperature a. Chart rectal temperature with an" R" (example 101°F (R)) b. Chart an axillary temperature with an "AX" (example 101°F $^{(Ax)}$) 4. Pulse readings other than radial must be noted (example; Apical pulse 86 (a) 5. Record respiratory rate B. Charting blood pressure 1. Record and report abnormal high or low reading to licensed nurse 2. Write on chart as a fraction: systolic/diastolic (example 120/80) 3. If taken in a place other than arm, note location (example 150/90-thigh)	A. Lecture/Discussion B. Provide facility flow chart and/or graphic sheets for students to practice recording C. Role play and record vital signs	A. Written test B. Accurately records vital signs on facility flow charts and graphic sheets according to facility policy

Sample Test: Module 10- Vital Signs

1. The amount of force exerted against the walls of the artery by the blood is commonly referred to as:
    A. Blood pressure
    B. Pulse
    C. Metabolism
    D. Hypertension

2. The normal oral temperature of an adult
    patient/resident is: A. 96.2 °F
    B. 98.6°F
    C. 101.0° F
    D. 99.6° F

3. The Nurse Assistant enters Mr. S's room to take his oral temperature and observes that he is drinking a glass of ice water. The Nurse Assistant should:
    A. Proceed with the oral temperature as planned
    B. Take a rectal temperature instead because the ice water will affect an oral reading
    C. Place a plastic sheath over the oral thermometer so the reading won't be affected
    D. Request that the patient not eat or drink anything else for 15 minutes and then return to take his temperature

4. Which of the steps mentioned below should the Nurse Assistant not do as part of taking a rectal temperature for an adult?
    A. Shake down the thermometer until it registers below 96°F.
    B. Position the patient in the prone position
    C. Lubricate the bulb end of the thermometer
    D. Insert the thermometer one inch into the rectum

5. Which of the following can increase the pulse rate?
    A. Depression
    B. Cold
    C. Pain
    D. Sleep

6. Before using a stethoscope from the nursing unit, the Nurse Assistant should:
    A. Wash the diaphragm with soap and water
    B. Clean the earpieces and the diaphragm with an alcohol wipe
    C. Disinfect the entire stethoscope with a strong disinfectant
    D. Replace the earpieces as they are disposable

7. A patient/resident's diastolic pressure is 104 mm Hg. A high diastolic reading could be serious because it:
    A. Means the patient/resident has hypotension
    B. Means the patient/resident is in shock
    C. Measures the amount of pressure in the arteries when the heart is contracting
    D. Measures the amount of pressure in the arteries when the heart is at rest

8. Mr. Johnson is a 75 year old, who has a cardiac condition and is experiencing bradycardia. Which pulse rate represents bradycardia?
    A. 152 beats per minute
    B. 84 beats per minute
    C. 68 beats per minute
    D. 42 beats per minute

9. The Nurse Assistant is taking routine vital signs on a patient/resident who is known to have an irregular pulse. The Nurse Assistant should take a:
    A. Radial pulse for 15 seconds and multiply by 4
    B. Radial pulse for 30 seconds and multiply by 2
    C. Radial pulse for one full minute
    D. Carotid pulse for 30 seconds and multiply by 2

10. The radial pulse is the most common site used for routine vital signs. The radial pulse is located on the:
    A. Internal side of the arm just below the elbow
    B. External side of the arm just below the elbow
    C. Thumb side of the wrist
    D. Little finger (pinkie) side of the wrist

11. When taking a patient's/resident's temperature, pulse, respirations (TPR), the respiration should be counted after the:
    A. Temperature has been taken
    B. Pulse has been taken, while the fingers remain on the pulse site
    C. Pulse has been taken and written down
    D. Nurse Assistant informs the patient/resident that the respirations will be counted

12. A respiration is defined as:
    A. One deep inhalation
    B. One full inhalation and exhalation cycle
    C. One deep exhalation
    D. A breath counted with each heartbeat

13. A patient/resident has a temperature of 102° F. What can the Nurse Assistant do to assist in lowering the fever without a physician's order?
    A. Give the patient/resident an alcohol bath
    B. Apply an ice cap to the patient's/resident's forehead
    C. Place the patient on a hypothermia blanket
    D. Encourage the patient/resident to drink cool fluids, if allowed to have oral intake

14. Which of the following pulse rates and blood pressure readings are within normal range for adult
    A. Pulse 100, BP 200/100
    B. Pulse 110, BP 140/90
    C. Pulse 72, BP 130/84
    D. Pulse 40, BP 90/60

15. Which of the following signs is not associated with a fever?
    A. Flushed face
    B. Thirst
    C. Skin dry and hot to touch
    D. Decreased pulse

16. When a patient/resident experiences difficult, painful or labored breathing, it is known as:
    A. Tachypnea
    B. Apnea
    C. Dyspnea
    D. Bradypnea

17. Which one of the following statements about blood pressure is true:
    A. The cuff can be placed over clothing
    B. Blood pressure can be measured on an injured arm or one that has an IV inserted
    C. The cuff is inflated 20mm – 30mm above the point where the radial pulse was palpated in the two step procedure
    D. Blood pressure cuffs should be the same size for all patients/residents

18. Which of the following pulses is located at the inner side of the elbow?
    A. Carotid
    B. Apical
    C. Popliteal
    D. Brachial

19. When taking a blood pressure reading, the higher number represents the pressure in the artery at the peak of cardiac contraction. This is called the:
    A. Apical pressure
    B. Diastolic pressure
    C. Systolic pressure
    D. Pulse pressure

20. When a patient/resident must be in a sitting position in order to breathe, this is known as:
    A. Cheyne-stokes respiratory
    B. Orthopnea
    C. Hyperventilation
    D. Snoring

21. When taking a patient's/resident's blood pressure, the Nurse Assistant will need to use a stethoscope and a:
    A. Wrist watch
    B. Specimen container
    C. Thermometer
    D. Sphygmomanometer

22. The Nurse Assistant is preparing to take a patient's/resident's blood pressure. The patient/resident has an IV in the right arm. The Nurse Assistant should:
    A. Take the blood pressure above the IV site in the right arm
    B. Take the blood pressure on the left arm
    C. Use a small cuff to take the blood pressure on the right arm
    D. Report the situation to the licensed nurse

23. The Nurse Assistant should know that the first sounds heard when taking a blood pressure reading is called the:
    A. Pulse pressure
    B. Diastolic pressure
    C. Auscultatory gap
    D. Systolic pressure

24. When taking a patient's/resident's vital signs, which of the following should the Nurse Assistant recognize as abnormal?
    A. Pulse 124
    B. Respirations 18
    C. Oral temperature, 99° F (37.2° C)
    D. Blood pressure 138/60 mmHg.

25. Which of the following is the correct order for the Nurse Assistant to use when recording a patient's/resident's vital signs?
    A. Pulse, temperature, and respirations
    B. Blood pressure, respirations, and temperature
    C. Temperature, pulse, and respirations
    D. Respirations, pulse, and blood pressur

26. When the patient/resident returns to his room after a short walk, he reports shortness of breath and tightness in the chest. Which of the following should the Nurse Assistant do FIRST?
    A. Tell the patient/resident that he will be fine soon
    B. Take their vital signs
    C. Stay with the patient/resident and call for the nurse immediately
    D. Call the family

27. When a Nurse Assistant is unable to obtain a patient's/resident's pulse rate:
    A. Ask another nurse assistant to check the pulse
    B. Take the pulse again for 15 seconds and multiply the rate by 4
    C. Ask the patient/resident if her pulse is sometimes hard to find
    D. Take the pulse for a full minute at another location

28. The Nurse Assistant is taking a patient's/resident's temperature. Which of the following would be a normal axillary temperature reading? A. 97.6° F (36.4° C)
    B. 98.6° F (37° C)
    C. 99.6° F (37.6° C)
    D. 100.6° F (38.1° C)

29. The Nurse Assistant is taking a patient's/resident's blood pressure. To read systolic pressure a second time, the Nurse Assistant should:
    A. Immediately pump the cuff back up to 200 mmHg and try again
    B. Deflate the cuff completely, wait 1-2 minutes and retake the blood pressure
    C. Continue to deflate the cuff and add 20 points to the first sound heard
    D. Wait at least 30 minutes before reading the blood pressure again

30. To take a patient's/resident's pulse, the Nurse Assistant should:
    A. Put on gloves
    B. Use the thumb to feel the pulse
    C. Count the pulse for 10 seconds
    D. Take the pulse on the thumb side of the wrist

Manual Skill: Oral Temperature

EQUIPMENT:

Disposable sheath (cover)
Gloves (check facility policy)
Pen and paper
Thermometer Glass—Oral with blue or green color coding; check for cracks, breaks or chips
Tissue
Watch

TEMPERATURE: Oral (98.6 degrees F or 37.0 degrees C)

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Rinse thermometer in cool water and dry with tissue. Shake mercury down below 96 degrees F, holding the thermometer at end opposite bulb. Check again for chips, cracks or breaks.
2. Apply thermometer cover.
3. Ask the patient/resident if he/she has recently had hot or cold liquids or smoked. If so, wait 15 minutes to take temperature.
4. Place bulb of the thermometer in patient's/resident's mouth under base of tongue. Instruct the patient/resident to close lips around the thermometer; stay with patient/resident.
5. Note time of insertion and remove in 2-3 minutes or time interval according to facility policy.

6. Remove thermometer cover with gloved hand and wipe thermometer from stem to bulb with tissue. Do not touch bulb end of thermometer.
7. Read thermometer to the nearest two tenths of a degree.
8. Record temperature on paper if ordered, and proceed with vital signs.
9. Wash the thermometer with cool water and soap, and shake down before storing in the proper container (according to facility procedure). Note – never use hot water.
10. Discard sheath according to facility policy.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

NOTE**:** Contraindications for oral temperatures include the patient/resident who is:

1. Confused.
2. Disoriented.
3. Restless.
4. Unconscious.
5. Coughing.
6. Unable to breathe through his/her nose.
7. Prone to seizures.
8. Receiving oral/nasal oxygen.
9. Has difficulty breathing.
10. Receiving nasogastric tube feeding.

Manual Skill: Axillary Temperature

EQUIPMENT:

Disposable sheath (cover)
Gloves (check facility policy)
Pen and paper
Thermometer Glass—Oral with blue or green color coding; check for cracks, breaks or chips
Tissue
Watch

TEMPERATURE: Axillary (97.6 degrees F or 36.4 degrees C)

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy using a curtain, screen, or door.
8. Apply gloves, if necessary.

SKILL STEPS:

1. Rinse thermometer in cool water, dry with tissue.
2. Shake thermometer down below 96 degrees F, holding thermometer at end opposite bulb.
3. Apply thermometer cover.
4. Remove the patient's/resident's arm from the sleeve of the gown. Protect patient's/resident's privacy. If the axillary region is moist with perspiration, pat dry with a towel.
5. Place the bulb of the thermometer in the center of the armpit (axilla).
6. Put the patient's/resident's arm across the chest or abdomen.
7. If the patient/resident is unconscious or too weak to help, hold the thermometer in place.

8. Hold the thermometer in place for 5-10 minutes. Stay with the patient/resident.
9. Remove the thermometer. Remove the disposable cover (with gloved hand if necessary) discard cover as per facility policy. Wipe thermometer off from stem to bulb.
10. Read the thermometer and record the temperature to the nearest two-tenths degree. Note that this is an axillary temperature by writing an “AX” after the figure.
11. Put the patient’s/resident’s arm back in the sleeve of the gown.
12. Wash the thermometer in cool water and soap and store according to facility policy.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (if wearing) without contaminating self into water container and washes hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Manual Skill: Tympanic Temperature

EQUIPMENT:

Pen and paper
Thermometer (electronic tympanic thermometer) with probe covers

TEMPERATURE: Tympanic (Aural) (98.6 degrees F or 37.0 degrees C)

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Apply disposable probe cover to thermometer.
2. Ask the patient/resident to turn their head so that the ear is in front of you.
3. Gently pull back on ear to straighten the ear canal.
4. Insert covered probe, making sure the canal opening is sealed off, rotating the probe handle until it is aligned with the jaw.
5. Activate thermometer by pressing appropriate button.
6. The temperature is measured within 2-3 seconds and is displayed in digital format.
7. Eject the used probe cover into the trash without touching it.
8. Record temperature on paper.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Manual Skill: Rectal Temperature

EQUIPMENT:

Gloves (check facility policy)
Paper towel
Pen and paper
Thermometer; glass; rectal (red color coded, check for cracks, breaks or chips)
Thermometer covers
Tissue
Watch
Water-soluble lubricant (unless probe covers are pre-lubricated)

TEMPERATURE: Rectal (99.6 degrees F or 37.5 degrees C)

BEGINNING STEPS

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Take the thermometer from the container; check for breaks or chips.
2. Shake thermometer down to below 96° F.
3. Apply thermometer cover.
4. Assist the patient/resident to lie on one side with their back toward you. (Sim's position).
5. Cover the patient/resident with the bed linens so that only the anal area shows.
6. Obtain a paper towel and tissues.

7. Place a small amount of lubricating jelly on the paper towel.
8. Lubricate the bulb end of the thermometer.
9. Apply gloves if not already wearing.
10. Lift the upper buttock so the anus is seen.
11. Insert the thermometer 1″ into the rectum. (NEVER FORCE, STOP IF UNABLE TO INSERT, notify charge nurse.)
12. Hold it in place for 2-3 minutes or as required by facility policy. Stay with the patient/resident.
13. Remove the thermometer.
14. Remove the plastic cover with a tissue.
15. Place the used tissue on the paper towel.
16. Place thermometer on the paper towel.
17. Wipe the rectal area clean of any excess lubricant with tissue.
18. Cover the patient/resident.
19. Discard soiled tissue in the toilet.
20. Read temperature to the nearest two-tenths degree and note it was measured rectally by writing an “R” after the number.
21. Shake down the thermometer.
22. Wash with cool water and soap from stem to bulb.
23. Place the thermometer into the proper container.
24. Remove gloves.
25. Wash hands.
26. Write down the temperature on a piece of paper.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Note: Contraindications for rectal temperatures include the patient/resident who has:

Diarrhea	Rectal bleeding	Surgical rectal closure
Fecal impaction	Hemorrhoids	

Manual Skill: Electronic Temperature

EQUIPMENT:

Battery-operated electronic thermometer; correct color coded probe (blue/green for oral or axillary, red for rectal)
Plastic disposable probe cover
Water-soluble lubricant (for rectal temperature)
Gloves (for rectal temperature)
Pen and paper

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Remove the probe from its stored position and insert it into the probe cover; turn on electronic thermometer.
2. Insert the covered probe in the appropriate opening (mouth, axilla, or rectum). For rectal temperature, lubricate the probe cover and wear gloves.
3. Hold probe in place and wait for beep to signal the temperature is complete, and note reading.
4. Remove the probe, release and discard the probe cover without touching it.
5. Return the probe to its stored position.
6. Write the temperature on a piece of paper.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Manual Skill: Apical Pulse

EQUIPMENT:

Alcohol wipe
Gloves if necessary
Pen and paper
Stethoscope
Watch with second hand

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Clean the earpieces and diaphragm with wipes.
2. Have patient/resident sit or lie down.
3. Expose the nipple area of the left chest. Do not expose a woman's breast.
4. Warm the diaphragm in your palm.
5. Place the earpieces in your ears.
6. Locate the apical pulse. Place the diaphragm 2-3 inches to the left of the breastbone and below the left nipple.
7. Count the pulse for one full minute, note if it is regular or irregular.
8. Cover the patient/resident; remove earpieces.

ENDING STEPS:

10. Clean and return equipment and supplies, if applicable.
11. Remove gloves (without contaminating self) into waste container and wash hands.
12. Position patient/resident comfortably.
13. Place call light within reach.
14. Lower bed to safe position for the patient/resident.
15. Leave room neat.
16. Wash hands.
17. Document.
18. Report abnormal findings to licensed nurse.

Manual Skill: Count and Record Radial Pulse

EQUIPMENT:

Wrist watch or other clock with second hand

BEGINNING STEPS

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen

SKILL STEPS:

1. Places fingertips on thumb side of client's wrist to locate radial pulse.
2. Count beats for one full minute.
3. After obtaining pulse by palpating in radial artery position, records pulse rate within plus or minus 4 beats of evaluators reading.

ENDING SKILLS:

1. Position patient/resident comfortably.
2. Lower bed to safe position for the patient/resident.
3. Signaling device is within reach.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

Manual Skill: Count and Record Respiration

EQUIPMENT:

Gloves if necessary
Pen and paper
Watch with second hand

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.

SKILL STEPS:

1. Count respirations for one full minute.
2. Washes hands.
3. Record respirations rate within plus or minus 2 breaths of evaluators reading.

ENDING STEPS:

1. Position patient/resident comfortably.
2. Lower bed to safe position for the patient/resident.
3. Signaling device is within reach.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

Manual Skill: Measure and Record Blood Pressure

EQUIPMENT:

Alcohol wipe
Blood pressure cuff (sphygmomanometer)
Pen and paper
Stethoscope

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.

SKILL STEPS:

1. Before using stethoscope, wipe bell/diaphragm and earpieces of stethoscope with alcohol.
2. Client's arm is positioned with palm up and upper arm is exposed.
3. Feels for brachial artery on inner aspect of arm, at bend of elbow.
4. Places blood pressure cuff snugly on client's upper arm, with sensor/arrow over brachial artery site.
5. Earpieces of stethoscope are in ears and bell/diaphragm is over brachial artery site.
6. Candidate inflates cuff between 160 mm Hg to 180 mm Hg. If beat heard immediately upon cuff deflation, completely deflate cuff. Re-inflate cuff to no more than 200mm Hg.
7. Deflates cuff slowly and notes the first sound (systolic reading), and last sound (diastolic reading) (If rounding needed, measurements are rounded UP to the nearest 2 mm of mercury.)
8. Removes cuff.
9. Before recording wash hands.
10. After obtaining reading using BP cuff and stethoscope, record both systolic and diastolic pressures each within plus or minus 8 mm Hg of evaluators reading.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Lower bed to safe position for the patient/resident.
4. Signaling device is within reach.
5. Leave room neat.
6. Wash hands.
7. Document.
8. Report abnormal findings to licensed nurse.

Manual Skill: Blood Pressure – Two Step

EQUIPMENT:

Alcohol wipe
Blood pressure cuff (sphygmomanometer)
Pen and paper
Stethoscope

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

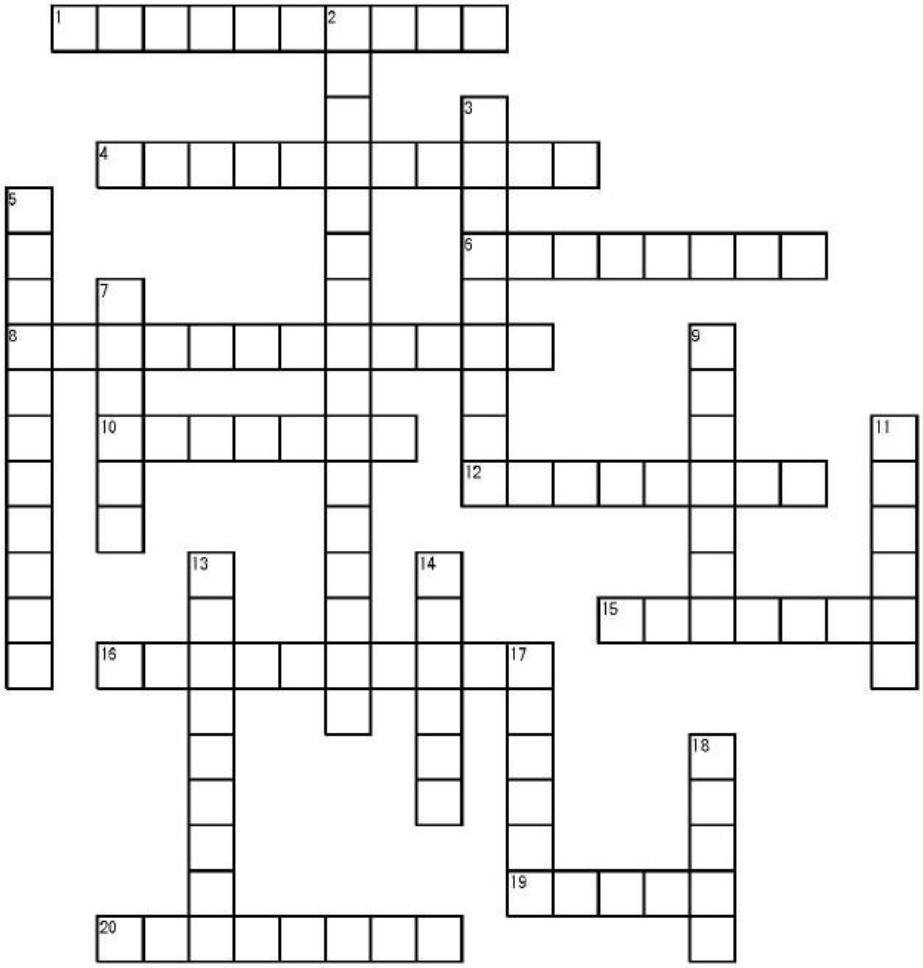
1. Wipe the stethoscope earpieces and diaphragm with alcohol wipes.
2. Have the person sit or lie down.
3. Position the person's arm so it is level with the heart. The palm should be up.
4. Stand no more than three feet away from the sphygmomanometer. A mercury model should be vertical, on a flat surface, and at eye level. Have the aneroid type directly in front of you.
5. Expose the upper arm.
6. Squeeze the cuff to expel any remaining air. Close the valve on the bulb.
7. Find the brachial artery at the inner aspect of the arm, at bend of elbow.
8. Place the arrow on the cuff over the brachial artery. Wrap the cuff around the upper arm at least one inch above the elbow. It should be even and snug.
9. Place the stethoscope earpieces in your ears.
10. Locate the radial artery, palpating the radial pulse. Inflate the cuff until you can no longer feel the pulse.

11. Deflate the cuff completely.
12. Inflate the cuff 30 mm Hg beyond the point at which you last felt the pulse.
13. Position the diaphragm over the brachial artery. Do not use thumb on diaphragm.
14. Deflate the cuff at an even rate of 2 to 4 millimeters per second. Turn the valve counterclockwise to deflate the cuff.
15. Note the point on the scale where you hear the first sound. This is the systolic reading. It should be near the point where the radial pulse disappeared.
16. Continue to deflate the cuff. Note the point where the sound disappears for the diastolic reading. Measurements are rounded up to the nearest 2mm of mercury if rounding is needed.
17. Deflate the cuff completely. Remove it from the person's arm. Remove the stethoscope.
18. Record the person's name and blood pressure on your note pad.
19. Return the cuff to the case or wall holder.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Vital Signs



Across

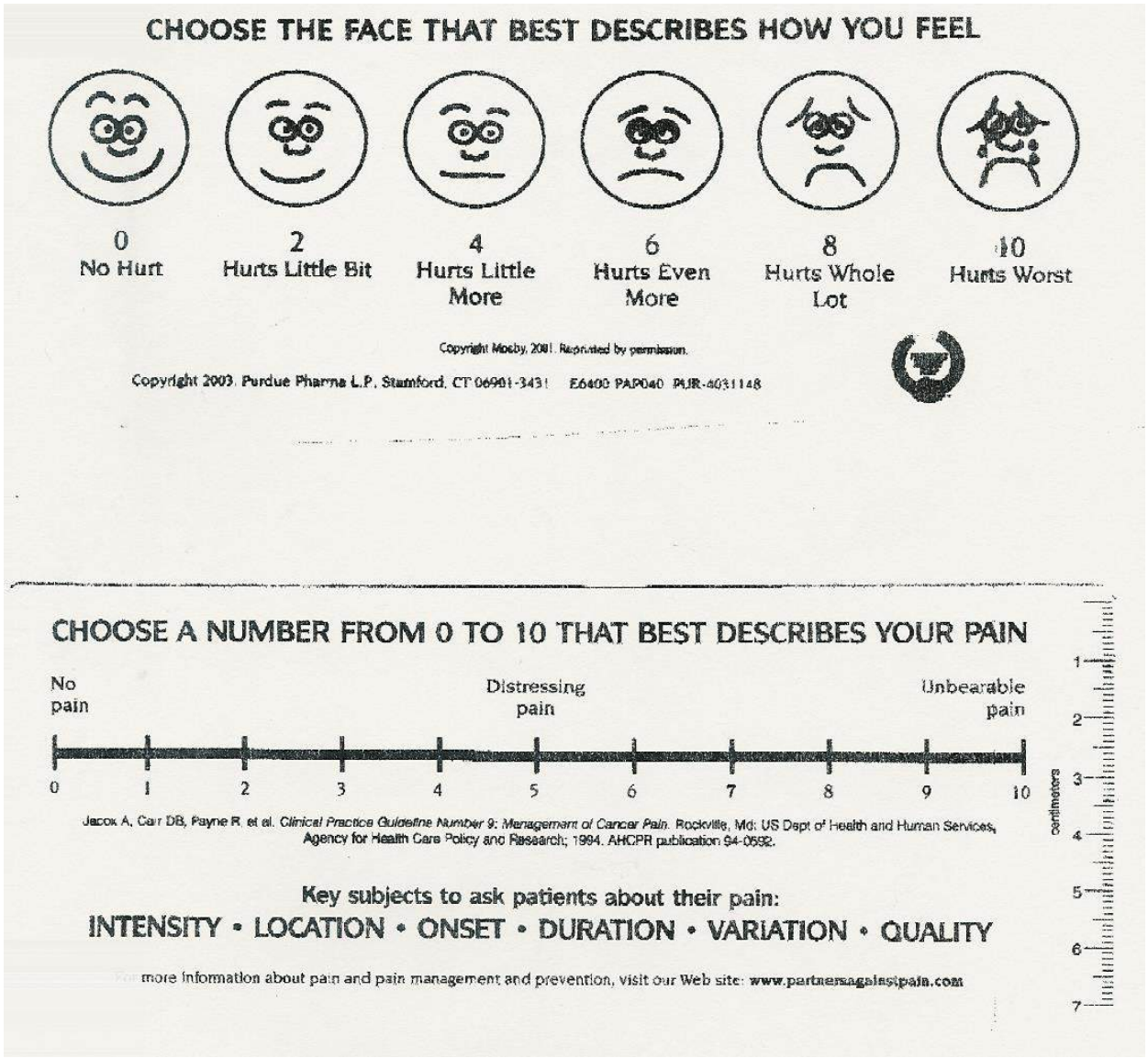
1 A particular type of temperature scale
4 Low blood pressure
6 Top or first number of blood pressure
8 High blood pressure
10 Pulse found in neck
12 Blue color to lips or skin
15 Labored breathing
16 Body burns food for energy
19 Not breathing
20 Pulse found at front of elbow

Down

2 Rapid, deep breathing
3 Second or lower number of blood pressure reading
5 Rapid heart beat
7 Pulse located over the heart
9 A centigrade thermometer
11 Pulse at wrist
13 Must sit upright to breathe
14 Underarm
17 A type of membrane in the mouth
18 Referring to the ear

	Temperature (T)	**Pulse (P)**	**Respiration (R)**	**Blood Pressure (BP)**
Normal Range	Oral: 97.6°-99.6°F Average: 98.6°F (37°C) Rectal: 98.6°-100.6°F Axillary: 96.6°- 98.6°F Tympanic: 97.6°-99.6°F Temporal: 99.4°-101.4°F	Adult:60-100 per minute	Adult: 12-20 per minute	**Normal:** Systolic- 100-139 Diastolic- 60-89 **High:** 140/90 or above
Factors that affect the vital signs	**Raises Temperature:** 1. Dehydration 2. Exercise 3. Exposure to external heat 4. Infection 5. Pain 6. Smoking 7. Strong emotions **Lowers Temperature:** 1. Cold drink or food 2. Depression 3. Exposure to cold 4. Rest/sleep 5. Shock 6. Starvation **Time of day (diurnal changes)** • Temperature highest in the P.M. (4-6pm) • Temperature lowest in the A.M. (2-6am) • Reflects changes in cellular activity, muscle activity, and food metabolism.	**Raises pulse:** 1. Anemia 2. Excitement 3. Exercise 4. Fever 5. Hemorrhage 6. Pain 7. Shock 8. Strong emotions **Lowers pulse:** 1. Depression 2. Lying down 3. Rest/sleep	**Raises respiration:** 1. Elevated body temperature and/or environmental temperature 2. Exercise 3. Infection 4. Strong emotions **Lowers respiration:** 1. Depression 2. Respiratory center depression 3. Rest/sleep	**Raises Blood Pressure:** 1. Digestion 2. Disease of blood vessels 3. Excitement 4. Exercise 5. Pain 6. Standing or sitting 7. Strong emotions **Lowers Blood Pressure:** 1. Depression 2. Hemorrhage 3. Lying down 4. Rest/sleep 5. Shock

Charting reminders	1. When written on chart as part of TPR Temperature is the first number. 98.6- 82-16 2. Note as a. Oral 98.6 b. Rectal 99.6(R) c. Axillary 97.6 (AX)	1. Rate; number of beats/minute 2. Rhythm refers to time interval between beats 3. Strength (force); thready, bounding **Examples:** a. Strong and regular: even beats with good force b. Weak and regular: even beats with poor force c. Irregular: both strong and weak beats occur within a minute d. Thready: generally means it is of weak force and irregular	1. Rate; number of respirations/minute 2. Rhythm; time interval between respirations 3. Depth; shallow, normal, deep 4. Effort it involves 5. Discomfort it causes 6. Position patient adopts 7. Sounds that accompany it. 8. Cyanosis **Examples:** a. Regular in both depth and rate b. Rapid, shallow c. Very slow or very deep d. Irregular depth and rhythm (Cheyne-Stokes) e. Dyspnea; labored or difficult R, usually with pain f. Orthopnea; breathing possible only when person sits or stands up.	• If taken in a place other than the arm, note the location: **Example:** 150/90 thigh


CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL
0
No Hurt
2
Hurts Little Bit
4
Hurts Little More
6
Hurts Even More
8
Hurts Whole Lot
10
Hurts Worst
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CHOOSE A NUMBER FROM 0 TO 10 THAT BEST DESCRIBES YOUR PAIN
No pain
Distressing pain
Unbearable pain
0 1 2 3 4 5 6 7 8 9 10
Jacox A, Carr DB, Payne R, et al. Clinical Practice Guideline Number 9: Management of Cancer Pain. Rockville, Md: US Dept of Health and Human Services, Agency for Health Care Policy and Research; 1994. AHCPR publication 94-0592.
Key subjects to ask patients about their pain:
INTENSITY • LOCATION • ONSET • DURATION • VARIATION • QUALITY
more information about pain and pain management and prevention, visit our Web site: www.partnersagainstpain.com
centimeters

Module 11: Nutrition
Minimum Number of Theory Hours: 2
Recommended Clinical Hours: 6

Statement of Purpose:
The purpose of this unit is to examine the body's need for food and the effect of food on the body. This module includes the basic food groups, nutrients, and common therapeutic diets, as well as ways to assist a patient/resident to meet nutrition and hydration needs.

Terminology:

1. Allergy
2. American Dietetic Association (ADA)
3. Amino acid
4. Anorexia
5. Aspiration
6. Bland diet
7. Carbohydrate
8. Cellulose
9. Cholesterol
10. Clear liquid diet
11. Clothes protector
12. Dehydration
13. Diaphoresis
14. Dietician
15. Digestion
16. Diuresis
17. Dysphagia
18. Edema
19. Emesis
20. Enteral feeding
21. Essential nutrient
22. Exchange list
23. Expectorate
24. Fats
25. Fiber
26. Fluid
27. Force fluids
28. Full liquid diet
29. Gastrostomy tube
30. Gavage
31. Graduate
32. Hydration
33. Hyperalimentation
34. Intake & output (I&O)
35. Intravenous infusion
36. Low fat diet
37. Low sodium diet
38. Mechanical soft diet
39. Mineral
40. Nasogastric tube
41. Nutrient
42. Nutrition
43. Over-hydration
44. Parenteral nutrition
45. Percutaneous endoscopic gastrostomy tube (PEG)
46. Pocketing
47. Protein
48. Pureed diet
49. Restrict fluid
50. Soft diet
51. Therapeutic diet
52. Thickened liquid
53. Total Parenteral Nutrition (TPN)
54. Vitamin

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of two (2) hours of class plus homework assignments and six (6) hours of clinical experience, the learner will be able to:

1. Define key terminology
2. Discuss the body's need for food and fluids
3. List common nutrients and their food sources
4. Describe the My Pyramid food guidance system
5. Describe the vegan basic four food groups
6. Discuss nutritional and fluid needs of the elderly
7. Describe therapeutic diets commonly ordered for patients/residents and the responsibilities of the Nurse Assistant
8. Describe proper techniques for feeding patients/residents
9. Discuss cultural and religious influences on dietary practices
10. Identify alternative ways to administer nutrition

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define Key Terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes E. Handout 11.1a- Nutrition Crossword Puzzle F. Handout 11.1b- Nutrition Crossword Puzzle KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Discuss the body's need for food and fluids.** A. The body depends upon foods and fluids to 1. Provide energy for daily living and bodily functions 2. Promote growth and repair of tissue 3. Provide necessary substances for regulation of bodily functions 4. Meet a basic physiological need for survival B. Nutrition is the science of food and its relationship to health C. A balanced diet is 1. Essential to good health Composed of sufficient nutrients to meet the body's daily requirements	A. Lecture/Discussion B. Have students share their beliefs about nutrition and malnutrition	A. Written test

3. Sufficient in amount of fluids (approximately 1500 milliliters per day minimum for an adult)		
Objective 3 **List common nutrients and their food sources.** A. Nutrients, their food sources, and functions 1. Carbohydrates a. Grains, pastas, breads, cereals, fruits, vegetables b. Main source of energy c. Provides dietary fiber 2. Proteins a. Eggs, milk, meat, fish, nuts, poultry, cheese, beans, peanut butter, and soy products b. Essential for tissue growth and repair c. Made up of amino acids 3. Fats a. Oils, milk, cream, cheese, meat, fats, butter, mayonnaise b. Provide energy, carry vitamins, conserve body heat, and protect internal organs 4. Vitamins a. Found in almost all foods, especially vegetables and fruits b. Do not contain calories c. Essential for building and repairing body tissues, assisting in regulation of body functions 5. Minerals a. Found in almost all foods b. Do not contain calories c. Essential for regulation of body functions, building and repairing body tissue 6. Dietary fiber a. Raw fruits and vegetables, whole grain breads and cereals	A. Lecture/Discussion B. Handout 11.3a-Food Content Exercise C. Handout 11.3b- Food Content Exercise KEY D. Have student bring in empty, labeled food containers. Review labels, identifying nutrients and calories per container and per serving	A. Written test

b. Provides bulk to assist in maintaining normal bowel elimination 7. Fluids a. Water, juices, other beverages b. May or may not provide calories and nutrients c. Water is essential for normal body functioning d. All chemical reactions in the body take place in water		
Objective 4 **Describe the My Plate food guidance system.** A. Grain Group 1. Whole grain bread, cereal, crackers, rice and pasta group 2. Minimum 5-6 ounces/day (women), 6-8 ounces/day (men) B. Vegetable Group 1. Eat more dark green and orange vegetables, dry beans and peas 2. Minimum 2-2 ½ cups/day (women), 2 ½-3 cups (men) C. Fruit Group 1. Fresh, frozen, canned or dried fruits 2. Limit fruit juices 3. Minimum 1 ½-2 cups/day (women), 2 cups (men) D. Dairy Group 1. Milk, yogurt, cheese 2. Choose low fat or non-fat 3. Minimum 3 cups/day (women and men) E. Protein 1. Meat, poultry, fish, dry beans, eggs, and nuts 2. Minimum 5-5 ½ ounces/day (women), 5 ½-6 ½ ounces/day (men) F. Oil Group 1. Make most oil choices from fish, nuts and vegetable oil 2. Limit solid fats such as butter, lard, and shortening 3. 5-6 teaspoons/day (women), 6-7 teaspoons/day (men)	A. Lecture/Discussion B. Internet Activity: Go to http://www.choosemyplate.gov/ for resources to download C. Assignment: Have students keep a food journal, listing all food and fluids taken in over a 24 hour period. Do this for one weekday and one weekend day • Compare diets for the two days • Use http://www.choosemyplate.gov/ website to identify categories of food • Comment on what influenced diet choices, desired changes, and ideas for making changes	A. Written test

Objective 5 **Describe the vegan basic four food groups.** A. Vegetarian diet 1. Excludes meat including game and slaughter by-products; fish, shellfish and other sea animals; poultry 2. Variations may include or exclude milk, fish, eggs, and honey B. Vegan diet excludes all animal products including milk, fish, eggs and honey C. The vegan basic four food groups 1. Whole grains – 5 or more servings each day 2. Vegetables – 3 or more servings each day 3. Fruits – 3 or more servings each day 4. Legumes – 2-3 servings each day	A. Lecture/Discussion B. Handout 11.5 - Vegan Diet	A. Written test
Objective 6 **Discuss nutritional and fluid needs of the elderly.** A. Age-related changes affecting nutritional needs of the elderly 1. Fewer calories may be needed if patient/resident is less active 2. Additional vitamins and minerals may be required due to digestive disturbances 3. Medications may interfere with fluid balance, digestion and nutrient use 4. Poor oral hygiene, loss of teeth, and ill-fitting dentures may lead to poor nutrition 5. Ability to taste foods may be diminished 6. Many common diseases interfere with eating and/or the ability to use nutrients 7. Social isolation may interfere with appetite and the body's utilization of nutrients 8. A patient/resident may need nutritional supplements (such as Ensure or Boost) one to three times a day to meet daily nutrient requirements B. Specific food allergies	A. Lecture/Discussion B. Identify and discuss common food and food allergies	A. Written test B. Identifies specific patients/residents experiencing age-related changes in nutritional needs and reports to licensed nurse C. Reports specific allergies to licensed nurse

1. Know patient's/resident's allergies 2. Check every tray served 3. Check for new allergies 4. Check for food additive allergies such as peanuts, shellfish, and wheat 5. Check for lactose intolerance C. Factors affecting patient's/resident's food choices 1. Likes and dislikes 2. Facility food service menus and options 3. Medical restrictions 4. Culture 5. Religious beliefs		
Objective 7 **Describe therapeutic diets commonly ordered for patients/residents and the responsibilities of the Nurse Assistant.** A. Therapeutic (special) diets most commonly ordered 1. Low sodium 2. Diabetic 3. Low fat 4. Low cholesterol 5. Liquid a. Clear Liquid b. Full liquid c. Thickened liquids 1) Nectar thick 2) Honey thick 6. Bland B. Special consistency 1. Mechanical soft; prepared to require very little chewing 2. Pureed; food that has been processed in a blender for easier swallowing and digestion. Requires little to no chewing 3. Soft; liquid or semi-solid foods that are easily digested	A. Lecture/Discussion B. Create a Jeopardy Game using content items from previous objectives C. Review foods and fluids allowed and restricted on each therapeutic diet D. Discuss the nutritional adequacy of each therapeutic diet E. Arrange conference with Speech Therapy and Occupational Therapy to discuss services	A. Written test B. Correctly identify all patients/residents, check diet card for name, diet order, specific instructions and allergies C. Accurately record all patient/resident food and fluid intake D. Reports significant changes in patient's/resident's dietary habits to licensed nurse

C. Responsibilities of the Nurse Assistant 1. Make sure all patients/residents receive their ordered diet 2. Check arm bands against names on trays at each meal 3. Report any problems related to diet such as food or liquid preferences, difficulty chewing or swallowing, nausea or vomiting, anorexia, food intolerances 4. Open containers on tray as needed 5. Assist nurses, dieticians, and physicians in evaluating fluid balance through accurate monitoring and documentation of intake and output 6. Calculate and record food intake according to facility guidelines 7. Determine reason for any tray or food refusal, offer alternates as allowed 8. If alternate is refused, report refusal to licensed nurse 9. Do not offer extra food or condiments without checking with licensed nurse 10. Serve hot foods hot and cold foods cold 11. Do not mix pureed foods 12. Always check trays to monitor percentage of diet eaten 13. Always have patient/resident in an upright position when eating unless otherwise ordered		
Objective 8 **Describe proper techniques for feeding patients/residents.** A. Proper techniques for feeding patients/residents 1. Provide a comfortable and enjoyable atmosphere a. Sit at patient's/resident's eye level b. Maintain a positive attitude when assisting patient/resident with feeding c. Encourage patients/residents to participate as able (holding bread, picking up juice cup, moving fork to mouth after food is put on it)	A. Lecture/Discussion B. Activity: Have students feed each other and simulate sensory impairments by wearing a blindfold, applying light coat of Vaseline to eye glasses, or placing cotton in ears. Then	A. Written test B. Identify symbols used to identify high risk patients/residents C. Utilizes proper feeding techniques for patient/resident with or without difficulty swallowing

d. Allow patient/resident to set the pace as much as possible e. Do not rush 2. Provide assistance as needed using adaptive equipment as indicated 3. Serve patients/residents in their rooms if unable to join other patients/residents in the dining area 4. Serve patients/residents in dining room if at all possible 5. Alternate liquids and solid foods 6. Check swallowing before patient/resident eats or is fed 7. Feed by placing food on unaffected side if applicable B. Prevention of choking 1. Identify patients/residents who are at high risk for dysphagia and choking a. Cerebrovascular accident (stroke) b. Neurological disease c. Trauma to head, neck, or throat d. Dementia 2. Supervise closely when eating 3. Follow patient's/resident's individual feeding plans 4. Cut food into small pieces, offer in small amounts, wait until each portion is chewed and swallowed before more is given 5. Notify licensed nurse if signs of dysphagia are observed a. Long intervals before swallowing b. Swallowing several times with each bite c. Frequent throat clearing d. Difficulty handling foods and fluids in mouth e. Wet gurgling voice f. Pocketing food g. Excessive drooling h. Patient/resident feels that food is sticking in mouth or throat 6. Proceed at the patient's/resident's pace. Do not rush 7. Keep patient/resident in an upright position during and 30 minutes	change roles C. Discuss the impact of sensory deprivation on appetite and enjoyment, the experience of feeding and being fed, if the feeder followed proper techniques D. Suggest using individual containers of pudding, Jello or yogurt E. Practice can also include liquids with and without straws F. Manual Skill 11.8a- Preparing the Patient/resident for Meal time G. Manual Skill 11.8b- Feeding a Patient/resident Who Cannot Feed Self H. Manual Skill 11.8c- Assisting the Patient/resident Who Can Feed Self I. Review Manual Skill 12.4; Choking Victim- Conscious and Unconscious	

after eating 8. Sit at eye level while feeding a patient/resident 9. Thicken liquids if patient/resident has difficulty swallowing (as ordered) 10. Assist patient/resident in using appropriate adaptive equipment C. Recognition of signs of choking 1. Universal sign of choking is hand(s) to throat 2. Inability to speak, cough or breathe 3. Cyanosis, especially of lips, skin, nails 4. Loss of consciousness		
Objective 9 **Discuss cultural and religious influences on dietary practices.** A. Dietary practices affiliated with religions and/or cultures B. Ask all patients/residents if they have any food preferences C. Ask family of non-communicative patients/residents about food preferences D. If allowed, encourage family to bring in ethnic and cultural foods E. Avoid making assumptions regarding food likes and dislikes	A. Lecture/Discussion B. List and discuss current knowledge of cultural and religious influences on dietary practices C. Ask students to search internet and share resources with the class D. Activity: Plan a potluck of various ethnic foods and share recipes	A. Written test B. Ask patient/resident about food preferences and practices. Document and report appropriately
Objective 10 **Identify alternative ways to administer nutrition.** A. Tube feedings 1. Ordered by the doctor when a patient/resident is unable to eat 2. Started by a licensed nurse 3. Nurse Assistant's responsibility a. Monitor for pressure on or kinking of tubing b. Monitor the level of feeding and report when low c. Keep head of bed elevated at least 20°– 30° at all times d. Do not lower bed even when repositioning patient/resident	A. Lecture/Discussion B. Show samples of tube	A. Written test B. Observe and record intake from a gastric tube feeding

e. Never turn off pump; notify licensed nurse of alarm f. Notify licensed nurse of signs or symptoms of aspiration B. Intravenous infusion 1. Ordered by the physician 2. Started and monitored by a licensed nurse according to facility policy 3. Nurse Assistant's responsibility a. Make sure there are no kinks, twisting, pressure or obstruction of IV tubing b. Report the following 1) Alarm ringing on IV 2) Complaints of pain or burning at the IV site 3) Swelling or redness at the IV site 4) Fever 5) Difficulty breathing 6) Bleeding or leakage of fluid at the IV site 7) Disconnected IV tubing 8) Empty IV fluid container c. Nurse Assistant should never adjust or turn off IV monitoring equipment d. Make sure patient/resident and family do not handle, adjust, or stop infusion		

Sample Test: Module 11- Nutrition

1. How much fluid should the average adult take in each day?
    A. 800 ounces
    B. 1,500 milliliters
    C. 2,500 milliliters
    D. 4,000 milliliters

2. Liquid nutritional supplements are offered:
    A. Between meals
    B. To anyone who wants them
    C. Warm
    D. On meal trays

3. Approximately how much daily urine output is normal for an average adult?
    A. 800 ounces
    B. 1,500 milliliters
    C. 2,500 milliliters
    D. 4,000 milliliters

4. Accurate recording of fluid intake includes:
    A. Only the fluid given in the patient's/resident's room
    B. Only the fluid that the nurse gives with medicine
    C. Only the fluid that comes on the dietary tray
    D. All fluid the patient/resident consumes during a shift

5. Which abbreviation is used most frequently to measure fluid intake and output?
    A. ml.
    B. kg.
    C. cm.
    D. mmHg.

6. After totaling the intake and output at the end of a shift, the Nurse Assistant realizes that a patient's/resident's intake is 1200 milliliters and output is 325 milliliters. What is the best action for the Nurse Assistant at this time?
    A. Record this information on the appropriate form
    B. Re-total the intake and output because it is probably an error
    C. Report the information to the charge nurse
    D. Offer the patient/resident additional fluids

7. A patient/resident has a gastrostomy tube. The Nurse Assistant knows that this is:
    A. A tube inserted through the nose to the stomach for feeding
    B. The same as total parenteral nutrition (TPN)
    C. A tube inserted through the abdominal wall into the stomach for feeding
    D. A tube that introduces high-density nutrients into a large vein

8. When caring for a patient/resident who receives tube feedings the Nurse Assistant must always:
    A. Elevate the head while the feeding is infusing
    B. Change the bag at the end of a shift
    C. Check the placement of the tube
    D. Position the patient/resident in the orthopneic position for each feeding

9. Which of the following is included in a clear liquid diet?
    A. Chicken noodle soup
    B. Liquid nutritional supplement
    C. Flavored gelatin
    D. Milk

10. Why is accurate recording of the food consumption of a patient/resident with diabetes important?
    A. Diet and insulin must balance to maintain a healthy protein level
    B. A diabetic patient/resident should not consume more than 2,600 calories per day
    C. The diabetic diet may be balanced by insulin or diabetic medications
    D. Diabetics must consume an adequate amount of sugar at each meal

11. A sign that states NPO is posted on the door of a patient/resident. This means that the patient/resident should:
    A. Not be fed
    B. Not have physical and occupational therapies
    C. Have intake only through a nasogastric or gastrostomy tube
    D. Have nothing by mouth

12. A patient/resident has to order "Force Fluids." What is the best way to follow this order?
    A. Force the patient/resident to drink a glass of water every hour
    B. Encourage the patient/resident to take in as much fluid as possible
    C. Force the patient/resident to drink 8-10 glasses of water every day
    D. Encourage the patient/resident to drink only water

13. What action is essential before serving a meal tray to a patient/resident?
    A. Check the diet card and patient/resident identification
    B. Wash hands and put on a hairnet
    C. Have the patient/resident go to the bathroom and wash hands
    D. Put on a pair of gloves

14. Hot liquids are best tested by:
    A. Inserting a thermometer into the center of the liquid
    B. Placing a few drops of liquid on the patient's/resident's wrist
    C. Placing a few drops of liquid on the Nurse Assistant's wrist
    D. Touching the outside of the dish or cup

15. When feeding a patient/resident who has had a stroke the Nurse Assistant will most correctly:
    A. Place food as far back on the tongue as possible
    B. Place food in the unaffected side of the mouth
    C. Place food in the affected side of the mouth
    D. Place food on the center of the tongue

16. A sign of dysphagia is:
    A. Shallow respirations
    B. Difficulty breathing
    C. Difficulty swallowing liquids
    D. Difficulty speaking

17. Food thickeners are designed to:
    A. Slow food intake into the mouth
    B. Slow the movement of fluids through the esophagus
    C. Provide a thicker mass for swallowing to help prevent choking
    D. Increase the number of calories the patient/resident consumes

18. While feeding a patient/resident, a Nurse Assistant is observed doing all the following actions. Which of the following is not correct?
    A. Standing at eye level
    B. Alternating liquid and solid food
    C. Only using a spoon for solids
    D. Feeding the patient/resident in his room

19. The Omnibus Budget Reconciliation Act (OBRA) includes all of the following requirements for food served in long-term care facilities except:
    A. Food must smell and taste good
    B. A patient/resident must receive at least three meals a day
    C. Hot food must be served hot, and cold food must be served cold
    D. Special eating equipment and utensils must be provided by the patient/resident or family

20. A patient/resident with a feeding tube is usually:
    A. On a regular liquid diet
    B. In a terminal condition
    C. Not allowed food or liquids by mouth (NPO)
    D. Receiving an intravenous infusion (IV)

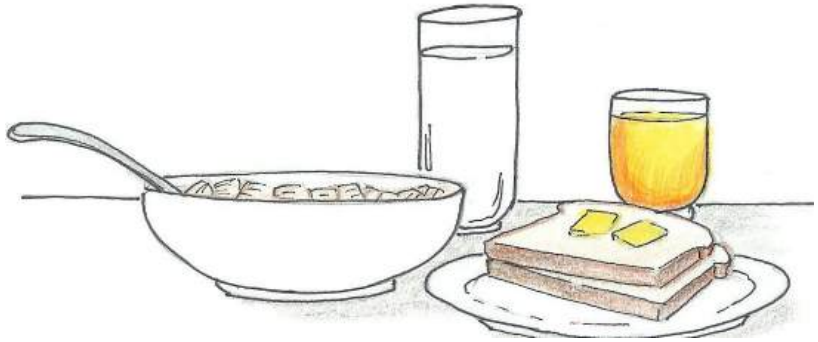
21. A patient/resident begins to cough during lunch in the dining room. No licensed nurses are in the room. Upon observing this, the Nurse Assistant will first:
    A. Place the patient/resident on the floor and open the airway
    B. Raise the patient's/resident's arms over their head
    C. Offer the patient/resident a glass of water
    D. Ask the patient/resident if they can speak

Matching: Match the following definitions with the correct term.

A. Difficulty Swallowing
B. Process of converting food into a form that can be used by the body
C. Excessive water loss
D. Process by which the body uses food for growth and repair and to maintain health
E. Substance that causes sensitivity
F. Vomit

22. _____Allergen
23. _____Dehydration
24. _____Digestion
25. _____Dysphagia
26. _____Emesis
27. _____Nutrition

28. A patient/resident was served the foods seen here. The patient/resident ate all of the cereal, one slice of bread and butter, and drank all of the milk. Approximately what percentage of the breakfast was eaten?
    A. 25%
    B. 50%
    C. 75%
    D. 100%



MANUAL SKILL: Preparing the Patient/resident for Mealtime

EQUIPMENT:

Bedpan/urinal if needed
Clothes protector
Food tray
Soap and water if needed
Tooth brush and Toothpaste
Towel
Washcloth

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure to patient speaking clearly, slowly, and directly. Maintain face to face contact whenever possible.
6. Gather equipment.
7. Provide for privacy with a curtain, screen, or door.
8. Wear gloves due to contact with body secretions.

SKILL STEPS:

1. Offer bedpan or assist patient/resident to bathroom.
2. Provide water, soap, and towel to wash hands and face.
3. Provide oral hygiene.
4. Encourage patient/resident to join other patients/residents for dining experience.
5. Clear and wipe off overbed table, if patient/resident will stay in room.
6. Remove unpleasant items from patient's/resident's sight.
7. Be sure patient/resident is in a safe and upright position.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILLS: Feed Patient/resident Who Cannot Feed Self

Equipment:

Bedpan/urinal if needed
Food and beverage tray
Hand wipes
Silverware
Soap and water if needed
Tooth brush and toothpaste

Beginning Steps:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Gather equipment, if applicable.
6. Provide for privacy with a curtain, door, or screen.

Skill Steps:

1. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
2. Before feeding, look at name card on tray and ask patient/resident to state name.
3. Before feeding, position patient/resident in an upright sitting position (75-90 degrees).
4. Places tray where it can be easily seen by patient/resident.
5. Candidate cleans patient's/resident's hands with hand wipe before beginning feeding.
6. Candidate sits facing patient/resident during feeding.
7. Tells patient/resident what foods are on the tray and asks what patient/resident would like to eat first.
8. Using spoon, offers patient/resident one bite of each type of food on tray, telling patient/resident the content of each spoonful.
9. Offers beverage at least once during meal.
10. Candidate asks patient/resident if they are ready for next bite of food or sip of beverage.
11. At end of meal, candidate cleans patient's/resident's mouth and hands with wipes.

12. Removes food tray and places tray in designated dirty supply area.
13. Signaling device is within patient's/resident's reach.
14. After completing skill, washes hands.

Ending Steps:

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Lower bed to safe position for the patient/resident.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

MANUAL SKILL: Assisting the Patient/resident Who Can Feed Self

EQUIPMENT:

Bedpan/urinal if needed
Clothing protector
Food tray
Soap and water if needed
Tooth brush and toothpaste
Towel
Washcloth

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

SKILL STEPS:

1. Wash hands.
2. Check diet card for name of patient/resident, diet order, special instructions, and allergies.
3. Make sure food on tray matches information on diet card.
4. Remove tray from food cart and make sure all necessary items are there such as silverware, napkins, salt and pepper if allowed.
5. Take tray to patient's/resident's room as quickly as possible to ensure that food is served at the appropriate temperatures.
6. Knock and pause before entering room.
7. Introduce self.
8. Verify patient's/resident's name by checking the armband against the name printed on the diet card.

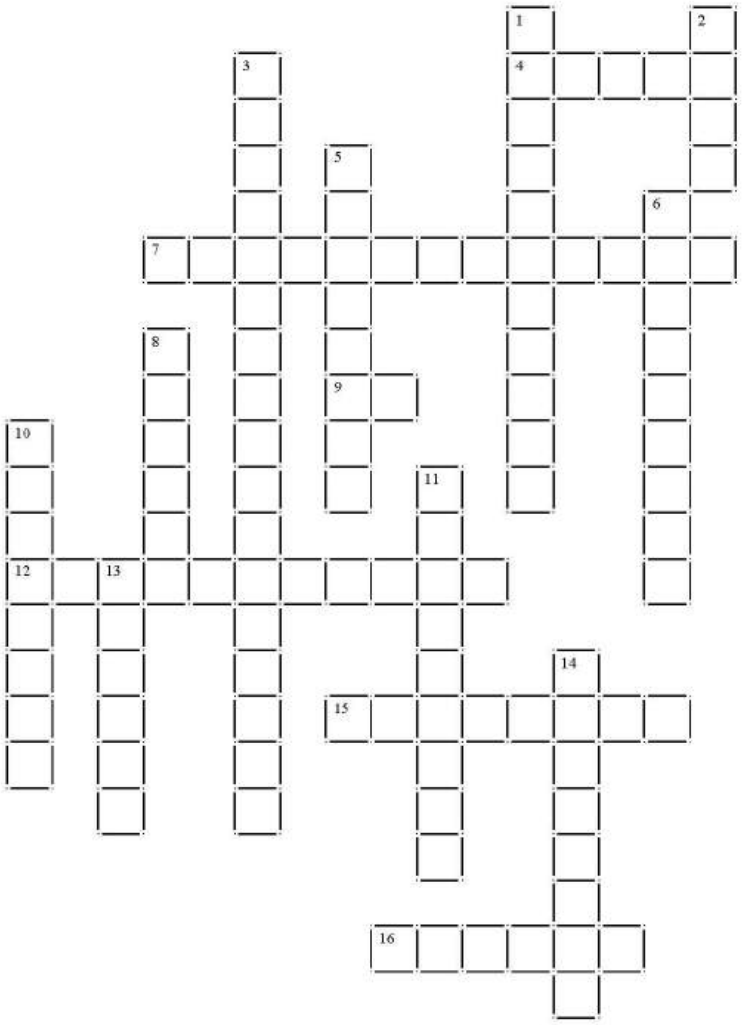
9. Explain procedure.
10. Lower one side rail if permitted.
11. Raise head of bed to semi Fowler's or higher position or assist to chair.
12. Place tray on overbed table in front of patient/resident.
13. Remove plate covers.
14. Arrange dishes and silverware for ease of use by patient/resident.
15. Arrange plate so that main entree is closest to the patient/resident.
16. Observe and provide whatever assistance the patient/resident needs by cutting meat, buttering bread, pouring liquids, and opening packets, use adaptive devices per patient's/resident's individual needs.
17. Encourage patient/resident to do as much as possible for him or herself.
18. Make sure patient/resident does not need more assistance before leaving room.
19. Return to patient's/resident's room periodically during mealtime to check on patient's/resident's progress.
20. Encourage patient/resident to eat all of diet served.
21. Talk with patient/resident and encourage socialization with other patients/residents.
22. Remove tray when patient/resident is finished.
23. Clean overbed table and return to position desired by patient/resident.
24. Raise side rail.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document percentage of soiled food intake, milliliters of fluid intake, and tolerance of procedure.
9. Report abnormal findings to licensed nurse.

Module 14- Nutrition Handout 14.1a- Crossword

Nutrition Crossword



ACROSS

4 Extra fluid in body tissues.
7 Provides body with energy- bread.
9 Short for "intravenous".
12 To spit.
15 Needed for growth, vision, bones, "A" is an example.
16 Vomitus.

DOWN

1 Not enough water in body tissues.
2 Adds flavor to food and helps body use some vitamins.
3 Highly concentrated IV solution.
5 Needed for tissue growth and repair.
6 Fiber or roughage; Indigestible.
8 Tube feeding.
10 Calcium and phosphorus are these.
11 The science of food and its relationship to human beings.
13 Food put through the blender is ___.
14 Increased excretion of urine.

Food Content Exercise

Directions: Label food items as protein, carbohydrate, fat, or combination of the above.

1. Pork chop _____
2. Pot pie _____
3. Lettuce _____
4. Apple pie _____
5. Green beans _____
6. Tortilla _____
7. Cupcakes _____
8. Taco _____
9. Banana _____
10. Rice _____
11. Potatoes _____
12. Green onions _____
13. Bread _____
14. Ice cream _____
15. Meatloaf _____
16. Onion _____
17. Strawberries _____
18. Beets _____
19. Pudding _____
20. Grapes _____
21. Turkey _____
22. Egg _____
23. Jello _____
24. Bean sprout _____
25. Enchilada _____
26. Roll _____
27. Broccoli _____
28. Shrimp/lobster _____
29. Hamburger _____
30. Meatloaf _____
31. Chop suey _____
32. Chicken _____
33. Pasta _____
34. Ceaser salad _____
35. Spaghetti _____
36. Tomatoes _____
37. Ham _____
38. Grilled cheese _____
39. Lasagna _____
40. Pear _____
41. Carrot _____
42. Fish _____
43. Beef stew _____
44. Cake _____
45. Bacon _____
46. Macaroni and cheese _____
47. Waldorf salad _____
48. Pizza _____
49. Apple _____
50. Cauliflower _____

Vegan Diet
The New Four Food Groups

Whole Grains:

- This group includes bread, rice, pasta, hot or cold cereal, corn, millet, barley, bulgur, buckwheat groats and tortillas. Build each of your meals around heart grain dish. Whole grains are rich in fiber and other complex carbohydrates, as well as protein, B vitamins and zinc.

Vegetables:

- Vegetables are packed with nutrients. They provide vitamin C, beta-carotene, riboflavin and other vitamins, iron, calcium, and fiber. Dark green, leafy vegetables such as broccoli, collards, kale, mustard and turnip greens, chicory, or bok choy are especially good sources of these important nutrients. Dark yellow and orange vegetables such as carrots, winter squash, sweet potatoes and pumpkin provide extra beta-carotene. Include generous portions of a variety of vegetables on your diet.

Legumes:

- Legumes, which is another name for beans, peas, and lentils, are all good sources of fiber, protein, iron, calcium, zinc, and B vitamins. This group also includes chickpeas, baked and refried beans, soy milk, tofu, tempeh, and texturized vegetable protein.

Fruits:

- Fruits are rich in fiber, vitamin C and beta-carotene. Be sure to include at least one serving each day of fruits that are high in vitamin C; Citrus fruits, melons, and strawberries are all good choices. Choose whole fruit over fruit juices, which don't contain as much healthy fiber.

Food Group	Number of Servings	Serving Size
Whole Grains	5 or more	½ cup hot cereal, 1oz. dry cereal, 1 slice of bread
Vegetables	3 or more	1 cup raw, ½ cup cooked
Legumes	2 or 3	8 oz soy milk
Fruits	3 or more	1 medium piece of fruit, ½ cup cooked fruit, 1.2 cup fruit juice

Module 12: Emergency Procedures
Minimum Number of Theory Hours: 2
Recommended Clinical Hours: 1

Statement of Purpose:
The purpose of this unit is to introduce the student to the concepts and procedures related to emergency procedures, signs and symptoms of distress, and the role of the Nurse Assistant in Long Term Care (LTC) in the response to immediate and temporary intervention in emergency situations.

Terminology:

1. Abdominal thrusts
2. Advance directive
3. Agitation
4. Airway
5. Aphasia
6. Aspirate
7. Automated External Device (AED)
8. Barrier device
9. Bradypnea
10. Breathing
11. Cardiac arrest
12. Cardiopulmonary Resuscitation (CPR)
13. Compressions, Airway, Breathing (CAB)-formerly (ABC)
14. Cyanosis
15. Defibrillator
16. Diaphoresis
17. Do Not Resuscitate (DNR)
18. Dyspnea
19. Emergency Medical Services (EMS)
20. Heimlich maneuver
21. Hemiplegia
22. Hemorrhage
23. Hyperventilation
24. Hypoglycemia
25. Hypoventilation
26. Hypoxia
27. Pallor
28. Pocket mask
29. Recovery position
30. Respiratory arrest
31. Respiratory distress
32. Stat
33. Syncope
34. Tachypnea
35. Unconscious

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

1. Define key terminology.
2. Identify common signs and symptoms of conditions associated with patient/resident distress and describe the Nurse Assistant's role and responsibility in preventing and/or responding.
3. Describe the immediate interventions in a medical emergency.
4. List the causes and signs of choking and discuss the use of abdominal thrusts for relief of obstructed airway.
5. Describe common emergency codes used in long-term care facilities.

This module may be taught concurrently with Module 4: Safe Environment

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define Key Terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards E. Handout 12.1a- Emergency Procedures Crossword F. Handout 12.1b- Emergency Procedures Crossword- KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Identify common signs and symptoms of conditions associated with patient/resident distress and describe the Nurse Assistant's role and responsibility in preventing and/or responding.** A. Myocardial infarction (MI, heart attack) 1. A disruption of the flow of blood to an area of the muscle of the heart with subsequent death of the tissue at that area 2. Signs and symptoms a. Chest pain 1) May be described as crushing, squeezing, or pressure 2) May radiate down arms, jaw, or back	A. Lecture B. Discussion Show online video (13 min) "Act in Time to Heart Attack Signs" from National Heart and Lung Institute. (May need to download RealPlayer) http://www.nhlbi.nih.gov/actintime/video.htm	A. Written test B. Recognizes patients/residents in distress and reports signs and symptoms immediately to charge nurse C. Provides appropriate

2) Complaint may be severe indigestion, heartburn, or stomach pain b. Shortness of breath, Dyspnea or absence of breathing c. Diaphoresis d. Wet, cold, clammy skin e. Confusion, mental status change, anxiety f. Syncope, fainting g. Weakness, fatigue h. Nausea, vomiting i. Irregular pulse 3. Nurse Assistant Role a. Call for help loudly and pull the emergency light if available b. Remain calm c. Stay with the patient/resident d. Place patient/resident in comfortable position (some heart attack victims can breathe easier in a sitting rather than lying position) e. Reassure the patient/resident f. Intervene at level of competence as directed by licensed nurse g. Assess condition and vital signs while awaiting assistance from licensed nurse h. Keep the patient/resident warm as needed B. Cardiac Arrest 1. Absence of heart function 2. Signs and symptoms a. No Pulse, no circulation b. Loss of consciousness c. No effective breathing (may be agonal breathing) d. Enlargement of pupils e. Gray color to skin, cyanotic nail beds	D. Go to American Stroke Association website for stroke information: http://www.strokeassociation.org/STROKEORG/AboutStroke/Lets-Talk-About-Stroke-atient-Information-Sheets_UCM_310731_Article.jsp	care or emergency measures until qualified help arrives D. Documents according to facility policy

3. Nurse Assistant Role - See Objective 3 for role in medical emergency C. Cerebrovascular accident (CVA, Stroke, or brain attack) 1. A disturbance or obstruction of the flow of blood to a particular area of the brain with subsequent death of tissue 2. Signs and Symptoms a. Hemiplegia or weakness of one side of the body or numbness or tingling on one side of the body b. Aphasia-difficulty in speaking or understanding speech c. Headache d. Vision changes, blurred vision, pupils unequal e. Facial changes 1) Cheeks may “puff “on exhalation 2) One eyelid or eye may droop 3) Face may appear asymmetrical 4) Drooling f. Loss of bowel or bladder control g. Shaking or trembling 3. Give Me 5 for Stroke Tool from American Stroke Association a. Walk (Is their balance off?) b. Talk (Is their speech slurred or is their face droopy?) c. Reach (Is one side weak or numb?) d. See (Is their vision all or partly lost) e. Feel (Is their headache severe?) 4. FAST from American Stroke Association a. Face drooping b. Arm weakness c. Speech difficulty d. Time to call 9-1-1 5. Nurse Assistant Role a. Call for help loudly and pull emergency call light if available b. Remain calm		

c. Stay with the patient/resident d. Place patient/resident in a position of comfort e. Reassure patient/resident f. Intervene at level of competence as directed by the licensed nurse g. Assess patient's/resident's condition and take vital signs while awaiting assistance from the licensed nurse h. Keep patient/resident warm as needed D. Syncope, fainting episode 1. A feeling of dizziness with possible temporary loss of consciousness 2. Signs and Symptoms a. Dizziness b. Visual changes-temporary loss of vision c. Pallor or paleness of the skin d. Cool, moist skin e. Eyes may roll back f. Unsteadiness or loss of upright position (patient/resident may fall) g. Weak pulse 3. Nursing Assistant Role a. Before loss of consciousness and during dizziness 1) Remain calm, call for help loudly, pull call light 2) Assist to floor, protect from injury 3) If sitting, place head towards knees 4) If lying flat on back, elevate legs slightly if no spinal, head or back injuries (If unsure, leave flat on back) 5) Loosen tight or binding clothing 6) Observe for any changes in condition b. After loss of consciousness 1) Raise legs approximately 8-12 inches if no spinal, head or back injuries (If unsure, leave flat on back)		

2) Loosen tight or binding clothing 3) Observe for any changes in condition and monitor vital signs while waiting for help to arrive E. Seizures; convulsions or epilepsy 1. An interference with the normal electrical activity of the brain with subsequent changes in mental status 2. Types of seizures and related Signs and Symptoms a. Absence or partial (petit mal) seizure 1) A mild blackout 2) Looks as though daydreaming b. Generalized tonic-clonic or grand mal seizure 1) Uncontrolled muscular contractions 2) Can be minimal to major with possible violent head jerking 3) May be frothing at the mouth 4) May be loss of bowel and bladder control 3. Nurse Assistant Role a. Assist patient/resident to ground safely b. Note time c. Cushion head d. Remain calm, call for help loudly, and pull emergency call light e. Stay with patient/resident and observe f. If possible, gently turn head to one side to reduce risk of choking (This may not be possible in a violent seizure) g. Loosen clothing and/or jewelry h. Pad any items that may be dangerous to the patient/resident or move items away from patient/resident (i.e. furniture) i. Do NOT attempt to restrain nor put anything into patient's/resident's mouth j. Note time seizure ends k. Follow licensed nurse instructions to assist with putting patient/resident into recovery position		

F. Insulin Shock
   1. Definition
      a. Hypoglycemia
      b. Condition resulting from an overdose of insulin resulting in reduction of the blood sugar level below normal
      c. May develop due to an insulin-dependent patient/resident skipping meals or snacks, stress, diarrhea and vomiting or possible medication reaction
   2. Signs and Symptoms
      a. Pale, moist skin
      b. Rapid bounding pulse
      c. Headache, confusion, weakness
      d. Anxiety, excitement
      e. Hunger
      f. Low blood pressure (hypotension)
      g. Unconsciousness
   3. Nurse Assistant Role
      a. Stay with patient/resident
      b. Remain calm, call for help loudly, and pull emergency call light
      c. Administer orange juice, milk, or snack if instructed by licensed nurse

G. Hemorrhaging, severe bleeding
   1. An extreme or unexpected loss of blood
   2. Signs and Symptoms
      a. External bleeding
         1) Bleeding in spurts (arterial)
         2) Steady flow of blood (venous)
         3) Slow oozing of blood (capillary)
      b. Internal bleeding
         1) Coughing up bright red blood
         2) Vomit that has the appearance of coffee grounds
         3) Blood in urine or stool (stool may be black and tarry in appearance)

3. Nurse Assistant Role a. Remain calm, call for assistance loudly, and pull emergency call light b. Stay with patient/resident c. Observe standard precautions, wear gloves d. Apply direct pressure, with gauze pad, over area that is bleeding e. Elevate affected limb f. Do not offer food or drink g. Keep patient/resident calm and cover to keep warm H. Shock 1. Failure of the cardiovascular system to provide sufficient blood circulation to every part of the body 2. Signs and Symptoms a. Skin pale, cold and clammy, or moist b. Pulse rapid (over 100) and weak; low or falling blood pressure c. Respiration shallow, irregular, or labored d. Eyes dull and lackluster e. Nausea, vomiting, and/or thirst f. Confusion, anxiety, restlessness g. May collapse (faint) 3. Nurse Assistant Role a. Remain calm, call for help loudly, and pull emergency call light b. Stay with patient/resident, give reassurance c. Maintain an open airway (head tilt-chin lift or modified chin lift) d. Do not give food or drink e. Cover patient/resident to keep warm I. Respiratory Distress 1. Increase or decrease in the effort and frequency of breathing movements		

2. Signs & Symptoms a. Shortness of breath (SOB) b. Cyanosis c. Dyspnea d. Hyper/Hypoventilation e. Hypoxia f. Bradypnea/Tachypnea g. Anxiety confusion 3. Nursing Assistant Role a. Stay with patient/resident b. Elevate HOB, or allow patient/resident to assume position of comfort c. Remain calm, call for help and pull emergency call light d. Reassure/calm patient/resident e. Assess vital signs while awaiting assistance from licensed nurse f. Be prepared to gather equipment as instructed by nurse; i.e., oxygen tank and tubing		
Objective 3 **Describe the immediate interventions in a medical emergency.** A. Advance directives 1. Signed document with instructions for care if you become unable to make medical decisions (if you are in a coma, for example) 2. Full code 3. Do Not Resuscitate (DNR) 4. Living will 5. Durable Power of Attorney for Healthcare B. Immediate interventions 1. Note that this is not a CPR course. The information is not intended to take the place of a CPR course 2. American Heart Association is re-arranging the ABCs of cardiopulmonary resuscitation (CPR) in its 2010 American Heart Association Guidelines	A. Lecture B. Discussion C. Review and practice CPR with manikins	A. Written test B. Responds to emergencies safely and per facility protocols C. Locates emergency equipment in facility

3. Perform CPR only if trained a. Check to see if patient/resident is conscious b. Circulation 1) Check for circulation by feeling for a pulse, palpating the carotid artery 2) If no definite pulse within 10 seconds, give chest compressions c. Airway 1) Open the airway if patient/resident unconscious 2) Use head tilt, chin lift or modified chin lift d. Breathing 1) Check for breathing by looking, listening and feeling 2) Give two full breaths using a barrier device (pocket mask) 3) A mask must be used by the Nurse Assistant to do rescue breathing e. Circulation 1) Check for circulation by feeling for a pulse, palpating the carotid artery 2) If no definite pulse within ten seconds, give chest compressions f. Sequence; continue per current standards with 30 compressions to 2 ventilations (30:2) C. General guidelines for a emergency situation with a patient/resident 1. Stay calm 2. Call for help – gain assistance of licensed nurse 3. Charge nurse will initiate EMS system by calling 911 4. Remain with patient/resident 5. Intervene at level of competence as directed by licensed nurse 6. Reassure/calm patient/resident 7. Emergency/crash cart; knowing the location of the crash cart is mandatory at most facilities 8. Automated External Defibrillator (AED) a. Be aware of AED location b. Chance of survival is greater with early defibrillation c. Must be trained to use defibrillators		

Objective 4 **List the causes and signs of choking and discuss the use of the abdominal thrusts for relief of obstructed airway.** A. Airway obstruction or choking can lead to cardiac arrest B. Causes 1. Foreign body – such as poorly chewed pieces of meat 2. Tongue – in the unconscious patient/resident the tongue can fall backward in the throat and block the airway 3. Small objects 4. Vomitus – aspiration of vomit 5. Thick mucus 6. Dentures C. Signs of choking 1. Respiratory difficulty – victim cannot breathe 2. High pitched sounds 3. Inability to speak or cough 4. Universal choking sign – victim clutches throat D. Abdominal thrusts (Heimlich maneuver) are used to relieve, obstructed airway in a conscious victim E. Chest compressions are used if the victim is unconscious and rescuer is unable to ventilate	A. Lecture B. Discussion C. Manual Skill 12.4: Choking victim- Conscious and Unconscious D. Practice abdominal thrusts on manikin- standing, sitting, and on floor E. May also be reviewed during Module 11- Feeding	A. Written test B. Recognizes universal sign for choking C. Demonstrates correct technique for abdominal thrusts for conscious and victim using manikin D. Responds to emergencies safely and per facility protocol
Objective 5 **Describe common emergency codes used in long-term care facilities.** A. Emergency code colors and meanings 1. Code Red – fire 2. Code Blue – adult medical emergency (Cardiac or Respiratory) 3. Code Yellow –bomb threat 4. Code Gray – combative person 5. Code Silver – person with weapon or hostage 6. Code Orange – hazardous waste spill or release B. Codes may vary according to facility **C.** Observe special consideration for hearing and sight impaired patients/residents	A. Lecture B. Discussion	A. Written test B. Recognizes emergency codes in facility

Sample Test: Module 12 - Emergency Procedures

1. Most communities have a common emergency telephone number that notifies the Emergency Medical Service (EMS). Which of the following numbers is the emergency number?
    A. 911
    B. 484
    C. 411
    D. 916

2. Mr. Johnson has cut his hand on a broken piece of glass and is bleeding heavily. The Nurse Assistant should:
    A. Apply a circular strap around the wrist to act as a tourniquet
    B. Call 911, STAT (immediately)
    C. Have Mr. Johnson lower his hand below his heart to slow circulation to the site
    D. Apply direct pressure (with a gloved hand) using a pad, raising the hand above the level of the heart

3. A patient/resident has epilepsy. In the event of a seizure, the Nurse Assistant should:
    A. Leave the patient/resident to summon help
    B. Protect the patient/resident from injury
    C. Force the patient's/resident's mouth open
    D. Call for help in order to restrain the patient's/resident's movements

4. Which of the following best describes the "universal choking sign" given by the victim:
    A. Both hands clasped around his/her neck
    B. His/her arms waving up and down
    C. Pointing to his mouth with one hand
    D. The victim coughs and calls for help

5. The Nurse Assistant discovers an unconscious victim on the floor in the hall. What action should the Nurse Assistant take first?
    A. Move the victim to his room
    B. Search the victim for any areas of bleeding
    C. Call for assistance, then open the victim's airway and check for breathing
    D. Straighten out any obvious deformities in the victim's arms & legs

6. Your patient/resident is complaining that he is having pains in his chest. He is sweating and breathing heavily. As the Nurse Assistant who is with the patient/resident, you should:
    A. Tell the patient/resident this happens to you when you eat spicy foods, also
    B. Stay with the patient/resident & call for the nurse in charge
    C. Begin CPR
    D. Tell the patient/resident that he is having a heart attack

7. What procedure is done for a conscious choking patient/resident?
    A. Chest compressions
    B. Rescue breathing
    C. Abdominal thrusts
    D. Head tilt, chin lift

8. Mr. D's family is present when Mr. D has a seizure. Which of the following actions should the Nurse Assistant take for the family?
    A. Ask them to wait in a nearby room
    B. Tell them how you feel the patient's/resident's condition is doing
    C. Ask them to stay with the patient/resident as you get help
    D. Ask them to assist in holding the patient/resident down

9. Which of the following might be most helpful in preventing choking?
    A. Have the patient/resident eat all his solid foods before liquids
    B. Cut foods, especially meat into small, bite size pieces
    C. Feed the patient/resident quickly to reduce the risk of choking
    D. Have the patient/resident stand while eating so it will go down better

10. Which of the following are causes for hypoglycemia?
    A. Not enough insulin
    B. Decrease activity, vomiting, and undiagnosed diabetes
    C. Too much insulin, omitting a meal, vomiting
    D. Stress, increased activity

11. Which of the following might be a sign of an obstructed airway?
    A. Elevated temperature
    B. Pinpoint pupils
    C. Inability to speak
    D. Coughing

12. When performing abdominal thrusts, place the fist in one hand:
    A. Just above the pubis and below the navel (belly button)
    B. On the neck
    C. Between the navel and end of the sternum (breast bone)
    D. Over the ribs

13. Mrs. Harvey is complaining that her chest and arm hurt very badly. She is breathing heavily and sweating. While waiting for the nurse what should the Nurse Assistant do?
    A. Perform ROM on all extremities so patient/resident will not lose function of joints
    B. Give patient/resident oxygen
    C. Reassure patient/resident while putting her in a comfortable sitting position
    D. Leave to get emergency equipment in case you need it

14. Mr. Jones is showing the following signs and symptoms: dizziness, headache, weakness on his right side, and aphasia. What could be the cause?
    A. Heart attack
    B. CVA
    C. Syncope
    D. Shock

15. What personal protective equipment would be used when caring for a patient/resident with external bleeding?
    A. Gloves
    B. Goggles
    C. Gown
    D. All of the above

16. While ambulating Mrs. S, she has a fainting episode (syncope). What should the Nurse Assistant do first?
    A. Go get help
    B. Take Mrs. S's vital signs
    C. Assist Mrs. S to the floor
    D. Get Mrs. S a glass of water

17. Which of the following are signs and symptoms of internal bleeding?
    A. Bleeding in spurts
    B. Coffee ground vomit
    C. Normal appearance of urine
    D. Slow oozing of blood

18. What is the Nurse Assistant's role in caring for a patient/resident in shock?
    A. Keep patient/resident calm and warm
    B. Give water and ROM
    C. Maintain open airway and keep cool
    D. Keep active and fed

19. DNR, Living Will and Durable Power of Attorney are examples of:
    A. Boundaries of Care
    B. Scope of Practice
    C. Advanced Directives
    D. Nursing plan

20. CAB in reference to emergency care mean:
    A. Sequence of assessment
    B. Caring, Ambulation, Bathing
    C. Cycle, Airway, Bleeding
    D. Compressions, Airway, Breathing

21. Mr. G is coughing forcefully after swallowing a piece of meat. The Nurse Assistant should:
    A. Call for help
    B. Stay with Mr. G to monitor coughing
    C. Abdominal thrusts only if not coughing
    D. Give Mr. Gomez a glass of water

22. While eating, a patient/resident suddenly clutches his throat. The Nurse Assistant should FIRST:
    A. Give the patient/resident back blows
    B. Have the patient/resident sip some water
    C. Ask the patient/resident if he is choking, call for help
    D. Do a finger sweep of the patient's/resident's mouth

23. A patient/resident is choking and unable to speak. Which of the following actions should the Nurse Assistant take?
    A. Place the patient/resident in a chair
    B. Perform an arm lift
    C. Perform abdominal thrusts
    D. Administer sharp back blows

24. AED delivers an electric shock to the heart. What is an AED?
    A. Automatic External Device
    B. Automated External Device
    C. Automatic External Defibrillator
    D. Automated Exit Defibrillator

25. While eating, a patient/resident suddenly has a problem breathing but is able to say, "I'm choking" and is not coughing. Which of the following should the Nurse Assistant do?
    A. Administer abdominal thrusts
    B. Do a finger sweep of the patient's/resident's mouth
    C. Apply chest thrusts
    D. Give the patient/resident black blows

26. Mr. S has epilepsy and suffers from grand mal seizures. During a seizure it is important to:
    A. Restrain the patient/resident securely
    B. Attempt to keep the patient's/resident's jaws open
    C. Try to get the patient/resident to control his movements
    D. Protect the patient/resident from injury

27. The Nurse Assistant finds a patient/resident having shortness of breath. The Nurse Assistant should do all of the following **except**:
    A. Keep calm
    B. Leave the patient
    C. Turn on the call light
    D. Call for help

28. A patient/resident complains of chest pain. The Nurse Assistant should know that the patient/resident may possibly be having:
    A. An insulin reaction
    B. A stroke
    C. Arthritis
    D. A heart attack

MANUAL SKILL: Abdominal Thrusts (Heimlich Maneuver) for the Conscious and Unconscious Patient/resident

CONSCIOUS PATIENT/RESIDENT

STEPS:

1. Remain calm, call RN STAT, remain with patient/resident, and ask patient/resident if he/she is choking.
2. Identify knowledge of first aid for choking.
3. If the patient/resident can cough, continue to observe.
4. If the patient/resident is sitting or standing, stand behind him/her.
5. When the patient/resident cannot speak, cough, or breathe, apply abdominal thrusts:
   a. Wrap your arms around the patient's/resident's waist.
   b. Make a fist with one hand.
   c. Place the thumb side of your fist against the patient's/resident's abdomen – just below the lower end of the sternum and above the navel.
   d. Grasp the fist with the opposite hand.
   e. Using both hands, push forcefully with the thumb side of fist against the midline of the patient's/resident's abdomen, inward and upward with a quick trust.
   f. Repeat until the foreign body comes out or the patient/resident loses consciousness.
   g. When normal breathing returns, watch for several minutes to be sure that breathing continues.

UNCONSCIOUS PATIENT/RESIDENT

EQUIPMENT:

Gloves (if available)
Ventilation device (i.e. ambu bag)
Pocket mask (if available)

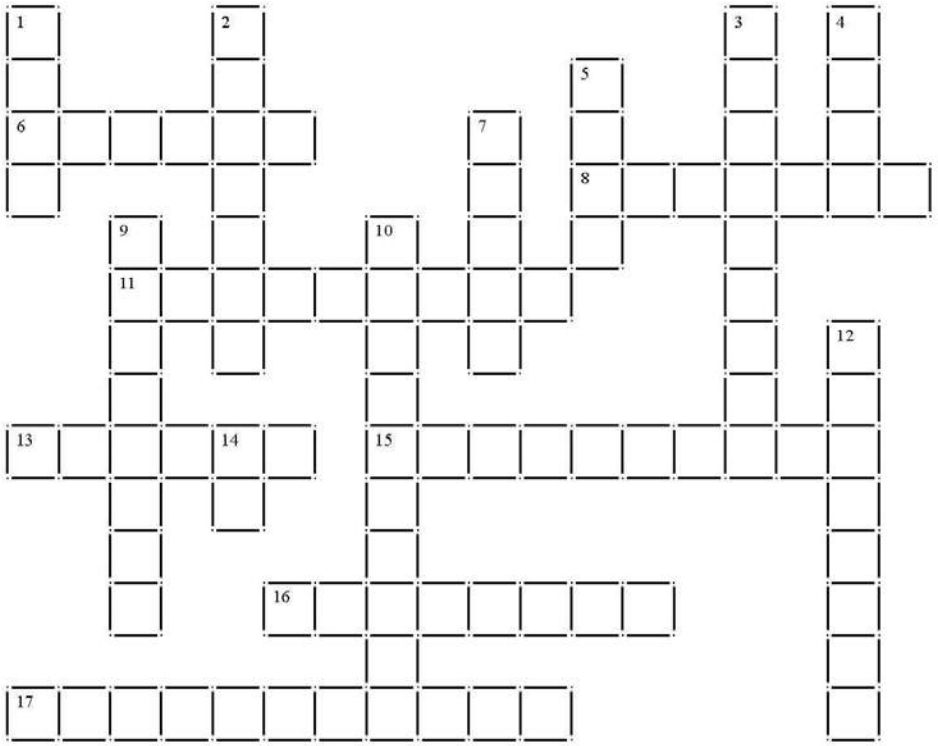
STEPS:

1. Call for help, but do not leave patient/resident.
2. Lower patient/resident to floor and position on back.
3. Apply gloves (if available), tilt head, open airway by pushing on forehead and lifting chin with fingertips.
4. Try two slow breaths using pocket mask, or ambu bag (one breath every five seconds).
5. Straddle patient's/resident's thighs.
6. Place heel of one hand on patient's/resident's abdomen below the lower end of the sternum and above the navel, place second hand over first (fingers pointing toward head), give six to ten thrusts.
7. Remove object if seen.
8. Attempt to give breaths through pocket mask or ambu bag.
9. If still obstructed repeat thrusts, checking for object and giving breaths until object is dislodged.
10. Continue until airway is open, help arrives, or rescuer cannot continue.

Module 12: Emergency Procedures

Handout 12.1a- Crossword

Emergency Procedures Crossword



Across

6 The heart or lungs stop.
8 Protective gloves.
11 A sudden threatening membranes.
13 Pale skin or mucous membranes.

15 Supports used to help prevent injury.
16 A bluish discoloration of the skin or mucous membranes.
17 Excessive perspiration.

Down

1 Immediately.
2 Difficult breathing
3 Restlessness.
4 Written Idea about what to do in case of a fire or disaster.
5 Unconscious.
7 Too much insulin produced.

9 A maneuver to help someone chocking.
10 Abnormal bleeding.
12 Someone having problems breathing has respiratory.
14 Abbreviation for oxygen.

Module 13: Long Term Care Patient/Resident
Minimum Number of Theory Hours: 5 SNF/ICF (or 3 non-SNF/ICF plus 2 additional training hours)
Recommended Theory Hours: 13
Required Clinical Hours: 4

Statement of Purpose:
The purpose of this unit is to introduce the student to the basic structure of the body and to review the effect of aging on body structure and function. Common physical and psychological conditions found in elderly patients are presented along with approaches to care. Community resources commonly available to assist elderly patients with their psychological, recreational, and social needs are presented.

Terminology:

Long Term Care Resident:

1. Acute
2. Assisted living
3. Chronic
4. Debilitating
5. Dementia
6. Long-term care
7. Reality orientation
8. Reminiscing
9. Patients/residents
10. Skilled nursing facility
11. Subacute care
12. Validation therapy

Medical and Anatomical Terms:

13. Anatomic position
14. Anatomy
15. Anterior
16. Cells
17. Connective tissue
18. Contractures
19. Disease
20. Distal
21. Epithelial tissue
22. Health
23. Inferior
24. Joints
25. Lateral
26. Membranes
27. Muscle tissue
28. Nerve tissue
29. Organ
30. Peritoneum
31. Physiology
32. Posterior
33. Prefix
34. Proximal
35. Suffix
36. Superior
37. System
38. Traction

Nervous System:

39. Age-related Macular Degeneration (AMD)
40. Agitated
41. Alzheimer's disease
42. Aphasia
43. Autonomic dysreflexia
44. Bipolar disorder
45. Brain
46. Cataract
47. Catastrophic reaction
48. Cerebral palsy
49. Cerebral Vascular Accident (CVA)
50. Concussion
51. Confusion
52. Delirium
53. Delusion
54. Dementia
55. Developmentally disabled
56. Disruptive behavior
57. Elopement
58. Epilepsy
59. Generalized anxiety
60. Glaucoma
61. Hallucination
62. Hemianopsia
63. Hemiplegia

64. Multiple sclerosis
65. Nerve
66. Neuron
67. Otosclerosis
68. Panic disorder
69. Paralysis
70. Paranoia
71. Paranoid schizophrenia
72. Paraplegia
73. Parkinson's disease
74. Peripheral nervous system
75. Post-traumatic stress syndrome
76. Quadriplegia
77. Reality orientation
78. Seizure
79. Stroke
80. Sundowner syndrome
81. Transient Ischemic Attack (TIA)
82. Tremor
83. Vertigo

Immune System:

84. Antibody
85. Antigen
86. Auto Immunodeficiency Syndrome (AIDS)
87. Carrier
88. Human Immunodeficiency Virus
89. Immunity
90. Lymph node
91. T-cell
92. White blood cell

Cardiovascular System:

93. Anemia
94. Angina
95. Anti-embolic stockings:
96. Artery
97. Atherosclerosis
98. Blood
99. Capillary
100. Congestive Heart Failure (CHF)
101. Coronary artery disease
102. Dyspnea
103. Edema
104. Embolism
105. Heart
106. Hypertension
107. Hypoxia
108. Ischemia
109. Myocardial infarction
110. Orthopnea
111. Pacemaker
112. Peripheral vascular disease (PVD)
113. Phlebitis
114. Pulmonary edema
115. Sequential compression device (SCD)
116. Systole
117. Thrombus
118. Varicose vein
119. Vein
120. Vessel

Integumentary System:

121. Abrasion
122. Allergies
123. Bony prominences
124. Cyanotic
125. Debride
126. Decubitus ulcer
127. Dermis
128. Epidermis
129. Excoriation
130. Friction
131. Gangrene
132. Hematoma
133. Lesion
134. Necrosis
135. Pallor
136. Pediculosis
137. Pressure ulcer
138. Pruritus
139. Psoriasis
140. Scabies
141. Shearing
142. Skin
143. Skin tears

Gastrointestinal System:

144. Absorption
145. Bile
146. Bowel movement
147. Colon
148. Colostomy

149. Constipation
150. Defecation
151. Diarrhea
152. Digestion
153. Diverticulitis
154. Elimination
155. Enema
156. Fecal impaction
157. Feces
158. Flatus
159. Gastrectomy
160. Gastric tube
161. Hernia
162. Ileostomy
163. Nasogastric tube (NG)
164. Obstruction
165. Occult blood
166. Ostomy
167. Percutaneous Endoscopic Gastrostomy (PEG)
168. Peristalsis
169. Stoma
170. Stool
171. Suppository
172. Ulcer
173. Urgency
174. Urostomy

Respiratory System:

175. Alveoli
176. Asthma
177. Bronchi
178. Carbon dioxide
179. Chronic Heart Failure (CHF)
180. Chronic Obstructive Pulmonary Disease (COPD)
181. Dyspnea
182. Emphysema
183. Expiration
184. Inspiration
185. Larynx
186. Lungs
187. Mucous
188. Nasal cannula
189. Nebulizer
190. Orthopnea
191. Oxygen mask
192. Pharynx
193. Pneumonia
194. Sputum
195. Tracheostomy
196. Tuberculosis (TB)
197. Upper respiratory infection (URI)

Musculoskeletal System:

198. Abduction
199. Adduction
200. Amputation
201. Arthritis
202. Atrophy
203. Bursitis
204. Contracture
205. Extension
206. Flexion
207. Fracture
208. Full weight-bearing (FWB)
209. Gout
210. Muscle
211. Muscular dystrophy
212. Osteoarthritis
213. Osteoporosis
214. Phantom pain
215. Pronation
216. Prosthesis
217. Range of Motion (ROM)
218. Rheumatoid arthritis
219. Rotation
220. Skeleton
221. Supination
222. Total hip arthroplasty
223. Trapeze
224. Vertebrae

Urinary System

225. Catheter
226. Calculi
227. Chronic renal failure
228. Clean catch
229. Condom catheter
230. Cystitis
231. Dialysis
232. Diuresis
233. Dysuria
234. End-Stage Renal Disease (ESRD)
235. Hematuria
236. Indwelling catheter
237. Kidney

238. Micturition
239. Nephritis
240. Renal calculi
241. Retention
242. Specimens
243. Ureter
244. Urethra
245. Urinalysis
246. Urinary bladder
247. Urinary drainage bag
248. Urinary incontinence
249. Urinary Tract Infection (UTI)
250. Void

Reproductive System:

251. Benign prostatic hypertrophy
252. Chlamydia
253. Cystocele
254. Douche
255. Genitalia
256. Genital herpes
257. Human Papilloma Virus(HPV)
258. Gonorrhea
259. Hemorrhoid
260. Herpes simplex 2
261. Hormones
262. Hysterectomy
263. Mammogram
264. Mastectomy
265. Pelvis Inflammatory disease (PID)
266. Penis
267. Prostate gland
268. Rectocele
269. Sexually transmitted disease (STD)
270. Syphilis
271. Testes
272. Trichomoniasis
273. Uterus
274. Vagina
275. Venereal
276. Vulvovaginitis

Endocrine System:

277. Diabetes mellitus
278. Fasting Blood Sugar (FBS)
279. Glucose
280. Glycosuria
281. Goiter
282. Hormones
283. Hyperglycemia
284. Hypoglycemia
285. Insulin
286. Insulin-Dependent Diabetes Mellitus (IDDM)
287. Metabolism
288. Non-Insulin-Dependent Diabetes Mellitus (NIDDM)
289. Pituitary gland
290. Thyroxine

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of five (5) hours SNF/ICF* or three (3) non-SNF/ICF** of class plus homework assignments and four (4) hours of clinical experience, the learner will be able to:

1. Define key terminology
2. Describe common basic human needs and interventions for the elderly patient/resident; environmental, psychological, social, recreational and spiritual
3. Describe common community resources to meet the needs of the elderly
4. Describe the special needs of persons with developmental and mental disorders including intellectual disability, cerebral palsy, epilepsy, Parkinson's disease, and mental illness
5. Describe the special needs of persons with Alzheimer's Disease and other related dementias
6. Describe the body's basic organization and composition
7. List the body systems, including basic anatomy and physiology, common diseases of the elderly with signs and symptoms, Nurse Assistant duties and observations, aging changes and complications of immobility
8. Describe changes in body systems associated with aging

Refer to CDPH 276C form:
*SNF/ICF providers need to complete A1 Special needs of persons with developmental and mental disorders including intellectual disability, cerebral palsy, epilepsy, Parkinson's disease, and mental illness (2 hours); A2 Special needs of persons with Alzheimer's disease and related dementias (2 hours); and B Introduction to anatomy and physiology (B-F minimum 1 hour).

**Non-SNF/ICF providers may complete A2 Special needs of persons with Alzheimer's disease and related dementias (2 hours), or two (2) hours of training from another module in order to meet the sixty (60) hours minimum theory training requirement and B Introduction to anatomy and physiology (B-F minimum 1 hour).

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes E. Handout 13.1a- Long Term Care Patient/resident Crossword F. Handout 13.1b- Long Term Care	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Describe common basic human needs and interventions for the elderly patient/resident; environmental, psychological, social, recreational and spiritual.** A. Environmental/physical 1. Safety a. More light for better vision b. Freedom from hazards c. Support (adaptive devices) d. Good personal hygiene 2. Shelter a. Appropriate living situation	A. Lecture B. Discussion C. Handout 13.2a- Elements of Friendship D. Handout 13.2b- Empathy E. Handout 13.2c- The Best Friends Philosophy of Communication	A. Written test B. Assists patients/residents in meeting environmental, psychological, social, recreational and spiritual needs C. Reports unusual signs to licensed nurse

b. Environmental control (heating, air conditioning) 3. Nourishment a. Balanced nutrition b. Adequate fluids B. Psychological 1. Maintain self-esteem b. Respectful treatment c. Recognition of individual differences 2. Adjustment to role change and loss of independence b. Respect privacy c. Give choices d. Encourage activities C. Social 1. Social interactions b. Encourage family involvement c. Encourage social/community activities 2. Adjustment to losses b. Death of spouse/friends c. Encourage verbalization, such as reminiscing d. Encourage new social contacts 3. Financial b. Changes in income interfere with meeting basic needs of security, love, belonging and self-esteem c. Refer to social service D. Recreational 1. Diversion b. Encourage hobbies c. Involve in facility/community events d. Encourage family involvement 2. Self-esteem b. Encourage involvement c. Give compliments		

c. Reinforce positive traits or abilities E. Spiritual 1. Provide respect for individual choices 2. Provide opportunities to participate in religious activities		
Objective 3 **Describe common community resources to meet the needs of the elderly.** A. Area Agency on Aging-AAA, (Request Community Resource Manual) B. Adult Day Care Center C. Support groups 1. American Diabetes Association 2. Braille Institute or Blind Center 3. Alzheimer's Society 4. Parkinson's Support 5. Multiple Sclerosis Support 6. Muscular Dystrophy 7. Hospice/Bereavement D. County Health Center E. Community Hospitals and their hospice F. Internal Revenue Service (IRS) information G. Long Term Care Ombudsman H. Meals on Wheels I. Medicare Office (see Social Security Office) J. Mental Health Department K. National Alliance for the Mentally Ill (NAMI) L. American Disability Act M. Adult Protective Services (APS) N. Red Cross/Blood Pressure Clinic O. Senior Center P. Senior Housing Q. Social Security Office Suicide prevention R. Home health agencies S. Voter registration T. American Association of Retired Persons (AARP)	A. Lecture B. Discussion C. Ask group to share any information they have used on community resources	A. Written tests B. Assists licensed nurse in providing information to patients/residents regarding community resources

U. Fraternal and social organizations V. Regional centers W. Churches/religious organizations		
Objective 4 **Describe the special needs of persons with developmental and mental disorders including intellectual disability, cerebral palsy, epilepsy, Parkinson's disease, and mental illness.** A. Epilepsy/Seizure Disorders 1. Description of different types of Epilepsy and Seizure Disorders a. Generalized seizure (Grand mal) b. Partial seizure (Petit mal) c. Absent Seizure d. Status epilepticus 2. Discuss potential causes a. Metabolic disorders b. Nutrition problems c. Medication problems 3. Signs/symptoms (Refer to objective 7) a. Depends on type of seizure b. May experience "aura" or certain taste before Entire body is involved c. May experience loss of consciousness d. Incontinence e. May be followed by period of fatigue, confusion, disorientation 4. Nurse Assistant duties and responsibilities a. Stay with person and call for assistance b. Assist to lay down c. Do not restrain movements or put anything in mouth d. Move away objects that may injure a person e. Maintain airway by loosening clothing, turn head so saliva/emesis drains to one side, lift shoulder and allow head to tilt back	A. Lecture B. Discussion C. Handout 13.4- An Alzheimer's Disease Bill of Rights D. Manual Skills 13.4- Reality Orientation to Promote or Maintain Awareness of Person Place and Time	A. Written tests B. Reports unusual signs and symptoms to licensed nurse

B. Parkinson's Disease
   1. Description and progression of disease
      a. Progressive nervous system disorder that affects movement
      b. Early stages of Parkinson's disease, may be mild and go unnoticed, but as symptoms worsen as the condition progresses over time
      c. Certain nerve cells (neurons) in the brain gradually break down or die, which causes a loss of neurons that produce a chemical messenger in your brain called dopamine
   2. Signs and symptoms
      a. Start gradually, sometimes starting with a barely noticeable tremor in just one hand
      b. Tremors and "pill rolling"
      c. Muscle rigidity
      d. Shuffling manner of walking Difficulty and slowness in carrying out voluntary motor activities
      e. Slurred speech
      f. Loss of expressiveness in face
      g. Drooling
      h. Incontinence
      i. Constipation
      j. Urinary retention
      k. Mood swings
      l. Depression
      m. Fatigue
   3. Nurse Assistant duties and responsibilities
      a. Safety activities and concerns
      b. Nutrition problems including swallowing and/or chewing issues
      c. Notify licensed nurse if behavior worsens or becomes dangerous
      d. Maintain calm environment; symptoms will worsen when patient/resident is under stress
      e. Assist in ADLs
      f. Provide emotional support
      g. Restorative care; exercises
      h. Dementia care; as above

C. Schizophrenia
   1. Mental disorder characterized by paranoia, hallucinations, delusions, bizarre behavior and distortions of reality
   2. Signs/symptoms
   3. Nurse Assistant duties and responsibilities
      a. Notify licensed nurse if behavior worsens or becomes dangerous
      b. Do not “feed in” to delusions, but do not try to convince them of reality
      c. Be aware of suicide precautions
      d. Keep patient/resident involved in reality activities
      e. Report and document observed responses to medication and psychotherapy
      f. Monitor nutrition and fluid balance - these patients/residents often refuse to eat or drink out of a fear of poisoning
      g. Find ways of reducing patient’s/resident’s fear and anxiety

D. Hypochondriasis
   1. Patient/resident imagines or magnifies each physical ailment
   2. Nurse Assistant duties and responsibilities
      a. Be supportive, some authorities feel this disorder stems from depression
      b. Do not overlook real illness; report all complaints
      c. Do not judge

E. Depression
   1. Most common functional disorder in older people
   2. Signs and Symptoms
      a. Feeling of sadness
      b. Lack of interest in and withdrawal from environment
      c. Feelings of worthlessness
      d. Negative outlook on the future
   3. Nurse Assistant duties and responsibilities
      a. Notify licensed nurse if patient/resident displays loss of appetite, weight loss, severe fatigue, crying, or sleeplessness
      b. Notify licensed nurse if patient/resident makes statements such as “I wish I could just die”
      c. Remain non-judgmental

d. Listen with empathy e. Encourage activities with others f. Encourage aerobic activity, as well as outdoor activities (releases endorphins) E. Suicidal patient/resident 1. The elderly patients/residents are at risk of suicidal behavior, especially white males over the age of 65 who live alone, and the very old (75 years and above) 2. Nurse Assistant duties and responsibilities a. Report clues of suicide attempts to licensed nurse b. Give constant care c. Monitor activities d. Work to preserve self-esteem e. Help patient/resident find support network; friends, clergy, family and support groups f. Never ignore the person's statements or threats about suicide F. Intellectual or Developmental Disabilities 1. Significant sub-average intellectual function and low adaptive ability 2. Nurse Assistant duties and responsibilities a. Provide an environment as normal as possible (normalization) b. Emphasize individual strengths c. Encourage independence, self-care d. Treat with dignity at age appropriate level e. Respect privacy f. Provide safe, structured environment G. Cerebral Palsy 1. Group of disorders characterized by motor dysfunctions 2. Nurse assistant duties and responsibilities a. Provide safe, structured environment b. Apply appropriate assistive devices c. Emphasize individual strengths		

d. Encourage independence e. Treat with dignity f. Respect privacy H. Alcoholism/Drug Abuse 1. Abuse of alcohol or drugs when healthy coping mechanisms have failed 2. 15% of elderly suffer from alcoholism 3. Often triggered by a. Retirement b. Loss of self-esteem c. Loneliness d. Chronic pain e. Decline in health f. Stress 4. Nurse Assistant duties and responsibilities a. Report to the licensed nurse any sign that the patient/resident is under the influence of alcohol or drugs b. Be sure alcohol/drugs are not available (alcohol can be in products such as aftershave, perfume, cooking extracts, cleaning products) c. Watch for mental impairment; loss of coordination, poor judgment d. Be careful when feeding, gag reflex may be impaired e. Set boundaries, avoid being manipulated f. Be aware of support groups such as Alcoholics Anonymous or the Mental Health Association g. Notify licensed nurse if signs of withdrawal 1) Alcohol: tremors, shaking, agitation, seizures 2) Drugs: runny nose, depression, headache, pacing, poor coping mechanisms, agitation h. Follow patient's/resident's care plan i. Be aware of dangerous behavior		

I. The Agitated Patient/resident 1. Uses inappropriate verbal, vocal, or motor activity due to causes other than disorientation or real need 2. Nurse Assistant duties and responsibilities a. Report to the licensed nurse any signs of agitation including aimless wandering, pacing, cursing, screaming, spitting, biting, fighting, arguing, demanding, and talking to self b. Maintain quiet, calm atmosphere c. Encourage distracting activities d. Check for constipation or other sources of discomfort/pain e. Realize that patient/resident may become more agitated due to feelings of loss of control f. Avoid restraints g. Allow patient/resident to walk, or rock in chair to diffuse energy h. Listen with empathy i. Make sure you stay safe - maintain area to escape (don't let patient/resident get between you and the door) j. Call for help if patient/resident gets violent k. Do not attempt to control patient/resident if they become violent l. Redirect		
Objective 5: **Describe the special needs of persons with Alzheimer's Disease and other related dementias** A. Explain the causes and differences of delirium, depression and dementia a. Dementia is a general term for a decline in mental ability severe enough to interfere with daily life b. Dementia describes a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life c. Not a specific disease, but several different diseases may cause dementia	A. Lecture B. Discussion	A. Written test

d. Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment e. Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest, which affects how you feel, think and behave, and can lead to a variety of emotional and physical problems f. Dementia and delirium may be particularly difficult to distinguish, and a person may have both g. Causes not known exactly known, but as with many mental disorders, a variety of factors may be involved, such as: b) Brain chemistry c) Hormones d) Traumatic or stressful events e) Abuse of alcohol or recreational drugs f) Serious or chronic illness, including cancer, stroke, chronic pain or heart disease g) Certain medications or drug toxicity h) Malnutrition or dehydration i) Sleep deprivation h. Common signs and symptoms include: 1) Memory loss, which is usually noticed by a spouse or someone else 2) Difficulty communicating or finding words 3) Difficulty with visual and spatial abilities, such as getting lost while driving 4) Difficulty reasoning or problem-solving 5) Difficulty handling complex tasks 6) Difficulty with planning and organizing 7) Difficulty with coordination and motor functions 8) Confusion and disorientation 9) Personality changes 10) Anxiety 11) Paranoia 12) Agitation 13) Hallucinations		

B. Describe the signs, symptoms and progression of Alzheimer's disease and other dementias 1. Alzheimer's disease (covered in objective 7: neurological section): caused by plaques and tangles in the brain's nervous system. Brain decreases in size as cells are lost. Progressive and incurable 2. Signs and Symptoms a. Stage 1: Mild Dementia 1) Short-term memory loss 2) Personality changes 3) Disorientation to time 4) Poor judgment 5) Lack of safety awareness 6) Careless in appearance 7) Anxious, depressed 8) Delusions of persecution b. Stage 2: Moderate Dementia 1) Increased short-term memory loss 2) Complete disorientation 3) Wandering and pacing 4) Sundowning 5) Perseveration phenomena 6) Motor skills deteriorate 7) Speech, reading, writing deteriorates 8) Incontinent of bowel and bladder 9) Catastrophic episode c. Severe Dementia 1) Totally dependent 2) Verbally unresponsive 3) May have seizures C. Explain the nursing care received by persons with Alzheimer's disease and other dementias a. Protect patient/resident from injury b. Be compassionate, patient, and calm; maintain sense of humor		

d. Encourage independence as long as possible e. Provide mental and physical activities within resident's capabilities f. Support resident's dignity and self-esteem g. Provide structured quiet environment that is uncluttered h. Use appropriate body language; resident's will "read" the staff's behavior and reflect the mood of the staff in their own behavior i. Give one, short, simple direction at a time j. Observe for signs and symptoms of physical ailments; resident may be unaware of illness k. Assist residents to maintain a dignified, attractive appearance by helping with grooming and dressing l. Monitor food and fluid intake a) Do not use plastic feeding utensils b) Provide nutritious finger foods when the resident is unable to use utensils c) Be aware of swallowing difficulties d) Prepare food (butter bread, cut into bites) and encourage resident to feed self as long as possible e) Check food temperatures f) Check resident's mouth after eating for "pocketing" (hoarding food in the cheeks) g) Weigh residents to detect patterns of weight gain or loss m. Use touch appropriately; surprising resident can result in a catastrophic reaction n. Avoid using logic, reasoning or lengthy explanations o. When ability to speak is lost, resident may communicate through non-verbal means a. Biting, scratching, and kicking to express displeasure b. Facial expressions and body language may express moods		

D. Identify specific activities that would improve the quality of life for persons with Alzheimer's disease and other dementias a. Use distraction and diversion when resident is agitated, take hand and calmly walk to another activity b. Realize that people with dementia are not responsible for what they say 1) They cannot change 2) They are not aware of what they are doing 3) They have poor impulse control 4) Allow them to "save face" by preserving their dignity 5) No one really knows what is happening in the mind of people with dementia c. Compliment positive behavior and accomplishments d. Encourage rocking chairs to diffuse nervous energy E. Identify specific safety measures for Alzheimer's and dementia populations a. Use reality orientation (R.O.) to regain connection to environment 1) Especially effective in 1st stages of Alzheimer's 2) Use clock and calendar at bedside 3) Call by name b. Answer questions honestly, but do not give information they are unable to handle; for example 1) The resident asks if their deceased husband is coming to visit 2) Nurse Assistant could respond by saying "tell me about your husband" c. Do not argue with resident's reality d. Use bulletin boards decorated for the season e. Keep curtains open during the day f. Make sure they have their glasses and hearing aids on g. Do not expect resident to remember you - identify yourself, as needed		

h. Incorporate validation therapy into all your interactions with dementia resident (maintains disorientated person's dignity by acknowledging the person's memories and feeling) i. Use reminiscing therapy j. Incorporate music therapy k. Incorporate animal therapy F. Identify *at-risk* behaviors that include modifiable and non-modifiable factors, as well as increased risk for abuse a. Research has shown that the same risk factors associated with heart disease may also increase the risk of Alzheimer's disease. These include: b. Lack of exercise c. Obesity d. Smoking or exposure to secondhand smoke e. High blood pressure f. High cholesterol g. Poorly controlled type 2 diabetes h. sleep patterns i. Age j. Family history and genetics		
Objective 6 **Describe the body's basic organization and composition.** A. Anatomy-Structure; Physiology-Function B. The Cell 1. The basic unit of body structure; building blocks of the body 2. Function, size, and shape of cells may differ 3. Cells need food, water, and oxygen to survive C. Tissues 1. Groups of cells with similar functions. Four basic types of tissues in body	C. Lecture D. Discussion	A. Written test

2. Epithelial tissue – protective 3. Connective tissue – support and connect 4. Muscle tissue – shorten and lengthen 5. Nerve tissue – carry electrical impulses D. Organs 1. Made up of different types of tissues 2. Perform special functions E. Systems 1. Groups of organs that work together to perform specific functions 2. Ten major body systems a. Integumentary System b. Respiratory System c. Cardiovascular System d. Musculoskeletal System e. Endocrine System f. Nervous System g. Gastrointestinal System h. Urinary System i. Reproductive System j. Immune System F. Health; state of mental, physical and social well-being G. Disease; any change from the healthy state		
Objective 7 **List the body systems, including basic anatomy and physiology, common diseases of the elderly, signs and symptoms, and Nurse Assistant duties and observations.** A. Integumentary system (skin) 1. Anatomy a. Epidermis is the top surface layer 1) It is primarily dry, dead cells that shed continuously 2) Thin layer with no blood supply	A. Lecture/Discussion B. Use visuals and videos to describe conditions C. Ask student to share experiences regarding common diseases of the	A. Written test B. Reports unusual signs and symptoms to licensed nurse

3) Functions as a barrier to water loss and prevention infection b. Dermis is the second layer 1) Varies in thickness in different areas of the body 2) Naturally very moist 3) Gives skin its strength 4) Contains the blood vessels, lymph vessels, nerve endings, oil glands, and hair follicles 5) Function of dermis is to aid in body temperature control and is the origin of our sense of touch, pressure, and pain c. Subcutaneous tissues are deeper tissues beneath the dermis 1) Tissues are fat and connective tissue 2) These tissues do not tolerate lack of oxygen and cell death results easily 2. Functions a. Provides protective barrier against microorganisms and infection b. Provides sensation through nerve endings c. Shields body tissue from injury d. Regulates body temperature e. Eliminates waste products f. Produces Vitamin D for body use g. Prevents loss of too much water h. It is the largest “organ” of the body 3. Diseases and Disorders a. Skin Lesions/Wounds - change in skin structure caused by injury, trauma, aging, or disease 1) Signs and Symptoms a) Rash b) Raised spots filled with pus or fluid	elderly	

c) Irregular reddened areas that itch (Pruritus) d) Dry crusts; scabs e) Break in skin integrity 2) Nurse Assistant duties and observations a) Observation and reporting of any skin abnormalities b) Observe drainage on dressing c) Soap and water are contraindicated d) Tepid water when bathing e) Gloves f) Do not remove crusts g) Notify licensed nurse if: • Skin lesions drain • Nature of drainage changes, increases • Drainage has odor • Drainage changes color • Dressing needs changing • Wound has signs of redness, red streaks, heat, pus, drainage b. Pressure Sores (Decubiti) - break in skin integrity that develops over bony prominence as result of pressure 1) Signs and Symptoms a) Stage One • Redness over bony prominence (dark skinned people may appear blue or black) that does not go away after 30 minutes • Will reverse if precautions are taken b) Stage Two • Reddened skin with abrasions, blisters or shallow crater • Epidermis and/or dermis may both be involved		

c) Stage Three • All layers of skin destroyed • Deep crater forms d) Stage Four • Ulcer extends through skin and subcutaneous tissue • Bone, muscle, and underlying structures may be involved 2) Nurse Assistant duties and observations a) Change position at least every two hours b) When sitting, teach patient/resident to shift every ten (10) minutes c) Proper nutrition and hydration d) Immediate removal of feces or urine e) Inspect skin area whenever personal care is given, especially over bony prominences f) Remove wrinkles and foreign objects from bed linens g) Avoid hot water and friction h) Lubricate skin with lotions i) Separate body areas to avoid rubbing j) Mechanical aids • Sheepskin • Alternating-pressure mattress • Pillows for bridging • Gel and air cushions • Heel protectors k) Use turning sheet to move dependent patients/residents in bed l) Elevate HOB no more than 30 degrees		

m) Check improperly fitted braces and restraints n) Check tubing for rubbing o) Know signs and symptoms of pressure sore, and report immediately to licensed nurse p) PREVENT: much easier to prevent than treat c. Pediculosis, Lice and Scabies: tiny parasites that are difficult or impossible to see 1) Signs and Symptoms a) Intense itching • Pediculosis: in areas of hair growth • Scabies: follows blood vessels, commonly seen in webs of fingers, inside wrists and elbows, underarms and waist and nipple areas • Rash 2) Nurse Assistant duties and observations a) Avoid direct contact; gloves b) Report any signs or symptoms of disorder c) Thorough washing of linen d) Medicated shampoos/lotions may be used d. Other related subjects (optional); Kaposi's Sarcoma, Monkey Pox, burns, impetigo B. Respiratory System 1. Anatomy & Physiology a. Nose and mouth b. Trachea c. Bronchi d. Lungs e. Alveoli 2. Functions a. Lifeline of the body		

b. Bring oxygen into the body and eliminate carbon dioxide from the body 3. Diseases and Disorders a. Upper respiratory infection (URI): infection in nose, sinuses, and throat 1) Signs and Symptoms a) Fever b) Runny nose and eyes c) Cough d) Sore throat 2) Nurse Assistant duties and observations a) Encourage rest b) Encourage fluids c) Dispose of tissues promptly to avoid spread d) Report to licensed nurse: • Fever • Dyspnea • Change in rate or rhythm of respiration • Change in mucus color from clear to green, yellow or blood-tinged • Pallor, cyanosis • Signs that infection is moving to chest or lungs b. Pneumonia: infection/inflammation of the lungs often seen in patients/residents with compromised immune system 1) Signs and symptoms a) Same as URI, only more severe b) Chest pressure and discomfort c) Extreme fatigue/weakness d) Cough 2) Nurse Assistant duties and observations		

a) As above for URI b) Monitor vital signs carefully, especially temperature & respiration c) Elevate head of bed/orthopneic position, as needed c. COPD (Chronic Obstructive Pulmonary Disease) - a condition that results in chronic obstruction of the respiratory system that is not reversible 1) Signs and symptoms a) Asthma: breathing disorder caused by reaction to allergen • Wheezing • Tightened airways • Mucus blocks passageways • Labored breathing • Frequent coughing b) Chronic Bronchitis: prolonged inflammation in the bronchi due to infection or irritants • Persistent cough • Sputum production (especially in the morning) • Respiratory distress c) Emphysema: occurs when air flow is obstructed at the level of the alveoli • Can bring O2 into lungs, but can't expel CO2 • Triggered by pollutants, smoke and cold • Frequent lung infections • Extreme dyspnea • Loss of appetite/weight loss • Irritability • Air hunger		

2) Nurse Assistant duties and observations a) Teach pursed-lipped breathing (to increase expiration of CO2) b) Calm patient/resident when anxious (to decrease O2 need) c) Raise head of bed/orthopneic position d) Oxygen therapy (O2 precautions)-.Do not change Low O2 settings) e) Nutrient dense foods; frequent snacks, not meals f) Encourage fluids g) Pace activities h) Avoid raising arms over head d. Tuberculosis 1) Definition a) A highly contagious lung disease caused by a bacterium that is carried on mucous droplets suspended in the air b) Two types of TB • Latent TB - Someone with latent TB shows no symptoms • Active TB – Shows symptoms. Occurs when tuberculosis enters the body and the inactive tubercle breaks down; bacteria multiply and spread to other parts of the body 2) Signs and symptoms a) Fatigue b) Night sweats c) Coughing up blood (hemoptysis) d) Prolonged coughing e) Slight fever f) Chills g) Shortness of breath and/or dyspnea		

h) Loss of appetite and weight 3) Nurse Assistant duties and observations a) Annual PPD (Mantoux test) b) Chest x-ray every two years if positive skin test c) Use of barriers if productive cough d) Discard tissues, sputum promptly 4. Other related subjects (optional): tracheostomy, esophageal speech and electronic speech, SARS, malignancies C. Cardiovascular System 1. Anatomy and Physiology a. Heart; pumps blood which carries oxygen and nutrients to cells b. Blood 1) Transports oxygen, food and hormones to cells 2) Removes carbon dioxide and other waste products from cells 3) Controls pH level and body temperature 4) Clots the blood and fights pathogens and poisons c. Blood vessels 1) Arteries carry blood away from the heart 2) Veins carry blood towards the heart 3) Capillaries; smallest vessels that connect arteries and veins 2. Functions a. Transportation system that delivers nutrition and oxygen to the cells and takes away waste products b. Closed system is kept in motion by the force of the heart 3. Common disease and disorders a. Coronary Artery Disease (CAD) occurs when the coronary arteries narrow, causing reduced blood supply to the heart depriving the heart muscle with oxygen and nutrients		

1) Signs and Symptoms a) Chest pain b) Pain in back, neck, jaw, arm, shoulder or back c) Dyspnea d) Cyanosis of lips, mucous membranes, and nail beds e) Dizziness 2) Nurse Assistant duties and observations a) Remain with patient/resident b) Notify licensed nurse immediately if above signs & symptoms are noted c) Monitor vital signs b. Myocardial Infarction (MI, heart attack) 1) Definition a) Clot in coronary artery causes a blockage of blood supply to the heart b) Damaged area can no longer function and turns to scar tissue 2) Signs and Symptoms a) Sudden, severe pain in chest usually described as crushing b) Radiating pain to arm, jaw, neck or back c) May present as indigestion or heartburn d) Diaphoresis, cool, clammy skin e) Dizziness f) Pallor/cyanosis g) Dyspnea (short of breath) h) Weak, irregular pulse i) Low blood pressure j) Loss of consciousness k) Nausea/vomiting l) Restless, anxious, feeling of impending doom		

m) Denial 3) Nurse Assistant duties and observations a) Notify licensed nurse immediately if above signs and symptoms are noted b) Remain with patient/resident; place patient/resident in comfortable position; loosen clothing c) Encourage patient/resident to rest d) Reassure patient/resident that help is coming e) Monitor vital signs f) Do not give the patient/resident liquids or food g) Prepare to transfer to acute care facility c. Congestive Heart Failure 1) Definition a) Occurs when the heart does not pump well enough to meet the body's needs b) Normal cardiac output cannot meet the needs for activities of daily living c) Can be left sided or right sided or both 2) Signs and Symptoms a) Hemoptysis (spitting up blood) b) Cough c) Dyspnea d) Orthopnea (difficulty breathing while lying down) e) Fatigue f) Decrease in ability to exercise and be active g) Confusion h) Increased pulse i) Possible irregular heartbeat j) Increased frequency of urination at night k) Cyanosis l) Edema in extremities m) Moist respirations		

n) High blood pressure 3) Nurse Assistant duties and observations a) Low sodium diet b) Raise head of bed c) Fluid restriction (if ordered) d) Anti-embolic stockings e) Assist with ADLs f) Range of motion to improve muscle tone g) Assist with O_2 therapy h) Measure intake and output i) Measure daily weight j) Bedside commode as indicated k) Check vital signs: monitor apical pulse for one full minute; report if it drops below 60 l) Pace activities d. Peripheral Vascular Disease (PVD) 1) Definition a) Condition in which the blood supply to the legs, feet, arms, or hands is decreased due to poor circulation b) Can be arterial or venous 2) Signs and symptoms a) Painful cramping in the hips, thighs or calves when walking b) Painful cramping in the legs that does not go away c) Cyanotic hands or feet (blue or gray tinged) d) Arms and/or legs feel cool or cold to the touch e) Edema in the hands and feet f) Ulcers on the legs or feet (that are slow to heal or don't heal) g) Gangrene 3) Nurse Assistant duties and observations a) Encourage patient/resident to follow special diet/fluid		

restriction b) Record accurately intake and output c) Monitor for increased edema d) Monitor vital signs report any changes (especially pulse and blood pressure) e) Report to nurse any complaints of pain or discomfort in the hands, legs or feet f) Report any type of chest, back, jaw, or shoulder pain or discomfort g) Apply anti-embolic stockings (if ordered) e. Anemia; a condition that results from a decrease in the quantity of quality of red blood cells 1) Signs and symptoms a) Lethargy b) Pale or jaundiced c) Dyspnea d) Digestive problems e) Rapid pulse and increased respiratory rate f) Cold g) Dizzy 2) Nurse Assistant duties and observations a) Provide nutritional meals; increase iron containing foods like red meat and green leafy vegetables b) Notify licensed nurse if signs of bleeding or black stool c) Monitor vital signs d) Observe for and notify if above signs and symptoms appear or worsen f. Hypertension, high blood pressure 1) Signs and symptoms a) Blood pressure elevated above 140 systolic and/or 90 diastolic b) Nosebleed		

c) Eye hemorrhage d) Dizziness e) Trembling f) Red complexion g) Headache h) Blurred vision 2) Nurse Assistant duties and observations a) Monitor blood pressure b) Assist with stress management techniques c) Low sodium diet d) Assist with weight loss efforts e) Encourage regular exercise f) Notify licensed nurse if above symptoms are noted g. Other related subjects (optional): pacemakers, angina, varicose veins, atherosclerosis, internal defibrillation, anemia, blood types D. Musculoskeletal System 1. Anatomy & Physiology a. Bones – hard rigid structures made of connective tissue cells b. Joints – point at which two or more bones meet; allow body movement c. Muscle – allows movement of body parts, maintains posture, and produces body heat 2. Functions a. Gives shape and form, maintains posture, permits movement, protects internal organs, stores calcium and phosphorus, produces heat and produces some blood cells b. Forms framework that supports the body and allows for movement		

3. Common diseases and disorders a. Arthritis; inflammation of the joints 1) Rheumatoid; joint tissue lining is affected 2) Osteoarthritis; cartilage covering ends of bones deteriorates and ends of bones rub together, causing pain and deformity 3) Gout; metabolic disease caused by deposits of crystals at joint due to increase in uric acid 4) Signs and Symptoms a) Pain at joint b) Deformity at joint c) Swelling d) Tenderness e) Heat at inflamed site f) Fatigue 5) Nurse Assistant duties and observations a) Notify licensed nurse if patient/resident requests medication for discomfort b) Balance rest and exercise c) ROM when no pain/inflammation, rest joint if pain/inflammation d) Prevent contractures b. Fractures; break in the continuity of the bone 1) Signs and symptoms (vary with type of fracture) a) Pain, swelling, bruising at fracture site b) Exposed broken bone through skin (compound fracture) c) Immobility of area affected d) Deformity 2) Nurse Assistant duties and observations a) Keep area immobilized (cast, splint) b) Report pain		

c) Reduce edema (elevate area affected) d) Maintain alignment e) Cast care (no breaks, chips, check distal pulses, check color, movement, and sensation distal to cast f) Report signs of infection c. Osteoporosis; caused by lost bone mass and results in porous, spongy bones that are easily fractured. Most common in elderly females 1) Signs and symptoms a) Fracture from very little or no trauma (often in hip or low back) b) Curvature of spine c) Loss of height d) Progressive weakness 2) Nurse Assistant duties and observations a) Prevent further fractures b) Report pain c) Gentle ROM d) Apply splints or braces as ordered e) Encourage high calcium meals (milk, dairy products, and green leafy vegetables) f) Mechanical lift for transfers g) Gentle handling and positioning d. Fractured hip; fracture of the femur, most frequent cause is falling and osteoporosis 1) Signs and symptoms a) Cannot get up after a fall b) Affected side is shortened and externally rotated c) Severe pain in hip or knee d) Edema in hip, thigh and groin 2) Nurse Assistant duties and observations		

a) Pre-surgery hip precautions
- Avoid moving patient/resident until instructed by licensed nurse
- Use sheet or back board to move

b) Post-surgery hip precautions
- Do not flex hip more than 90 degrees
- Do not cross affected leg over midline of body
- Do not internally rotate hip on affected side
- Do not do passive ROM on affected side
- No weight bearing for several weeks after surgery
- Use fracture bedpan
- Maintain proper hip alignment; may use trochanter roll and abduction pillow

4. Other related subjects (optional): fibromyalgia, traction, Continuous Passive Motion (CPM) machine, back injuries (ruptured disk), extremity amputation

E. Endocrine System
1. Anatomy and physiology
   a. Pituitary; master gland
   b. Thyroid; controls metabolism
   c. Pancreas; secretes insulin to promote glucose use by cells
   d. Adrenals; secretes adrenalin (fight or flight hormone)
2. Function; network of glands that secrete hormones into the blood stream
3. Common diseases and disorders
   a. Diabetes Mellitus; chronic disease that results from a deficiency of insulin or a resistance to the effects of insulin
   b. Body is unable to properly process food, and convert food into energy. There are two types of diabetes:

1) Type 1; Insulin dependent diabetes mellitus (IDDM) 2) Type 2; Non-insulin dependent diabetes mellitus (NIDDM) 3) Signs and symptoms a) The 3 polys: polyuria (excessive urination), polydipsia (excessive thirst), and polyphagia (excessive hunger) b) Fatigue c) Skin infections that are slow to heal d) Itching e) Burning on urination f) Vision changes g) Hyperglycemia; caused by inadequate insulin for metabolic needs • Develops slowly (over 24 hour period) • Confusion, drowsiness, slow slippage into coma • Headache • Sweet fruity odor to breath • Deep breathing • Low blood pressure • Nausea or vomiting • Flushed, dry, hot skin • Unconsciousness • Sugar in urine • High blood sugar on glucose monitoring h) Hypoglycemia; occurs when blood glucose is below normal; most commonly from overdose of insulin (insulin shock or insulin reaction)		

• Occurs rapidly • Hunger, weakness, dizziness, shakiness • Moist and clammy • Rapid, shallow respiration • Nervous and excited • Rapid pulse • Unconscious • No sugar in the urine • Low blood sugar glucose monitoring 4) Nurse Assistant duties and observations a) Know signs & symptoms of hyperglycemia and hypoglycemia b) Notify licensed nurse immediately if diabetic symptoms appear c) Offer meals and snacks at regular intervals, report uneaten portions d) Be aware that illness, stress, and infection can make blood sugars increase e) Observe extremities for infection, trauma or wounds (especially feet) f) Notify licensed nurse if patient/resident vomits after meal g) Offer easily assimilated source of carbohydrates if signs of hypoglycemia occur (after notifying licensed nurse) h) Make sure right diet is given i) Urine testing for sugar and acetone (rarely done in LTC now) j) Special foot care • Wash daily, dry between toes • Inspect feet for signs of irritation • Toenails to be cut by licensed nurse or podiatrist only		

• Shoes and stockings to be worn at all time when out of bed (never go barefoot) • Check for anything that impairs circulation • Remember: diet, exercise and medication are the most important components of diabetic treatment 4. Related subjects (optional): hyper and hypothyroidism, Cushing's and Addison's disease, glucose monitoring F. Nervous System 1. Anatomy and Physiology (see handouts) a. Brain (part of CNS) 1) Center of conscious thought and voluntary action 2) Motor coordination 3) Centers of control for respiration, heart function, and body temperature b. Spinal Cord (part of CNS) 1) Transmission of impulses to and from brain 2) Approximately 17 inches long 3) Protected by spinal column (vertebrae) c. Peripheral nerves 1) Transmission of impulses to and from spinal cord 2) Connects the CNS with the various structures of the body d. Sensory organs 1) Eye 2) Nose 3) Tongue 4) Skin 5) Ears 2. Functions		

a. Controls, directs, and coordinates functions of the body b. There are two major divisions; the central nervous system (CNS) and the peripheral nervous system (PNS) 3. Common diseases and disorders a. Dementia; any disorder of the brain that causes deficits in thinking, memory and judgment i. Causes 1. Alzheimer's disease (most common) 2. Multi-infarction dementia (multiple TIAs) 3. Parkinson's disease 4. Syphilis 5. AIDS 6. Nutrition problems 7. Medication problems 8. Depression 9. Metabolic disorders ii. Alzheimer's disease (previously covered): caused by plaques and tangles in the brain's nervous system. Brain decreases in size as cells are lost. Progressive and incurable iii. Signs and Symptoms 1. Stage 1: Mild Dementia a. Short-term memory loss b. Personality changes c. Disorientation to time d. Poor judgment e. Lack of safety awareness f. Careless in appearance g. Anxious, depressed h. Delusions of persecution 2. Stage 2: Moderate Dementia		

- Increased short-term memory loss
- Complete disorientation
- Wandering and pacing
- Sundowning
- Perseveration phenomena
- Motor skills deteriorate
- Speech, reading, writing deteriorates
- Incontinent of bowel and bladder
- Catastrophic episode

c) Stage 3: Severe Dementia

- Totally dependent
- Verbally unresponsive
- May have seizures

4) Nurse Assistant duties and observations for patient/resident with dementia (all types)
   a) Protect patient/resident from injury
   b) Be compassionate, patient, and calm; maintain sense of humor
   c) Encourage independence as long as possible
   d) Provide mental and physical activities within patient's/resident's capabilities
   e) Support patient's/resident's dignity and self-esteem
   f) Provide structured quiet environment that is uncluttered
   g) Use appropriate body language; patient's/resident's will "read" the staff's behavior and reflect the mood of the staff in their own behavior
   h) Give one, short, simple direction at a time
   i) Observe for signs and symptoms of physical ailments; patient/resident may be unaware of illness
   j) Assist patients/residents to maintain a dignified, attractive

appearance by helping with grooming and dressing h) Monitor food and fluid intake a. Do not use plastic feeding utensils b. Provide nutritious finger foods when the patient/resident is unable to use utensils c. Be aware of swallowing difficulties d. Prepare food (butter bread, cut into bites) and encourage patient/resident to feed self as long as possible e. Check food temperatures f. Check patient's/resident's mouth after eating for "pocketing" (hoarding food in the cheeks) g. Weigh patients/residents to detect patterns of weight gain or loss i) Use touch appropriately; surprising patient/resident can result in a catastrophic reaction j) Avoid using logic, reasoning or lengthy explanations k) When ability to speak is lost, patient/resident may communicate through non-verbal means a. Biting, scratching, and kicking to express displeasure b. Facial expressions and body language may express moods c. Observe for what triggers agitation or anger and work on prevention l) Use distraction and diversion when patient/resident is agitated, take hand and calmly walk to another activity m) Realize that people with dementia are not		

responsible for what they say • They cannot change • They are not aware of what they are doing • They have poor impulse control • Allow them to "save face" by preserving their dignity • No one really knows what is happening in the mind of people with dementia q) Be aware of wandering and pacing concerns • Keep record to detect patterns of wandering and pacing • Some triggers are as follows ○ Noise; keep quiet, avoid crowds ○ Boredom; give activities ○ Unmet physical needs; evaluate needs ○ Stress; create calm environment ○ Pain; evaluate for sources of discomfort ○ Hunger; offer frequent snacks ○ Thirst; encourage fluids ○ Need to use restroom; take to restroom at least every two hours ○ Looking for companionship, security, or loved one; therapeutic touch, talk, consistency ○ Physical restraints; feel threatened ○ Looking for a state of mind, not physical location • If they are in an area they shouldn't be, calmly take their hand and redirect them to a safe area • Avoid large numbers of staff approaching patient/resident		

• Use positive directions “stay inside” instead of “don’t go outside” • Use gentle persuasion r) Compliment positive behavior and accomplishments s) Encourage rocking chairs to diffuse nervous energy t) Be aware that “sundowning” (increased agitation and confusion in late afternoon or evening) can occur and how to prevent it • Avoid over-fatigue • Encourage patient/resident to remain awake as much as possible during the day • Evening meal should be at least two hours before bedtime • Eliminate caffeine • Evening activities should be quiet and calm • Soft music is calming • Give massage/back rub • Light bedtime snack • Follow bedtime routine (check with family members) • Check lighting; shadows and reflections can be disturbing u) Discourage “pillaging and hoarding” • Label all patient’s/resident’s belongings to identify if they are taken by confused patient/resident • Check room daily for stale food • Keep patient’s/resident’s hands busy • Provide a “rummaging” drawer or box for patient/resident		

v) Use reality orientation (R.O.) to regain connection to environment • Especially effective in 1st stages of Alzheimer's • Use clock and calendar at bedside • Call by name • Answer questions honestly, but do not give information they are unable to handle; for example ○ The patient/resident asks if their deceased husband is coming to visit ○ Nurse Assistant could respond by saying "tell me about your husband" • Do not argue with patient's/resident's reality • Use bulletin boards decorated for the season • Keep curtains open during the day • Make sure they have their glasses and hearing aids on • Do not expect patient/resident to remember you - identify yourself, as needed w) Use reminiscing therapy • Encourage sharing memories of past events • Use "prompting" questions to show interest in their history • Use active listening skills • Realize the need to reminisce increases as we age • Reminiscing serves as a life review and may validate the worth of their life • Acknowledge validity of feelings and emotions- be comfortable with patient's/resident's tears as well as laughter		

• Reminiscing helps people adapt to aging by maintaining self-esteem and working through personal loss x) Incorporate validation therapy into all your interactions with dementia patient/resident (maintains disorientated person's dignity by acknowledging the person's memories and feeling) • Developed by Naomi Feil • May be a way for patient's/resident's to work through issues from the past that were unresolved • Maintain identity and dignity of patient/resident by having pictures or reminders of who they once were in patient/resident room • Realize there is a reason for all behavior What appears to be confusion could be the person acting on an experience long ago • Disoriented people have a right to express emotions • Living must be resolved in order to prepare for dying • To live in reality is not the only way to live • Disoriented people have worth; they can still experience joy, pleasure and the ability to appreciate kindness • Within each confused person is a human being that was once a child and later an adult with hopes, joys, sadness, failures, and successes. They deserve to be respected, cared for, and loved in their final years • This therapy has been effective on lessening the need for restraints		

y) Incorporate music therapy z) Incorporate animal therapy b. Stroke (brain attack, cerebrovascular accident "CVA"): complete or partial loss of blood supply to cells of the brain 1) Signs and Symptoms a) Loss of sensation b) Paralysis/hemiplegia c) Aphasia d) Dysphagia e) Emotional lability f) Loss of consciousness/confusion g) Cognitive impairments 2) Nurse Assistant duties and observations a) Report changes in Level of Consciousness; headache or change in motor ability to licensed nurse b) Sudden onset of symptoms indicates probable stroke c) Prevent complications of immobility d) Begin Restorative Care; assist with ADLs, encourage patient/resident to do as much as possible e) Be supportive emotionally. Patience is vital! f) Explore alternative methods of communication if unable to speak g) Be aware of swallowing/choking difficulties when feeding h) Incorporate reality orientation into care; clock, calendar, open curtains c. TIA (Transient Ischemic Attack) "mini stroke" 1) Multi-infarction dementia (multiple Transient Ischemic Attack; TIAs)		

2) caused by lack of oxygen to the brain cells 3) Signs & symptoms are temporary and subside when circulation is improved. (See CVA/Stroke) for possible signs & symptoms d. Parkinson's Disease (refer to objective 4) 1) Signs and symptoms a) Tremors and "pill rolling" b) Muscle rigidity c) Difficulty and slowness in carrying out voluntary motor activities d) Shuffling manner of walking e) Slurred speech f) Loss of expressiveness in face g) Drooling h) Incontinence i) Constipation j) Urinary retention k) Mood swings l) Depression 2) Nurse Assistant duties and observations a) Maintain calm environment; symptoms will worsen when patient/resident is under stress b) Assist in ADLs c) Provide emotional support d) Restorative care; exercises e) Dementia care; as above e. Seizure disorder; recurrent, transient attacks of disturbed brain function (refer to objective 4) 1) Signs and symptoms a) Generalized seizure (Grand mal) • May experience "aura" or certain taste before seizure occurs • Jerking and twitching of the body occurs		

• Entire body is involved • May experience loss of consciousness • Incontinence • May be followed by period of fatigue, confusion, disorientation b) Partial seizure (Petit mal) • Momentary loss of muscle tone • May have periods of unconsciousness • May chew, blink, or breathe rapidly • Last 2-10 seconds • "Absence seizures" in children can result in poor learning in school • Only one extremity or part of an extremity may be involved c) Status epilepticus • Seizure lasts for a long period • Serious medical emergency; life threatening • Death may result 2) Nurse Assistant duties and observations a) During a seizure • Stay with person and call for assistance • Assist to lay down • Do not restrain movements or put anything in mouth • Move away objects that may injure a person • Maintain airway by loosening clothing, turn head so saliva/emesis drains to one side, lift shoulder and allow head to tilt back • Watch and observe so you can report type of seizure activity b) After a seizure		

• Allow to sleep • Clean if incontinence has occurred • Check vitals f. Vision impairments; following are common disorders of the eye that cause visual limitation and/or blindness 1) Cataracts; the normally clear lens of the eye becomes cloudy a) Signs and symptoms • Cloudy lens over the eye • Leading cause of vision loss in adults over the age of 55 b) Follow post-op protocol if surgery has been performed 2) Glaucoma; increased pressure within the eye a) Signs and symptoms • Eye pain • Difficulty adjusting to darkness • Unable to detect color • May see “halos” • Headache • Fatigue • Blurred vision 3) Nurse Assistant duties and observations for visual impairments a) Announce yourself by name when entering the room b) Encourage television or radio listening c) Be extra careful in explaining what you are doing d) Describe the food you are going to feed them; is it hot? Cold? Describe food placement like the hands of a clock		

e) Do not disrupt environment; keep ADL supplies in same place and do not move furniture unless necessary f) Encourage independence g. Hearing Impairments 1) Otosclerosis; progressive form of deafness, unknown cause 2) Signs and symptoms - progressive loss of hearing 4. Related subjects (optional): West Nile Virus, Autonomic Dysreflexia, Mad Cow Disease 5. Nervous system complications of inactivity a. Weakness, limited mobility b. Insomnia from sleeping during the day G. Gastrointestinal system 1. Anatomy and physiology a. Mouth, tongue, teeth b. Esophagus c. Stomach d. Small intestine e. Large intestine f. Liver and gall bladder g. Pancreas 2. Functions a. Extends from mouth to anus b. Responsible for breaking food into simpler substances that can then be used by the body cells for nutrition 3. Common diseases and disorders a. Malignancies; cancerous growths in GI tract that can cause obstruction, and may result in surgery and/or an ostomy 1) Signs and symptoms a) Vomiting		

b) Extreme abdominal discomfort c) Indigestion d) Constipation e) Blood in the stool f) Flatus g) No bowel movement at all 2) Nurse Assistant duties and observations a) Monitor bowel movements b) Report discomfort to licensed nurse c) Care of ostomy; artificial opening in the abdominal wall for elimination of solid waste and flatus • Standard precautions • Remove appliance gently to prevent irritation to skin (follow facility policy) • Empty bag and wash if reusable with soap and water • Secure clamp at base • Discard disposable bag in biohazard waste and replace with new bag • Observe stoma for redness, irritation, and skin breakdown (report to licensed nurse if this is noted) • Wipe area around stoma gently after appliance is removed and wash with mild soap and water • Apply creams as ordered • Fit opening of appliance to stoma as needed • When applying appliance, seal well to prevent leaking Observe color, character, amount and frequency of stools, and chart		

- Be matter of fact, avoid looking repelled or disgusted (patient/resident may be self-conscious)

b. Common problems with elimination
   1) Constipation
      a) Abdominal or rectal pain
      b) Inability to pass stool
      c) Loss of appetite
      d) Feel urge to defecate, but unable to pass stool
      e) Bloating
      f) Abdominal distention/hardness
      g) Liquid stool or mucus seeping from rectum
      h) Hard, dry stool
      i) Feces that moves too slowly through the body
      j) Caused by decreased fluids, diet, inactivity, ignoring the urge to defecate
   2) Fecal impaction
      a) Stool is unable to pass from the rectum
      b) Results from unrelieved constipation
   3) Diarrhea
      a) Liquid or unformed stool with increased frequency
      b) Feces that moves rapidly through the intestines
      c) Caused by infection, medications, irritating foods
   4) Bowel incontinence
      a) Inability to control the passage of feces and gas
      b) Possible cause due to injury or diseases of the nervous system or sphincter damage
      c) May result when patients/residents do not receive the assistance they need in a timely manner
   5) Flatulence (gas)
      Excessive formation of gas in the stomach and intestines

b) Caused by foods, medications, or air swallowing c. Nurse Assistant duties and observations 1) Monitor and record bowel movements 2) Notify licensed nurse if above signs and symptoms develop 3) Encouraged high fiber diet for constipation 4) Encourage liquids whenever in contact with patient/resident 5) Encourage exercise to stimulate bowel activity 6) Prompt attention to call light 7) Monitor skin integrity 8) Prompt attention to incontinence care a) NOTE: Nurse Assistants never perform removal of an impaction (digital disimpaction) 4. Related subjects (optional): Diarrhea, bowel incontinence, gall bladder disease, cholecystitis, hernias, ulcerations, bowel training, enemas, rectal tube, hemorrhoids, gastroesophageal reflux disease (GERD) H. Urinary System 1. Anatomy and physiology a. Kidneys; filters the blood, forms urine b. Ureter; tube carrying urine from the kidneys to the bladder c. Bladder; storage for urine d. Urethra; tube for passage of urine to outside during urination (voiding) 2. Functions a. Filters blood and produces urine in which excess fluids and toxins are excreted b. The body excretes 1000 to 1500 ml of urine/day c. Characteristics of normal urine 1) Clear		

2) Amber (medium yellow color) 3) Mild odor 4) Approximately 1000 - 1500 cc in a 24-hour period 3. Common diseases and disorders a. Cystitis; inflammation of the urinary bladder, especially common in women 1) Signs and symptoms a) Dysuria, burning b) Frequent urination c) Cloudy urine d) Hematuria e) Bladder spasm f) Loss of appetite g) Fever h) Confused patient/resident may exhibit agitation 2) Nurse Assistant duties and observations a) Encourage fluids b) Observe for normal urine c) Sitz bath d) Perineal care e) Always wipe front to back (from anterior to posterior) f) Rest b. Urinary incontinence; loss of control of urine 1) Signs and symptoms a) Unable to control urination b) Stress incontinence; urinate when exerting (sneezing, standing up, coughing) 2) Nurse Assistant duties and observations a) Bladder training b) Toilet patient/resident regularly c) Answer call light promptly		

d) Be positive when changing soiled linen or garments, do not be critical e) Perineal care f) Avoid liquids after dinner (if incontinent at night, or to prevent nocturia) 4. Related subjects (optional): renal dialysis, suppression, retention, renal calculi, specimen collection, urinary drainage systems, pylonephritis, renal dialysis I. Reproductive System 1. Anatomy and physiology a. Structures and organs (male): 1) Penis; tissue enlarges during sexual arousal to introduce sperm into vagina 2) Testes; secretes male hormone, produces sperm 3) Prostate gland; secretes fluid necessary for sperm activity 4) Epidiymis; coiled tube on top of testis 5) Vas deferens; stores sperm b. Structures and organs (female) 1) Ovaries; produce female hormone and eggs 2) Fallopian tubes; egg travels through to the uterus 3) Uterus; internal pear-shaped organ in the pelvis; holds fetus during pregnancy 4) Vagina; receives penis during sexual activity 5) Vulva; the external female genitalia 2. Functions a. Reproduction of human life b. Production of some hormones 3. Common diseases and disorders a. Male reproductive system 1) Enlarged prostate gland; urethra passes through prostate, and the prostate enlarges. It “strangles”		

urethra, causing difficulty in starting stream and in emptying bladder completely 2) Cancer of the prostate 3) Cancer of the testes; self-check of the scrotal sac should be done monthly b. Female reproductive system 1) Cystocele; weakening of muscles between bladder and vagina a) Signs and symptoms • Urinary incontinence • Frequent urinary tract infections 2) Rectocele; weakening of muscles between wall of rectum and vagina a) Signs and symptoms • Hemorrhoids (varicose veins of the rectum) • Constipation b) Prolapsed uterus 3) Malignancies a) Breast b) Ovarian c) Uterine d) Cervical c. Nurse Assistant duties and observations 1) Supportive care 2) Notify licensed nurse if distress occurs 4. Sexually transmitted disease a. Human Immunodeficiency Virus (HIV)/AIDS: viral infection transmitted primarily through direct contact with the bodily secretions of an infected person 1) Signs and symptoms a) Flu-like symptoms		

b) Fever c) Night sweats d) Fatigue e) Swollen lymph nodes f) Sore throat g) GI upset h) Headache i) Kaposi's sarcoma j) Pneumocystis carinii pneumonia 2) Nurse Assistant duties and observations a) Be aware that virus is killed by 10:1 water to bleach solution; potency of solution good for three days b) Prevent secondary infections (immunosuppressed) c) Report new symptoms and complaints of discomfort to licensed nurse d) Provide comfort measures 5. Related subjects (optional): vulvovaginitis, tumors of reproductive tract, sexually transmitted diseases (STDs), breast self-exam, testicular self-exam J. Immune System 1. Special cells and substances function to produce immunity a. White blood cells b. Antibodies c. Antigens d. "T" cells - type of cell that destroys invading cells 2. When the body senses an antigen, the immune system is activated 3. Functions to provide the body with immunity; protection against a disease or condition 4. Common diseases and disorders		

a. Acquired Immunodeficiency Syndrome (AIDS); caused by a virus called Human Immunodeficiency Virus (HIV) 1) Spread through certain body fluids a) Blood b) Semen c) Vaginal secretions d) Breast milk 2) Affects the body's ability to fight other viruses and bacteria 3) Signs and Symptoms a) Loss of appetite b) Weight loss c) Fever d) Night sweats e) Diarrhea f) Painful or difficulty swallowing g) Tiredness, extreme or constant h) Skin rashes i) Swollen glands in the neck, underarms, and groin j) Cough k) Sores or white patches in the mouth or on the tongue l) Purple blotches or bumps on the skin that look like bruises but do not disappear m)Confusion n) Forgetfulness o) Dementia 4) Nurse Assistant duties and observations a) Practice standard precautions b) Follow blood borne pathogen standard c) Provide daily hygiene; avoid harsh soaps that		

irritate the skin d) Provide oral hygiene before meals and at bedtime. Make sure the patient/resident uses a toothbrush with soft bristles e) Provide oral fluids as ordered by licensed nurse f) Measure and record intake and output g) Measure weight daily h) Have patient/resident perform deep breathing exercises as ordered i) Practice measures to prevent pressure sores j) Assist with range-of-motion exercises and ambulation as ordered k) Encourage the patient/resident to perform self-care as able. The person may need assistive devices (walkers, commode, eating devices, etc.) l) Encourage the patient/resident to be as active as possible m) Change linens, gowns, or pajamas as often as needed when fever is present n) Be a good listener and provide emotional support 5) Other Considerations a) AIDS is often missed during diagnosis because aging can mask the signs and symptoms of AIDS b) Some persons infected with HIV don't develop AIDS for as long as 10-15 years and may not show signs/symptoms. However, they are carriers and can spread disease to others		
Objective 8: **Describe changes in body systems associated with aging** A. Integumentary System 1. Skin becomes thin, fragile, dry and wrinkled	A. Lecture B. Discussion	A. Written test B. Reports signs and

2. Blood supply to fingers and toes decreases; sensitivity to hot and cold decreases 3. Hair loses color 4. Nails thicken 5. Bruises easily due to fragile blood vessels B. Respiratory System 1. Lung strength decreases 2. Air sacs become less elastic and decrease in number 3. Airways become stiff and less elastic 4. Lung capacity decreases 5. Cough reflex is less effective 6. Cough becomes weaker 7. Gas exchange in lungs is less effective C. Cardiovascular System 1. Blood flow decreases leading to less efficient circulation 2. Blood vessels narrow and lose elasticity 3. Longer recovery to normal pulse after exercise 4. Heart is a less effective pump D. Musculoskeletal 1. Muscles weaken and lose tone 2. Loss of elasticity in muscles 3. Loss of muscle mass causes weight loss 4. Less flexible 5. Bones lose minerals, become porous and brittle (easily broken) 6. Height is gradually lost due to space between vertebrae shrinking; posture slumped 7. Joints are less flexible and stiffer, slows normal body movement 8. Degenerative changes in joints 9. Decreased reflexes: prone to injury and falls E. Endocrine System	C. Handout 13.7- Effects of Aging and Nursing Care Measures	symptoms to licensed nurse

1. Decrease in sex hormones (estrogen and progesterone) signals menopause; testosterone levels decrease 2. Insulin production decreases 3. Metabolism and body functions slow 4. Body is less able to handle stress 5. Body less able to handle sugar 6. Metabolism and body functions slow F. Nervous System 1. Slowing nerve transmission results in delayed reaction time, poor coordination and balance 2. Less effective temperature regulation 3. Decreased sensitivity to pressure and temperature changes 4. Decreased blood flow to brain resulting in memory loss and confusion 5. Deep sleep is shortened, naps are needed G. Gastrointestinal System 1. Decreased saliva production causing dysphagia 2. Taste buds not as sensitive 3. Decreased gag reflex leading to chance of choking 4. Slowed peristalsis leading to indigestion and constipation 5. Increased flatulence 6. Decreased digestive enzymes, avoid dry, fried and fatty foods 7. Decreased ability to absorb nutrients 8. Medication related to side effects 9. Sensitivity to sensation of full bowel 10. Urgency is exaggerated with the bowel H. Urinary System 1. Kidneys decrease in size and are less efficient 2. Bladder loses tone, leading to retention and infection (have patient/resident bear down after voiding to completely empty bladder) 3. Decreased bladder capacity leads to frequency of urination 4. Kidney function increases at rest, causing urination at night		

5. Prostate enlargement in male causes frequency, dribbling, and urinary retention 6. Elderly patient/resident may exhibit behavior changes with usual UTI signs and symptoms 7. Decreased sensitivity to sensation of a full bladder 8. Urgency is exaggerated with the bladder I. Reproductive System 1. Male reproductive system a. Scrotum less firm b. Number and capability of sperm decreases c. Sexual response delayed d. Increase in size of prostate gland e. Hormone production decreases 2. Female reproductive system a. Menopause when menstruation ends b. Decrease production of estrogen and progesterone results in loss of calcium, causing brittle bones and osteoporosis c. Fewer hormones are produced d. Ovulation and menstrual cycle cease e. Vagina becomes thinner, drier f. Breast tissue decreases and muscles supporting breast weaken		

Sample Test: Module 13 - Long Term Care Patient/resident

1. The following are common with otitis media **EXCEPT**
    A. Pain
    B. Hearing loss
    C. Tinnitus
    D. Dizziness

2. Arthritis is
    A. The surgical replacement of a joint
    B. Joint inflammation
    C. A disease in which bones become porous and brittle
    D. The repair of a fracture

3. Tissues die and become black, cold and shriveled. This is
    A. Cancer
    B. Gangrene
    C. Arthritis
    D. Metastasis

4. Which of the following body parts commonly enlarges in the elderly male causing urinary tract obstruction?
    A. Testes
    B. Prostate gland
    C. Ureter
    D. Adrenal gland

5. A malignant tumor
    A. Grows slowly and in a localized area
    B. Can spread to other parts of the body
    C. Invades nearby tissues
    D. Is not cancer

6. A patient/resident has osteoarthritis. The person is overweight. Why is weight loss important for the person?
    A. It will improve the person's mental well-being
    B. The person is too old to be overweight
    C. Weight loss reduces stress on weight-bearing joints
    D. It will be easier to lift and mover the person

7. These statements are about arthritis. Which is incorrect?
    A. It is the most common joint disease
    B. Pain is common
    C. Decreased mobility is common
    D. It is cured with arthroplasty

8. A patient/resident has a fractured right hip. What position is usually not allowed?
    A. Left side-lying position
    B. Right side-lying position
    C. Fowler's position
    D. Semi-Fowler's position

9. The two most common causes of stroke are
    A. Bleeding in the brain and blood clots
    B. Hypertension and diabetes
    C. Infection and accidental injury
    D. Aging and poor nutrition

10. Care of a person after a stroke often includes the following except
    A. Ostomy care
    B. A bowel and/or bladder training program
    C. ROM exercises to prevent contractures
    D. Measures to prevent pressure ulcers

11. Functions lost as a result of stroke depend on
    A. The cause of the stroke
    B. The person's age
    C. The area of brain damage
    D. The person's attitude

12. A patient/resident has heart failure. The doctor is likely to order
    A. A splint or brace
    B. Elastic stockings
    C. Trochanter rolls
    D. A cane or walker

13. When the urinary bladder is removed, a new pathway is needed for urine to exit the body. The new pathway is called a
    A. Urinary diversion
    B. Ureterostomy
    C. Renal pathway
    D. Renal tubule

14. Heart failure means that the heart
    A. Has stopped beating
    B. Is damaged
    C. Cannot pump blood normally
    D. Is old and weak

15. In diabetes, the body lacks or is unable to use
    A. Estrogen
    B. Testosterone
    C. Insulin
    D. Protein and carbohydrates

16. Persons with diabetes need
    A. Good foot care
    B. Frequent oral hygiene
    C. Daily weight measurements
    D. I & O measurements

17. To prevent pressure ulcers, you must:
    A. Keep the person's skin clean and dry
    B. Massage pressure points
    C. Use soap to clean the skin
    D. Scrub and rub the skin during bathing

18. You are applying an elastic bandage to a person's left leg. Which is incorrect?
    A. Position the part in good alignment
    B. Face the person during the procedure
    C. Start at the top (proximal) part of the extremity
    D. Expose the toes if possible

19. A female patient/resident is obese. She is at risk for pressure ulcers in the following areas except.
    A. Between abdominal folds
    B. Under her breasts
    C. Between her legs and buttocks
    D. Her forehead and chin

20. A dressing is loose. What can happen?
    A. Microbes can enter the wound
    B. Wound edges can separate
    C. Dehiscence can occur
    D. The wound can become larger

21. The leading cause of blindness in persons 60 years of age or older is
    A. Glaucoma
    B. Cataract
    C. Eye infection
    D. Age related Macular Degeneration (AMD)

22. A patient/resident has a hearing aid. Which is incorrect?
    A. The hearing aid corrects the person's hearing problems
    B. Hearing aids are costly
    C. Batteries are removed at night
    D. When not in use, the hearing aid is turned off

23. A patient/resident has glaucoma. What do you know about the person's sight?
    A. Print and colors appear faded
    B. The person cannot see to the side
    C. The person is blind in the affected eye
    D. The person's vision is cloudy

24. Which means low blood sugar?
    A. Hyperglycemia
    B. Hypoglycemia
    C. Hyperthyroidism
    D. Hypothyroidism

25. The person with Parkinson's disease needs protection from
    A. Falls
    B. Burns
    C. Poisoning
    D. Cold, damp weather
    E.

26. Risk factors for stroke include the following except
    A. Hypertension and a family history
    B. Diabetes, osteoporosis, and obesity
    C. Heart disease, inactivity, and excessive alcohol use
    D. Smoking and high blood cholesterol

27. The following are common with Parkinson's disease **EXCEPT**
    A. Tremors
    B. Shuffling gait
    C. Facial expression
    D. Flare-ups or relapses

28. With coronary artery disease, the coronary arteries are
    A. Hardened and narrow
    B. Enlarged and less elastic
    C. Infected
    D. Opened or bypassed

29. A hallucination is
    A. A false belief
    B. An exaggerated belief
    C. Seeing, hearing, smelling, or feeling something that is not real
    D. A persistent thought or idea

30. Delirium is
    A. A false belief
    B. The loss of cognitive function caused by changes in the brain
    C. A false disorder of the mind
    D. A state of temporary but acute mental confusion

31. Sundowning is
    A. When signs, symptoms, and behaviors of Alzheimer's disease increase during hours of darkness
    B. The loss of cognitive and social function caused by changes in the brain
    C. A false dementia
    D. A state of temporary but acute mental confusion

32. These statements are about permanent dementia. Which is incorrect?
    A. There is no cure
    B. Loss of cognitive function worsens over time
    C. Disease progression is the same for everyone affected
    D. The person has signs and symptoms of dementia

33. A patient/resident has Alzheimer's disease. She is trying to rub her perineum through her clothes. Which statement is incorrect?
    A. The behavior is sexual
    B. She may be wet or soiled from urine or feces
    C. She may have a urinary or reproductive infection
    D. She may have pain or discomfort in her urinary or reproductive system

34. The Nurse Assistant is providing foot care to a patient/resident with diabetes. What is he/she not allowed to do?
    A. Rub lotion on the patient's/resident's feet
    B. Use an orange stick under the nails
    C. Clip the nails
    D. Check for fungus between the toes

35. A patient/resident has AD. The person has the following behaviors. Which has the greatest risk for danger?
    A. Wandering
    B. Delusions
    C. Catastrophic reactions
    D. Screaming

36. Which is not a risk factor for gastroesophageal reflux disease (GERD)?
    A. Being underweight
    B. Alcohol use
    C. Pregnancy
    D. Smoking

37. What is the greatest risk(s) from osteoporosis?
    A. Fractures
    B. Burns
    C. Infection
    D. Pneumonia

38. The patient/resident has a cast on the right leg. Which action is **INCORRECT**?
    A. Allow the cast to get wet
    B. Use your palms to lift and turn a casted extremity
    C. Turn the person every two hours
    D. Elevate the casted part on pillows

39. The skin is injured. Which is a major threat?
    A. Incontinence
    B. Infection
    C. Gangrene
    D. Evisceration

40. An injury usually from unrelieved pressure is
    A. A wound
    B. A thrombus
    C. Phlebitis
    D. A pressure ulcer

41. Skin tears are caused by the following except
    A. Friction and shearing
    B. Pulling or bumping a body part
    C. Direct pressure on the skin
    D. Incontinence and moisture on the skin

42. The skin or mucous membrane is broken. This is
    A. An open wound
    B. A clean wound
    C. A closed wound
    D. An intentional wound

43. Elastic bandages and elastic stockings do the following except
    A. Promote comfort
    B. Promote circulation
    C. Prevent injury
    D. Prevent infection

44. A patient/resident has cancer. You find him crying in his room. What should you do?
    A. Close the door after leaving the room. He needs to cry in private
    B. Use touch and listening to communicate that you care
    C. Tell the nurse at once
    D. Tell his spiritual advisor what you observed

45. The common causes of chronic renal failure are
    A. Tumors and infections
    B. Hypertension and diabetes
    C. Coronary artery disease and COPD
    D. Severe allergic reactions and severe bleeding

46. Hepatitis A is spread by
    A. Airborne droplets
    B. Blood
    C. The fecal-oral route
    D. Direct contact

47. What is the highest level of anxiety?
    A. Panic
    B. Phobia
    C. Obsession
    D. Compulsion

48. Which is not an early warning sign of dementia?
    A. Getting lost in familiar places
    B. Personality changes
    C. Poor or decreased judgment
    D. Not recognizing self or family members

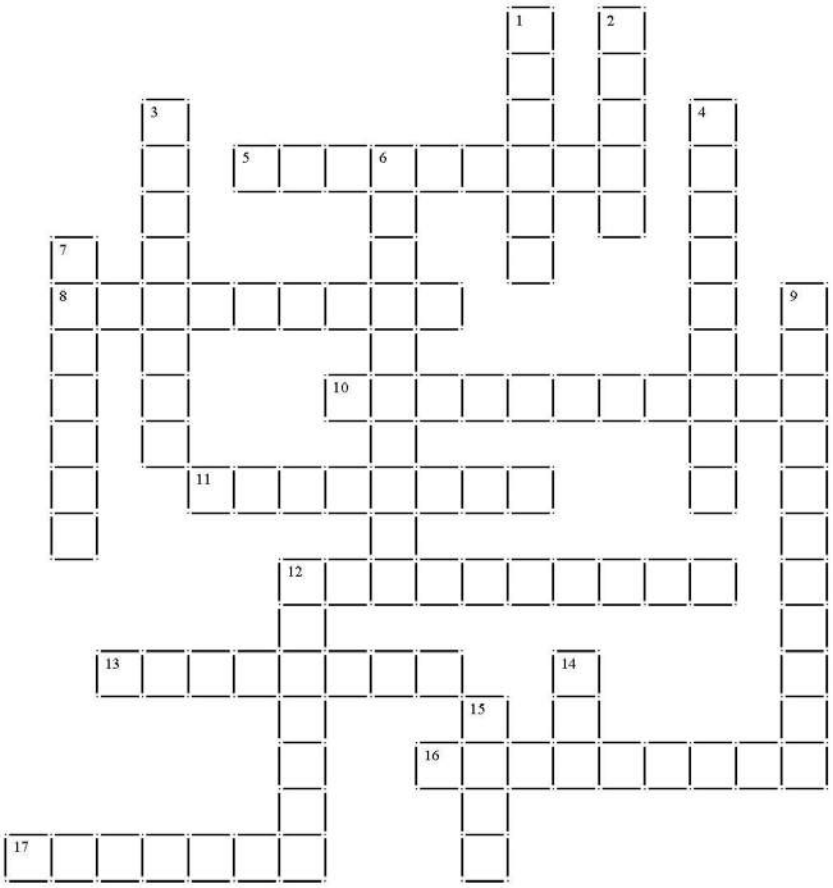
49. A patient/resident is confused. It is time for the person's shower. What should you do?
    A. Explain what you are going to do and why
    B. Ask the person to undress
    C. Ask if the person wants a tub bath or shower
    D. Let the confusion pass before you assist with the person's shower

MANUAL SKILL: Reality Orientation to Promote or Maintain Awareness of Person, Time, Place

SKILL STEPS:

1. Be calm and gentle in approach, face person, and speak clearly and slowly.
2. Address the patient by name with each contact (know how he/she prefers to be addressed).
3. State your name and show your nametag.
4. Tell the person the date and time each morning. Repeat the information as often as necessary during the day and evening.
5. Be patient with repeated instructions.
6. Explain what you are going to do and why.
7. Give clear and simple answers to questions.
8. Ask clear and simple questions. Allow enough time for a response.
9. Keep calendars and clocks with large numbers in the patient's/resident's room and in view in other rooms.
10. Encourage the patient/resident to wear glasses and a hearing aid if needed.
11. Keep glasses, dentures, and hearing aid in same place.
12. Use touch to communicate.
13. Encourage the patient/resident to place familiar objects and pictures within view.
14. Provide newspapers and magazines, read to the individual if appropriate.
15. Discuss current events with the patient/resident.
16. Allow the use of television and radio.
17. Maintain the day-night cycle. Open curtains, shades, and drapes during the day and close them at night.
18. Use a night light at night.
19. Encourage the person to wear regular clothes during the day, rather than gowns or pajamas.
20. Maintain a calm, relaxed atmosphere; avoid loud noise, rushing, or congested hallways and rooms.
21. Maintain a routine for patient/resident for meals, bathing, and activities.
22. Keep furniture in same place.
23. Do not rearrange patient's/resident's belongings.
24. Encourage patient/resident to participate in ADLs.
25. Be consistent with activities by all health care workers.
26. Remind the person of holidays, birthdays, and other special events.
27. Post activity boards and draw attention to it.
28. Post reality orientation boards and draw attention to it.
29. Call attention to color-coding of facility areas.

Long Term Care Resident Crossword



Across

5 Chemical breakdown of food for use by body

8 Loss of function of a part of the body.

10 The smallest blood vessels.

11 Itching.

12 Refers to signs of Alzheimer's Disease during the hours of darkness.

13 A decline in memory and other thought processes.

16 Disoriented to time, place, and person.

17 Wasting of muscle tissue.

Down

1 A condition causing severe pain in the chest.

2 Blood vessels that carry unoxygenated blood.

3 The front part.

4 The back portion.

6 Breathing out.

7 Loss of ability to speak.

9 Breathing in.

12 Referring to organs responsible for sight, hearing, touch, taste, smell.

14 Short for "Congestive Heart Failure"

15 Short for "Chronic Obstructive Pulmonary Disease."

ELEMENTS OF FRIENDSHIP

Friends Know Each Other's History and Personality

In Alzheimer's care, a Best Friend

- Becomes the person's memory.
- Is sensitive to the person's traditions.
- Learns the person's personality, moods, and problem solving style.

Friends Do things Together

In Alzheimer's care, a Best Friend

- Involves the person in daily activities and chores.
- Initiates activities.
- Ties activities into the person's past skills and interests.
- Encourages the person to enjoy the simpler things in life.
- Remembers to celebrate special occasions.

Friends Build Self-Esteem

In Alzheimer's care, a Best Friend

- Gives compliments often.
- Carefully asks for advice or opinions.
- Always offers encouragement.
- Offers congratulations.

Friends Laugh Often

In Alzheimer's care, a Best Friend

- Tells jokes and funny stories.
- Takes advantage of spontaneous fun.
- Uses self-deprecating humor often.

Friends Communicate

In Alzheimer's care, a Best Friend

- Listens skillfully.
- Speaks skillfully.
- Asks questions skillfully.
- Speaks using body language.
- Gently encourages participation in conversations.

Friends Are Equals

In Alzheimer's care, a Best Friend

- Does not talk down to the person.
- Always works to protect the dignity of the person, to "save face."
- Does not assume a supervisory role.
- Recognizes that learning is a two-way street.

Friends Work at the Relationship

In Alzheimer's care, a Best Friend

- Is not overly sensitive.
- Does more than 50% of the work.
- Builds a trusting relationship.
- Shows affection often.

Empathy

Nurse Assistants who demonstrate empathy can deliver service and care more effectively. Empathizing improves communication because the empathetic listener focuses on the feelings of the speaker. Sympathy, sometimes confused with empathy, focuses on the listener's own feelings of being sorry or sad for the other person. Understanding the difference between sympathy and empathy can be difficult. The exercises below will help Nurse Assistants understand the nature of empathy and provide opportunities for them to practice skills that will increase their capacity to experience empathy, demonstrate understanding, reserve judgment, and communicate effectively. When Nurse Assistants have more empathy with patients/residents, as well as with co-workers, the health care setting is more effective and humane.

Physical Limitations

What students will learn:

1. What it is like to experience the signs and symptoms of various physical conditions.
2. To develop empathy with patients and what they are experiencing.

What you will need:

1. Short (3-4 inches) straws that are not very large in diameter. Small cocktail straws work well.
2. Nonprescription eyeglasses with clear lenses that have been coated with petroleum jelly.
3. Gardening gloves
4. Blindfolds for half of the students.
5. Earphones or cotton balls.

What to do:

Instruct students to use the items on the list to create conditions that simulate physical limitations caused by disease, accident, or aging; for example:

1. Give each student a straw and have him/her breathe through the straw for 5 minutes (if they can last that long). This activity will simulate what it is like for a premature baby who struggles for air. It also simulates breathing with lung disorders such as asthma, emphysema, and bronchitis.

2. Have students put on the glasses coated with petroleum jelly to demonstrate what it is like to have a cataract or other vision disorder.
3. Students can wear the gloves and try to perform simple tasks like buttoning a shirt, picking up some coins, writing, opening the wrapper on chewing gum, etc. This activity will help them understand what it is like to have an impaired sense of touch.
4. Give a short lecture while students are wearing earphones or cotton balls in ears to simulate hearing loss. Give a "test" to let them see how much they missed.
5. Blindfold half the students and have the remaining half lead them around campus.
6. Have students maneuver around the classroom using a wheelchair, crutches, walker or cane. Make an obstacle course and time the students when they go through it in a wheelchair. If possible, have students take the wheelchair outside to use it on a sidewalk and other uneven surfaces. Ask the students using assistive devices to open doors by themselves. Have something on the floor for the students to pick up while seated in the wheelchair (be careful they don't fall).

Follow-up Discussion

1. How did it feel to experience a physical limitation?
2. What are the ways you might demonstrate empathy for future patients/residents who have physical limitations?
3. What are some ways that you might help patients/residents who have these limitations?

THE BEST FRIENDS PHILOSOPHY OF COMMUNICATION

- Create an environment that facilitates good communication.
- Do most of the work.
- Do not argue or confront.
- Do not take the person too literally.
- Employ good timing.
- Employ humor in communication.
- Maintain caregiving integrity.
- Make a good first impression.
- Remember the basics of good communication.
- Remember the importance of non-verbal communication.
- Respond to emotional needs.
- Screen out troubling messages or news.
- Speak using positive language.
- Treat the person as an adult.
- Understand the person's desire to communicate.
- Use repetition to facilitate better communication.

AN ALZHEIMER'S DISEASE BILL OF RIGHTS

Every person diagnosed with Alzheimer's disease or a related disorder deserves the following rights:

- To be informed of one's diagnosis.
- To have appropriate, ongoing medical care.
- To be productive in work and play for as long as possible.
- To be treated like an adult, not like a child.
- To have expressed feelings taken seriously.
- To be free from psychotropic medications, if possible.
- To live in a safe, structured, and predictable environment.
- To enjoy meaningful activities that fill each day.
- To be outdoors on a regular basis.
- To have physical contact, including hugging, caressing, and hand holding.
- To be with individuals who know one's life story, including cultural and religious traditions.
- To be cared for by individuals who are well trained in dementia care.

Effects of Aging and Nursing Care Measures Handout

Skin

Changes:

1. Wrinkles (loss of elasticity).
2. Dry and itchy (decrease in skin oils).
3. Chills easily (loss of fatty tissue).
4. Bruises easily (fragile blood vessels).
5. Discoloration, liver spots on back of hands (due to pigments in the hand being exposed to sun).
6. Easily irritated perineal area (decreased lubricant production glands).
7. Dry mouth (decrease in mucus production).
8. Brittle nails.
9. Hair color changes and balding (loss of pigmentation and wearing out-atrophy-of-hair follicles).

Nursing Care Measures:

1. Treat gently to avoid tissue damage, pat dry after bathing.
2. Adequate clothing/bed covering to prevent chilling. Keep environmental temperature constant.
3. Adequate nutrition and fluids.
4. Immobility can cause breakdown at a faster rate.
5. Avoid drying and irritating soaps, use soap sparingly.
6. Aged may not need as frequent bathing.
7. Apply lotion to bony prominences and itchy skin, especially after bathing.

Circulatory system (heart and blood vessels)

Changes:

1. Fatigues easier, loss of oxygen in tissues (heart wears out, heart valves become rigid, leading to decreased output of blood; blood vessels thicken).
2. Hardening of the arteries-arteriosclerosis (due to decreased elasticity of the blood vessels).
3. Fat deposits in heart and blood vessels-arteriosclerosis (due to decreased elasticity of the blood vessels).
4. Fainting-orthostatic hypotension (due to inability of heart and blood vessels to adjust rapidly to changes in position).
5. Increased and sustained blood pressure under stress or strain (heart and blood vessels cannot react fast to react to changes).

6. Faster pulse (due to hardening of arteries).
7. Feet and hands may be cold (due to hardening of arteries in feet and hands).

Nursing Care Measures:

1. Adequate nutrition and fluids.
2. Relief of undue stress and strain; periods of rest and relaxation.
3. Encourage active exercise and mobility to stimulate circulation.
4. Proper positioning if patient is in bed to prevent pressure on blood vessels.
5. Change position of patient frequently every 2 hours. Being in one position too long can cause pooling of blood, and slowing of circulation.
6. Ensure good bowel elimination to prevent strain on the heart from constipation.
7. Give patient time to get used to position changes. Protect from falls or fainting. Aged may need to move more slowly.

Respiratory system (lungs)

Changes:

1. Fatigue, less efficient breathing; must breathe harder and longer (decreased lung capacity, loss of elasticity in lung tissue).
2. Shallow breathing (chest muscle weakens).
3. Ineffective coughing (muscle weakens, less lung capacity).

Nursing Care Measures:

1. Accurate observation of patient's breathing rate and characteristics.
2. Proper positioning to allow for good chest expansion and breathing.
3. Deep breathing exercises.
4. Adequate rest and relaxation, although active exercise helps maintain good breathing and muscle tone.

Muscular system

Changes:

1. Weakness of muscles (muscles wear out-atrophy-because of disuse of muscle groups due to inactivity).
2. Fatigue of muscles, loss of energy reserve (decreased).
3. Shuffling, slow gait (muscle weakness in knees and hips).

Nursing Care Measures:

1. Maintain correct body alignment and positing.
2. Encourage active exercise and ambulation.
3. Adequate nutrition and fluids.
4. Provide for safety; prevent falls-remove scatter rugs from floor and keep paths for ambulation open and free of clutter.
5. Hand rails on walls and in toilets assist in transfer and ambulation.

Skeletal system (bones)

Changes:

1. Bones fracture easily (calcium is lost from bones, bones are porous).
2. Stiffness of joints and ligaments (hardening of tissues in joints).
3. Postural changes, stooped back (degeneration of back bones).

Nursing Care Measures:

1. Elderly are more prone to injury and fractures. Handle gently and take safety precautions to prevent falls.
2. Adequate nutrition-especially foods containing calcium (dairy products).
3. Active exercise helps relieve stiffness.

Digestive system (mouth, stomach, intestines)

Changes:

1. Poor appetite (loss of teeth, decrease in taste and smell).
2. Prone to constipation (loss of muscle tone in stomach and intestines).

Nursing Care Measures:

1. Encourage a balanced diet with adequate protein and bulk foods.
2. Fluids and exercise to help maintain normal bowel function.

Module 14: Rehabilitative Nursing
Minimum Number of Theory Hours: 2
Recommended Clinical Hours: 4

Statement of Purpose:
The purpose of this unit is to introduce the Nurse Assistant to restorative care. Each individual is entitled to reach his/her optimal level of functioning. The Nurse Assistant assists the patient/resident in achieving maximum independent living skills through use of rehabilitative or restorative procedures.

Terminology:

1. Active-assistive range of motion
2. Active range of motion
3. Activities of daily living (ADL)
4. Adaptive
5. Airbed (Kinair, Clinitron, Hill-Rom)
6. Alternating pressure mattress
7. Ambulation
8. Atrophy
9. Bed cradle
10. Cast
11. Contractures
12. Decline
13. Decubitus
14. Disability
15. Egg-crate mattress
16. Embolism
17. Eversion
18. IDT-Interdisciplinary team
19. Heel/elbow protector
20. Fleece pad
21. Flotation pads
22. Foot board
23. Hemiplegia
24. Independence
25. Inversion
26. Joint
27. Open Reduction Internal Fixation (ORIF)
28. Paralysis
29. Paraplegia
30. Passive range of motion
31. Phlebitis
32. Pneumonia
33. Pressure ulcers
34. Prosthesis
35. Quadriplegia
36. Range of Motion (ROM)
37. Restorative care/rehabilitation
38. Risk factors
39. Self-care activities
40. Stasis pneumonia
41. Thrombophlebitis
42. Traction
43. Trochanter rolls
44. Turn, cough, deep breathe (TCDB)
45. Water bed

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of the two- (2) hours of class plus homework assignments and four (4) hours of clinical experience, the learner will be able to:

1. Define key terminology
2. Discuss rehabilitation (restorative care) and how it promotes independence and patient/resident potential
3. State goals of restorative care that promote independence and patient/resident potential
4. Describe the rehabilitation team, state its purpose, and discuss the role of the Nurse Assistant as a member of the team
5. List the responsibilities of the Nurse Assistant in promoting patient/resident self-care
6. List activities that make up Activities of Daily Living (ADLs)
7. List common comfort and adaptive devices and explain the purposes of each
8. Identify steps to prevent complications from inactivity
9. Describe range-of-motion exercises (ROM)
10. Identify procedures and devices used to promote mobility and ambulation for patients/residents with physical and/or visual impairment
11. Discuss relationship between patient's/resident's self-esteem and family involvement in care
12. Discuss the process of documentation and the Nurse Assistant role in care plan meeting

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes E. Handout 14.1a- Rehabilitative and Restorative Care Crossword F. Handout 14.1b- Rehabilitative and Restorative Care Crossword – KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Discuss rehabilitation (restorative care) and how it promotes independence and patient/resident potential.** A. Disability is a physical and/or mental condition which interferes with meeting basic human needs B. Effects of disability related to Maslow's hierarchy 1. Feelings of loss 2. Damage to self-image 3. Loss of self-esteem C. Restorative/rehab care helps disabled individuals return to their	A. Lecture B. Discussion C. Guest speaker on rehab	A. Written test B. Class Participation

highest possible level of physical and psychological functioning; promotes independence 1. Helps patient/resident adjust to the disability 2. Emphasizes abilities – learn new skills and retain old skills 3. Prevention of deterioration – leading to decline in condition 4. Prevents complications – rehab begins when patient/resident first enters facility 5. Identify risk factors contributing to disability		
Objective 3 **State goals of restorative care that promote independence and patient/resident potential.** A. Physical goals of rehabilitation/restorative care and ADLs 1. Maintain present level of function 2. Improve/restore physical function 3. Encourage independence and performance of self-care activities B. Psychosocial goals of rehabilitation/restorative care 1. Adjust to psychosocial effects of disability 2. Recognizes small and simple accomplishments a. Social service referrals b. Job skill development	A. Lecture B. Discussion	A. Written test B. Promotes patient's/resident's independence in self-care activities
Objective 4 **Describe the rehabilitation team, state its purpose, and discuss the role of the Nurse Assistant as a member of the team.** A. Rehabilitation team 1. Rehabilitation is a skilled care provided by licensed therapy staff and their assistants 2. Members a. Patient/resident b. Family members c. Nurse Assistant d. Licensed nursing staff e. Physical Therapist	A. Lecture B. Discussion C. Arrange for guest speaker from a rehab facility D. Show examples of patient/resident rehabilitation plan E. Participate in patient/resident care conference	A. Written test B. Provides patient/resident care consistent with rehabilitation efforts

f. Occupational Therapist g. Speech Therapist h. Physician i. Activity Leader j. Social Worker k. Clergy l. Dietitian B. Purpose of rehabilitation 1. Discuss and evaluate patient's/resident's level of functioning 2. Establish patient's/resident's care plan and goals for rehabilitation 3. Evaluate progress and adjust plan of care to achieve patient's/resident's goals with a greater degree of patient/resident independence 4. Restore the patient/resident to his/her optimal level of functioning C. Nurse Assistant responsibilities as a member of the rehabilitation team 1. Participate in patient/resident care planning conferences 2. Observe and report patient's/resident's responses to care 3. Follow the patient's/resident's care plan 4. Encourage the patient/resident to follow the rehabilitation plan 5. Observe and report early signs and symptoms of complications		
Objective 5 **List the responsibilities of the Nurse Assistant in promoting patient/resident self-care.** A. Protect patient's/resident's rights B. Ensure safety and privacy C. Communicate therapeutically – ask patient's/residents' opinions and let them have control D. Adhere to legal and ethical principles E. Follow instructions of immediate supervisor and plan of care	A. Lecture B. Discussion	A. Written test B. Demonstrates consistent application of Nurse Assistant responsibilities in promoting self-care

F. Report significant changes in patient/resident condition G. Practice appropriate and effective nursing care H. Implement rehabilitative measures as ordered, i.e., ROM, training plan for patient/resident self-care I. Encourage patient/resident independence – praise even small accomplishments J. Provide emotional support and reassurance K. Follow the documentation guidelines L. Concentrate on patient's/resident's abilities M. Use equipment and devices appropriately (cast, prosthesis, walker, cane, wedge for post open reduction internal fixation – hip surgery) N. Protect patient/resident from abuse		
Objective 6 **List activities that make up Activities of Daily Living (ADLs).** A. Daily hygiene, grooming, eating, and self-care activities necessary for normal functioning in society B. Examples: 1. Grooming 2. Dressing 3. Eating 4. Hygiene 5. Elimination – bowel and bladder 6. Mobility/ambulation 7. Self-turning and positioning	A. Lecture B. Discussion C. Clinical observation	A. Written test B. Assist patients/residents in performing ADLs as necessary
Objective 7 **List common comfort and adaptive devices and explain the purposes of each.** A. Comfort devices and their purposes: 1. Footboard; prevents plantar flexion 2. Trochanter roll; prevents external rotation and pressure sores 3. Hard splint; prevents contractures 4. Bed cradle; prevents foot drop	A. Lecture B. Discussion C. Demonstrate devices D. Catalogs from medical stores to show pictures E. Role play students	A. Written test B. Uses adaptive/comfort devices appropriately

5. Trapeze; strengthens muscles and facilitates movement 6. Sheepskin; avoids friction, skin breakdown 7. Heel/elbow protectors; protect against friction, skin breakdown 8. Flotation pads, egg crate mattress, water bed, alternating pressure mattress; Clinitron bed protects pressure points, prevents skin breakdown 9. Pillows and boosters; provide support, positioning, and prevent contractures 10. Cast/traction; keep the affected site in proper alignment, prevent complication B. Adaptive/self-help devices – their purpose and use: 1. Cuffed or swivel-handled utensils, plate guards or holders; eating utensils 2. Long-handled combs/brushes, button hooks, sock puller, specially designed clothing; hygiene and grooming aides 3. Reachers, telephone holder, communication boards; promote independence 4. Artificial limbs, application, care and removal 5. Casts and splints; immobilization, alignment, and support, cast care	assisting disabled persons with adaptive devices F. Return demonstration on range-of-motion manual skills and care of casts G. Manual Skills 14.7- Providing Cast Care	
Objective 8 **Identify steps to prevent complications from inactivity.** A. Complications 1. Types: a. Neurological (stress, depression, changes in behavior, sleep disturbances) b. Respiratory (stasis pneumonia or atelectasis) c. Circulatory 1) Thrombophlebitis 2) Pulmonary embolism d. Musculo-skeletal 1) Contractures – are permanent 2) Osteoporosis – demineralization due to lack of weight bearing 3) Muscle atrophy	A. Lecture B. Discussion	A. Written test B. Uses appropriate methods to prevent complications from inactivity

e. Integumentary (pressure sores) f. Gastro-intestinal (constipation and decrease of appetite) g. Genito-urinary (kidney stones, urinary tract infection) h. Psychosocial (loneliness, depression) 2. Causes: a. Bed rest b. Prolonged illness c. Immobility due to injury d. Surgery B. Preventive methods 1. Turning/repositioning 2. TCDB (turn, cough, and deep-breathing exercises) 3. Body alignment 4. Range of motion 5. Supportive devices 6. Skin care 7. Encouraging patient/resident independence 8. Toileting 9. Bowel and bladder training 10. Elastic stockings 11. Ambulation is best a. Maintains muscles and bones; moves joints b. Reduces pressure on the skin c. Increases circulation d. Increases respiratory and heart function e. Improves bowel function and promotes emptying of bladder f. Promotes independence and self-esteem g. If patient/resident cannot walk, at least stand, or transfer them to a chair		

Objective 9 **Describe range-of-motion exercises (ROM).** A. Range of motion is movement of joints through their normal range of movement to the point of resistance or discomfort B. Purpose 1. Maintain muscle strength 2. Stimulate circulation 3. Maintain body alignment and make positioning easier 4. Prevent thrombophlebitis 5. Prevent contractures C. Frequency 1. At least three times each day with at least three repetitions of each movement of the joint 2. As indicated in the care plan D. Technique 1. Active ROM a. Best b. Patient/resident moves own joints through their normal range of movement c. Maintains muscle 2. Passive ROM a. Nurse Assistant moves the patient's/resident's joints through their normal range of movement to the point of resistance or discomfort b. Still gets muscle atrophy 3. Active assistive ROM - the Nurse Assistant helps the patient/resident move his/her joints through their normal range of movement to the point of resistance or discomfort or the patient/resident uses a resistive device E. General rules to avoid injury 1. Exercise joint correctly 2. Avoid unnecessary exposure of patient/resident 3. Use good body mechanics	A. Lecture B. Discussion C. Demonstrate ROM; active and passive D. Manual Skills 14.9a - Range of Motion exercises E. Manual Skills 14.9b - Performs passive range of motion - PROM for one knee and one ankle F. Manual skills 14.9c - Passive range of motion- PROM for one shoulder	A. Written test B. Performs basic range of motion exercises correctly

4. Fully support each extremity 5. Move joint slowly, smoothly and gently 6. Do not force the joint to move past the point of resistance or patient/resident discomfort 7. Do not cause the patient/resident to have pain 8. Report patient/resident complaint of pain to the licensed nurse		
Objective 10 **Identify procedures and devices used to promote mobility and ambulation for patients/residents with physical and/or visual impairment.** A. Things to check to determine if patient/resident can be more independent 1. Physical strength and ability 2. Available special training 3. Assistive devices 4. Financial resources 5. Cognitive ability 6. Motivation B. Procedures 1. Transfer techniques – review from Module 5 a. Follow facility policy on lifting and transferring b. Patient/resident weight above 100 lbs. requires two person assists c. Patient/resident with osteoporosis should be transferred using manual team lift 2. Gait training 3. Training in self-transfer techniques 4. Use of gait belt for ambulation 5. Check to see if the patient/resident can sit unassisted and steadily, as well as stand a few seconds alone C. Assistive devices 1. Cane 2. Walker 3. Wheelchair	A. Lecture B. Discussion C. Role play various physical and visual impairments. Have students discuss how they felt and what devices or procedures would help them D. Demo, practice E. Review video showing techniques as needed	A. Written test B. Uses assistive devices and procedures appropriately

4. Transfer board 5. Braces, splints, and prostheses 6. Service animals (Seeing Eye and Hearing Ear dogs) 7. Braille 8. Modifications to accommodate wheelchair access 9. Disabled parking D. Care and use of adaptive, assistive, and orthotic devices		
Objective 11 **Discuss relationship between patient's/resident's self-esteem and family involvement in care.** A. Basic needs as defined by Maslow which can be met by involving the patient/resident and his/her family in developing and participating in the plan of restorative care 1. Love/belonging/affiliation needs 2. The need for self-esteem 3. The need for self-actualization B. Methods of assisting the patient/resident to meet these needs – therapeutic communication 1. Promote interaction between the patient/resident, the family, and the rehabilitation team 2. Treat the patient/resident and family with respect and dignity 3. Be supportive of the patient/resident and his/her family and use praise as appropriate to reinforce progress 4. Encourage patient/resident independence 5. Use a positive approach to restorative plan	A. Lecture B. Discussion	A. Written test B. Practices consistent, effective therapeutic communication with patients/residents and their families
Objective 12 **Discuss the process of documentation and the Nurse Assistant role in care plan meeting.** A. Nurse Assistant helps the team members in completing the Patient/resident Assessment Instrument (RAI) as mandated by federal government	A. Lecture B. Discussion	A. Written test B. Assist student to

B. RAI consist of three parts: 1. Minimum Data Set 3.0 (MDS 3.0) – assessment tool 2. Triggers – condition that identifies problem (risk factors) that may require care plan 3. Patient/resident Assessment Protocol (RAPs) – list of information and guidelines that will link to care plan goals C. MDS Assessment is utilized and completed upon admission, quarterly, annually, and when there is a significant change in condition D. Nurse Assistant will provide information to complete the appropriate section(s) of the MDS E. Care Plan will be reviewed during IDT meeting F. Team discusses the appropriate interventions; updates the information that reflects current patient/resident functioning G. Nurse Assistant contributes valuable information because of being the direct patient care provided, especially in the areas of activities of daily living	C. Sample minimum data set 3.0 Form D. Download MDS form at http://www.cms.hhs.gov/ E. Show sample of Care Plan Form	review the patient/resident clinical record under MDS section and Care Plan section of the record C. Interpret the codes as appropriate that reflect patient/resident functioning

Sample Test: Module 14- Rehabilitative Nursing

1. Rehabilitation
    A. Assists the patient/resident to attain his/her highest level of ability
    B. Requires the services of only licensed personnel to be successful
    C. May be provided in the hospital, subacute unit, home, or skilled care facility
    D. All of the above

2. OBRA regulation requires:
    A. Hospitals to provide rehabilitation services
    B. Skilled nursing facilities to provide restorative care
    C. Patients to participate in rehabilitation programs
    D. Restorative care for alert patients/residents only

3. The main therapy that assists patients/residents to re-learn activities of daily living is:
    A. Physical therapy
    B. Speech therapy
    C. Occupational therapy
    D. Cognitive therapy

4. Which of the following is **NOT** an activity of daily living?
    A. Ambulating
    B. Taking medications
    C. Dressing
    D. Toileting

5. A complication of immobility that affects the musculoskeletal system is:
    A. Contractures
    B. Pressure sores
    C. Thrombus
    D. Pain

6. A complication of immobility that affects the gastrointestinal system is:
    A. Hemorrhoids
    B. Constipation
    C. Diarrhea
    D. Confusion

7. A psychological reaction to immobility is:
    A. Euphoria
    B. Delusions
    C. Depression
    D. Schizophrenia

8. A verbal cue is:
    A. Telling the patient/resident how to perform a procedure
    B. Specific instruction on how to perform a skill
    C. A thorough explanation of a self-care technique
    D. A short, simple phrase to prompt the patient/resident

9. Continuity and consistency of care means that all staff:
    A. Use variations in approaches to the patient/resident
    B. Use the same approaches when caring for the patient/resident
    C. Choose which staff members will work together in the care of the patient/resident
    D. Agree on the plan of care that is needed by the patient/resident

10. If completing an entire task is too difficult for a patient/resident in a restorative program:
    A. Stop trying, and complete the task yourself
    B. Provide total care, which is easier for the patient/resident
    C. Ask the charge nurse (RN/LVN) what you should do
    D. Break the task into a series of smaller tasks

True and False

11. Using the care plan is a key to success when caring for patients/residents in rehabilitation and restorative programs.
12. For effective restorative care, there must be a continuity of care between caregivers and between shifts.
13. Edema will develop if the patient/resident is very active.
14. Emphasize the individualism, value, and worth of each patient/resident.
15. Avoid comparing patients/residents and their progress.
16. People with disabilities are special and should be treated differently from other patients/residents.
17. Patients/residents who are newly disabled adapt as easily to their problems as people who have lived with their disability a long time.
18. People with disabilities are not capable to doing the same things that other people do.
19. One of the goals of restorative care is to prevent complications.
20. Restorative care is designed to maintain the patient's/resident's current abilities.
21. One of the goals of providing rehabilitation services to a patient/resident with quadriplegia is to teach the patient to walk again.
22. Patients/residents with spinal cord and brain injuries cannot benefit from a rehabilitative program.
23. Patients/residents with arthritis may benefit from rehabilitation.
24. A patient/resident who has been in bed for a long time will not benefit from a rehabilitative program.
25. Some rehabilitative programs are designed for geriatric patients/residents.
26. Grooming is not important to the restorative program.
27. The patient's/resident's sexuality is respected in the restorative environment.
28. Restorative care is part of the assessment item in the Minimum Data Set.

MANUAL SKILL: Providing Cast Care

EQUIPMENT:

Pillows
Pillow cases
Plastic pillow covers

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Care of newly casted patient/resident:
   A. Support cast with two (2) pillows covered with plastic cover and cloth pillowcase. Keep cast elevated and uncovered.
   B. Observe fingers or toes of casted limb for swelling, cyanosis, or coldness. Ask patient/resident if he/she feels pain, tingling or numbness. Report to licensed nurse immediately if above symptoms are present.
   C. Use palms of hands if cast must be moved, not fingers, they will indent soft drying cast.
   D. Check skin area around cast edges for signs of irritation (red, dry, itching, scratching). Notify licensed nurse if edges of cast need to be taped or padded.
2. After cast is dry:
   A. Support cast with pillows or sling as ordered.
   B. Turn patient/resident according to facility policy.
   C. Promote independence; encourage use of overhead (trapeze) bar to assist patient/resident in helping self.
   D. Perform capillary check of toes or fingers on casted extremity.
   E. Check skin areas around edge of cast for redness or abrasions.
   F. Observe for unusual odors or areas of warmth on the surface of the cast.

G. Do not allow any objects such as coat hangers to be inserted into the cast for scratching.
H. During elimination, use plastic wrap to protect edges of cast near genitals and buttocks to prevent soiling from urine or feces.
I. Check with licensed nurse for bathing procedures. You may need to wrap entire casted area with plastic bag so patient/resident can be showered.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Range-of-Motion Exercises

EQUIPMENT:

Bath blanket

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

SKILL STEPS:

1. Raise bed to working height.
2. Lower rail on the side you will be working on
3. Position the patient/resident in supine position and in good alignment.
4. Cover the patient/resident with a bath blanket. Fan fold linen in the foot of the bed.
5. Determine the areas to be exercised, full body or extremities only. (See patient/resident care plan for specific instructions as to areas to exercise). Move joints through normal range of motion to point of resistance or discomfort; do not force joint to point of pain. Each joint should be moved through its ROM at least three times.
6. Instructs client to inform Nurse Assistant if pain is experienced during exercise.
7. To exercise the shoulder moving joints slowly, gently and smoothly:
   A. Support the arm by grasping the wrist with one hand and elbow with the other.
   B. Flexion, raise the arm straight in front and over the head.
   C. Extension, bring the arm down to the side.
   D. Hyperextension, turn the patient/resident to the side and move the top arm behind the body. (If the person is sitting in a straight chair or standing, move the arm behind the body). Turn patient/resident back to supine position to continue.
   E. Abduction, move the straight arm away from the side of the body.
   F. Adduction, move the straight arm to the side of the body.

   G. Internal rotation, bend the elbow to a 90-degree angle and place it at the same level as the shoulder. Keeping the angle of the elbow constant, move the forearm down toward the lower body.
   H. External rotation, reverse the procedure, moving the forearm toward the head.
8. To exercise the elbow:
   A. Grasp the patient's/resident's wrist with one hand and the elbow with the other.
   B. Flexion, bend the arm so that the same-side shoulder is touched by the patient's/resident's thumb.
   C. Extension, straighten the arm.
9. To exercise the forearm:
   A. Pronation, turn the hand so that the palm is down.
   B. Supination, turn the hand so that the palm is up.
10. To exercise the wrist:
   A. Hold the wrist firmly with both of your hands.
   B. Flexion, bend the hand down.
   C. Extension, straighten the hand.
   D. Hyperextension, bend the hand back.
   E. Radial flexion, turn the hand toward the thumb.
   F. Ulnar flexion, turn the hand toward the little finger.
11. To exercise the thumb:
   A. Hold the patient's/resident's hand with one hand and the thumb with your other hand. (Support the wrist of the hand being exercised).
   B. Abduction, move the thumb out from the inner part of the index finger.
   C. Adduction, move the thumb back next to the index finger.
   D. Opposition, touch each fingertip with the thumb.
   E. Flexion, bend thumb into hand.
   F. Extension, move the thumb out to the side of the fingers.
12. To exercise the fingers:
   A. Abduction, spread the fingers and the thumb apart.
   B. Adduction, bring the fingers and thumb together.
   C. Extension, straighten the fingers so that the fingers, hand, and arm are straight.
   D. Flexion, make a fist.
13. To exercise the hip:
   A. Place one hand under the knee and the other under the ankle to support the leg.
   B. Flexion, raise the leg.
   C. Extension, straighten out the leg.
   D. Abduction, move the leg away from the body.
   E. Adduction, move the leg toward the other leg.
   F. Internal rotation, turn the leg inward.

   G. External rotation, turn the leg outward.
14. To exercise the knee:
   A. Place one hand under the knee and the other under the heel to support the foot and ankle. Slide the hand supporting the foot up toward the thigh while lifting the knee.
   B. Flexion, bend the knee.
   C. Extension, straighten the knee.
15. To exercise the ankle:
   A. Place one hand under the heel with foot supported by forearm and the other under the ankle to support the ankle.
   B. Dorsiflexion, lean toward head of bed, bringing foot into dorsiflexion.
   C. Plantar flexion, with supporting hand, move heel downward, plantar flexing the foot.
16. To exercise the foot:
   A. Eversion, turn the outside of the foot up and the inside down.
   B. Inversion, turn the inside of the foot up and the outside down.
17. To exercise the toes:
   A. Flexion, curl the toes.
   B. Extension, straighten the toes.
   C. Adduction, pull the toes together.
   D. Abduction, spread the toes apart.
18. Cover the leg and raise the side rail.
19. Go to the other side. Lower the side rail and repeat the range of motion beginning at the shoulders.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILLS: Performs Passive Range of Motion (PROM) for One Shoulder

Equipment:

None

Beginning Skills:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
6. Provide for privacy with a curtain, door, or screen.

Skill Steps:

1. Instruct client to inform candidate if pain is experienced during exercise.
2. Supports client's upper and lower arm while performing range of motion for shoulder
3. Raises client's straightened arm from side position upward toward head to ear level and returns arm down to side of body (flexion/extension) (AT LEAST 3 TIMES unless pain is verbalized). Supporting the limbs moves joint gently, slowly, and smoothly through range of motion, discontinuing exercise if client verbalizes pain.
4. Moves client's straightened arm away from the side of the body to shoulder level and returns to side of body (abduction/adduction) (AT LEAST 3 TIMES unless pain is verbalized). Supporting the limbs moves joint gently, slowly, and smoothly through range of motion, discontinuing exercise if client verbalizes pain.

Ending Steps:

1. Position patient/resident comfortably.
2. Place call light within reach.
3. Lower bed to safe position for the patient/resident.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

MANUAL SKILLS: Performs Passive Range of Motion (PROM) for One Knee and One Ankle

Equipment:

None

Beginning Steps:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible
6. Provide for privacy with a curtain, door, or screen

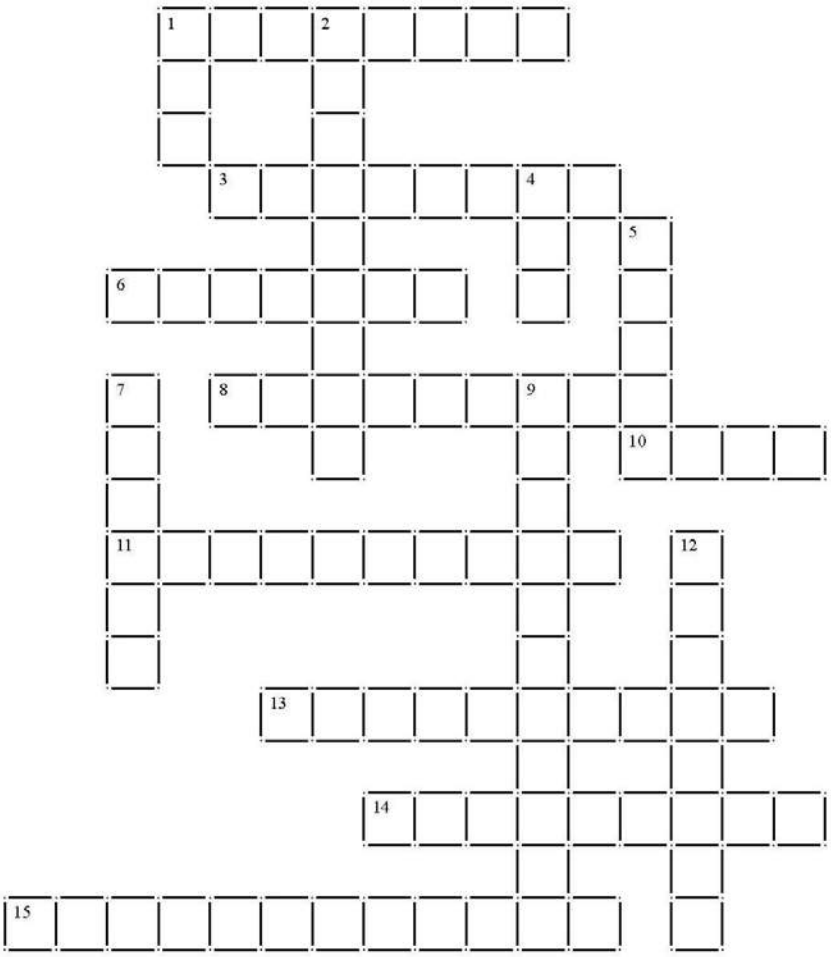
Skill Steps:

1. Instructs client to inform candidate if pain is experienced during exercise.
2. Supports leg at knee and ankle while performing range of motion for knee.
3. Bends the knee and then returns leg to client's normal position (extension/flexion) (AT LEAST 3 TIMES unless pain is verbalized).
4. Supports foot and ankle close to the bed while performing range of motion for ankle.
5. Push/pull foot toward head (dorsiflexion) and push/pull foot down, toes point down (plantar flexion) (AT LEAST 3 TIMES unless pain is verbalized).
6. While supporting the limb, move joints gently, slowly, and smoothly through the range of motion, discontinuing exercise if client verbalizes pain.

Ending Steps:

1. Position patient/resident comfortably.
2. Place call light within reach.
3. Lower bed to safe position for the patient/resident.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

Rehabilitative-Restorative Care Crossword



Across

1. Devices used to help someone adjust to their environment.
3. Physical force on a body part.
6. Not active.
8. A special type of bed.
10. Short for “turn, cough, and deep breath.”
11. A physical handicap which prevents someone from engaging in certain activities.
13. Walking.
14. Helpful; referring to devices.
15. Shortening of a muscle causing limited movement of a joint.

Down

1. Short for “activities of daily living.”
2. Inflammation of a vein.
4. Short for “range of motion.”
5. Where one bone connects with another bone.
7. A wire frame placed over the lower part of the bed.
9. Return to a normal condition.
12. A clot or substance in blood vessel causing obstruction.

Module 15: Observation and Charting
Minimum Number of Theory Hours: 4
Recommended Clinical Hours: 4

Statement of Purpose:
The purpose of this unit is to prepare students to know how, when, and why to use objective and subjective observation skills. They will report and record observations on appropriate documents using medical terms and abbreviations.

Terminology:

1. Abbreviation
2. Activities of Daily Living (ADL)
3. Assessment
4. Assessment Reference Day (ARD)
5. Incident report
6. Kardex
7. Minimum Data Set (MDS)
8. Objective
9. Observation
10. Paraprofessional Healthcare Institute (PHI) http://phinational.org/about/
11. Prefix
12. Range of Motion (ROM)
13. Resident Assessment Instrument (RAI)
14. Resident Assessment Protocol (RAP)
15. Patient/resident care plan
16. Root word
17. Subjective
18. Suffix

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):
Upon completion of the four (4) hours of class plus homework assignments and four (4) hours of clinical experience, the learner will be able to:

1. Define key terminology
2. Identify word elements used in medical terms
3. Identify medical terminology and abbreviations commonly used in medical facilities
4. Define observation and list the senses used to observe a patient/resident.
5. Describe objective and subjective observations
6. List types of charting documents and the use for each
7. Explain how to accurately complete ADL assessment for MDS
8. Discuss procedures to use when recording on a patient's/resident's chart

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes E. Handout 15.1a- Observation and Charting Crossword F. Handout 15.1b- Observation and Charting Crossword- KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Identify word elements used in medical terms.** A. Medical words are composed of several small words or word elements B. Word elements 1. Root 2. Prefix 3. Suffix 4. Combining vowel	A. Lecture/Discussion B. Handout 15.2- Prefixes and Suffixes	A. Written test B. Class participation

Objective 3 **Identify medical terminology and abbreviations generally used in medical facilities.** A. Identify medical terminology and abbreviations from list determined by instructor B. Abbreviations are/may be 1. A shortened form of words or phrases 2. Commonly used in health care settings 3. Designations for medical specialty areas: ER, OR, OB, etc. 4. Shortened forms of a word or the first letters of a word: amb, BRP, lab, etc. 5. A shortened form of a Latin or Greek word: ad lib, prn, po, etc. C. Refer to facility policy on approved abbreviations	A. Lecture B. Discussion	A. Written test B. Class participation C. Uses correct terms and abbreviations in charting
Objective 4 **Define observation and list the senses used to observe a patient/resident.** A. Observation – use of senses to collect information about a patient/resident 1. Senses used for evaluation a. Sight b. Touch c. Hearing d. Smell 2. Observations should be made with regard to a patient's/resident's a. Skin color and temperature b. Mood and mental status c. Behavior, movement d. Unusual odors e. Respiration f. Ability to respond g. Appetite h. Performance of ADL i. Elimination j. Pain or discomfort Learn to observe the patient/resident throughout daily contacts noting any changes or needs 4. Report all changes or needs to licensed nurse	A. Lecture/Discussion B. Role-play a scene and have students write down their observations when scene is over	A. Written test B. Class participation

B. ABCs of observation 1. Appearance 2. Behavior 3. Communication		
Objective 5 **Describe objective and subjective observations.** A. Objective 1. Signs that you can see, hear, feel and smell 2. Factual, measurable and/or observable signs B. Subjective 1. What the patient/resident tells you 2. Not directly seen (observed) by the nurse assistant 3. Symptoms reported by patient/resident	A. Lecture/Discussion B. Develop lists of observable signs and statements from client and items that would not have been observed directly. Ask students to label as Objective or Subjective	A. Written test B. Class participation
Objective 6 **List types of charting documents and the uses for each.** A. Patient/resident record and patient's/resident's chart 1. Communicates and records health history, status, and treatment 2. A legal record B. Patient care summary/care plan 1. Summarizes physician's orders 2. Identifies critical data such as allergies, code status, diet, activity, etc. 3. Gives medication and treatment information C. Nursing care plan 1. Lists patient's/resident's need and provides specific nursing activities that address the patient's/resident's needs 2. A guide for the Nurse Assistant for delivering care D. Graphic sheet - used in some facilities to document	A. Lecture/Discussion B. Examples of Mock Charts E. Example of Patient care summary/care plan C.	A. Written test B. Class participation

1. Vital signs 2. Intake and output 3. Weight E. ADL sheet 1. Used to document care at each shift for activities of daily living 2. The record on which most facilities have the care work chart		
Objective 7 **Explain how to accurately complete ADL assessment for MDS.** A. Minimum Data Set (MDS) 1. Mandated assessment tool by Federal regulation (483.20 (b)) and (F272) to give facility structured, standardized approach to care 2. Basis for payment/or reimbursement to the facility B. Patient/resident Assessment Instrument (RAI) 1. Each facility must use its state-specified RAI to assess newly admitted patients/residents, conduct an annual reassessment and assess those patients/residents who experience a significant change in status 2. The facility is responsible for addressing all needs and strengths of patients/residents regardless of whether the issue is included in the Minimum Data Set (MDS) or Patient/resident Assessment Protocol (RAPs) 3. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the patient/resident C. MDS Section G refers to physical functioning and structural problems 1. Bathing 2. Functional limitation in Range of Motion 3. Modes of Transfer D. Assessment Reference Day (ARD) 1. ARD – set date for the last day of assessment period 2. Assessments are made during the seven days preceding the ARD (the look back period) 3. Example: ARD is Jan. 8. Therefore, the look back period of observation will start from Jan. 2 until Jan. 8	A. Lecture/Discussion B. Refer to MDS form Section G Appendix 7.5. ONLINE FORM C. Refer to Appendix H-MDS Version 3.0 All Forms Access form at http://www.cms.hhs.gov/nursinghomequalityinits/	A. Written test B. Class participation C. Document patient/resident ADL functioning using the ADL flow sheet

E. Two categories of ADL section: 1. Patient/resident ADL Self-performance - what the patient/resident actually did for himself or herself and/or how much verbal or physical help was required by staff members during all shifts 2. Patient/resident ADL support provided or needed F. The reporting of the Nurse Assistant on changes in patient/resident assessment may "trigger" (identify) a problem that needs evaluation and require care planning by the licensed nurse G. Coding for ADL Self-performance: 1. 0: Independent – no help or staff oversight –OR – staff help oversight provided. Only one or two times during the last seven days 2. 1: Supervision – oversight, encouragement, or cueing provided three or more times during the last seven days – OR – supervision (three or more times) plus physical assistance provided, but only one or two times during the last seven days 3. 2: Limited Assistance – patient/resident is highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance on three or more occasions – OR – limited assistance three or more times), plus more weight-bearing support provided, but for only one or two times during the last seven days 4. 3: Extensive Assistance – while the patient/resident performed part of the activity over last seven days, help of following type(s) was provided three or more times: a. Weight bearing support three or more times b. Full staff performance of activity (three or more times) during part (but not all) of last seven days 5. 4: Total Dependence – full staff performance of the activity during entire seven-day period. There is complete non-participation by the patient/resident in all aspects of the ADL definition task 6. 8: Activity did not occur – over the last seven days, the ADL		

activity was not performed by the patient/resident or staff. In other words, the particular activity did not occur at all H. ADL support provided: 1. 0 – No set up or physical help from staff 2. 1 – Set up help only 3. 2 – One-person physical assist 4. 3 – Two + persons physical assist 5. 8 – ADL activity itself did not occur during entire seven days		
Objective 8 **Discuss procedures used when recording on a patient's/resident's chart.** A. Charting procedures 1. Make sure you have the correct chart or ADL sheet 2. Write legibly and neatly a. Write notes on paper first b. Check for accuracy and spelling 3. Place events in proper sequence 4. Chart according to facility/policy standards 5. Be concise and use appropriate terms and abbreviations 6. Always use ballpoint pen a. Black ink b. No felt tip, fountain pens, pencils or gel pens c. Use color only if approved in facility policy 7. Errors – cross out with one line a. DO NOT ERASE OR USE WHITEOUT b. Write "error" above the line c. Initial the entry 8. Include patient's/resident's complete information on each page a. Some facilities have imprint stampers b. If not, write in patient's/resident's name and any other information as the facility mandates 9. Never skip lines 10. Signature example; J. Jones, Nurse Assistant or R. Smith, NA.	A. Lecture/Discussion B. Handout 15.8- Charting Guides C. Use chart forms from facilities for charting exercises	A. Written test B. Class participation C. Documents observations promptly and correctly according to facility policy

11. Always date and time entries – or make sure you are charting under correct date and time 12. Chart only procedures YOU HAVE PERFORMED – and only after you have performed the procedure 13. Never chart for someone else 14. Chart only those observations which you know to be true (objective data) a. Do not chart opinions b. Subjective data must be in quotation marks and exactly as the patient/resident states B. Computers and charting 1. Some facilities may have a computerized charting system 2. Basic principles of charting apply – confidentiality and privacy are important issues 3. Systems are password protected a. Each user receives a personal password b. Never share and/or use others' passwords c. Sharing/using another's password may be grounds for termination C. Legal issues of charting 1. Patient's/resident's record is a legal document; it can be used in a court of law 2. Information in the chart must be kept confidential 3. Information in the chart should be accurate, objective and truthful 4. The Nurse Assistant has access only to the charts of the patients/residents for whom they are caring		

Sample Test: Module 15- Observation and Charting

1. Which of the following most completely defines observation?
   A. Watching the activities of the patient/resident
   B. Listening to the patient/resident and to staff reports
   C. Reading the charts and records
   D. Gathering patient/resident information by using the four main senses

2. An error made while writing in the patient's/resident's chart is corrected by:
   A. Crossing out the mistake until it can no longer be read
   B. Tearing out the sheet of paper in the chart and write on a new one
   C. Drawing a line through the wrong entry and write an explanation of why it was an error
   D. Drawing a single line through the entry, writing the word "error" above the line, and initial the entry

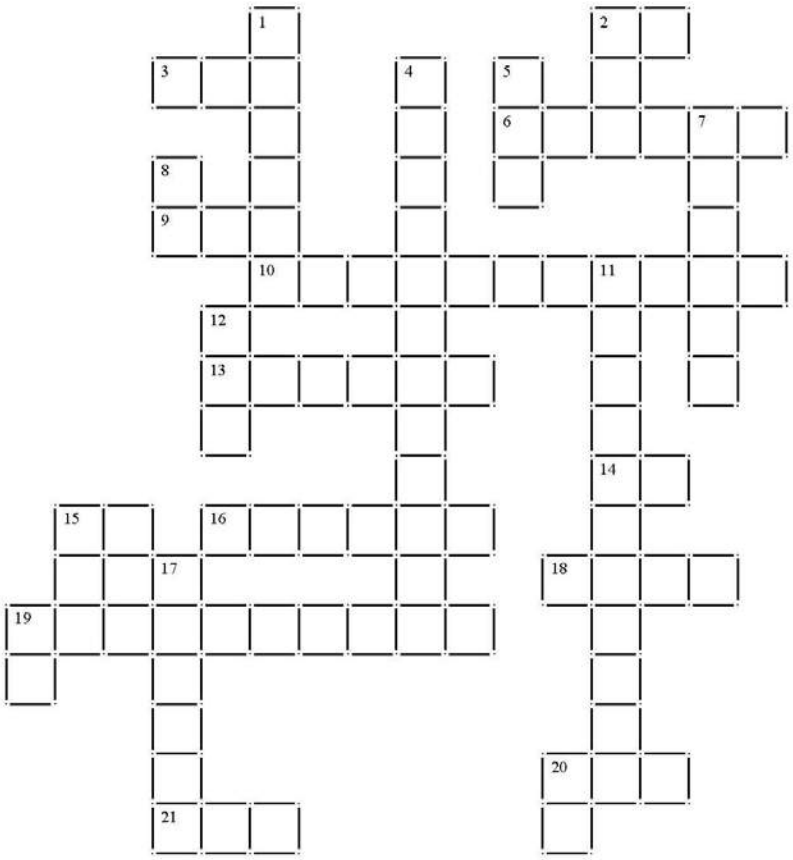
3. Which of the following statements is an example of objective data or information?
   A. "Mrs. O'Hara said she felt sick to her stomach"
   B. "Mr. Jones says he has pain in the lower part of his back"
   C. "Mrs. O'Hara complained of feeling chilled, so I closed the window"
   D. "Mr. Jones vomited 250cc of fluid after lunch"

4. Using the following statement, identify the sentence that uses the correct abbreviations: Patient/resident up in wheelchair all afternoon. Range of motion done three times a day. Physical Therapy to ambulate patient/resident after meals every day. Patient/resident may be out of bed as desired.
   A. Res. in w/c all P.M. ROM TID. P.T. to amb. res. pc qd. Res. OOB ad lib.
   B. R. up in W/C all P.M. ROM three qd. Phys.Ther. to amb. R. pc qd. R. out of bed ad lib.
   C. Res. up in wc. qd Range of mot tid. Pt. to amb res qd Patient/resident may be oobed prn.
   D. Res. up in wc. No c/o pain. To x-ray for UGI series

5. The words "ambulatory," "bathroom privileges" and "before meals" are correctly abbreviated in only one of the sentences below. The correct abbreviations are:
   A. Amb., BR, and p.c.
   B. Amb., BR, and a.c.
   C. Amb., BRP, and a.c.
   D. Amb., BRP and p.c.

6. A quick, easy, source of patient/resident information which includes the patient's/resident's diagnosis, diet, activity, special treatments and routine care measures is known as a:
   A. History and physical
   B. Kardex file
   C. Patient flowchart
   D. Graphic chart
7. The Nurse Assistant has just given Mrs. Kennedy a complete bed bath. What type of information would be appropriate to chart?
   A. The condition of Mrs. Kennedy's skin and how she tolerated the bath
   B. The fact that Mrs. Kennedy accidentally dropped the water pitcher
   C. The fact that Mrs. Kennedy likes her toilet items kept in the overbed table
   D. Mrs. Kennedy's roommate talked to the Nurse Assistant throughout the entire bathing procedure
8. The routine, daily nursing tasks performed for a patient/resident are charted on the:
   A. Progress sheet
   B. Nurses notes
   C. ADL sheet
   D. Incident report
9. When charting on a patient's/resident's medical record, the Nurse Assistant should:
   A. Erase any errors in charting
   B. Always use ink
   C. Skip a line between entries
   D. Chart all procedures to be done
10. A list of the patient's/resident's needs and specific nursing activities to address those needs would be found
    A. Patient's/resident's care plan
    B. Patient's/resident's history and physical
    C. Graphic chart
    D. Nurse's notes
11. The Minimum Data Set (MDS) manual
    A. Gives a standardized approach to care
    B. Gives a structure to facility care
    C. Helps the nurse complete accurate assessments
    D. Triggers needed assessments
    E. All of the above

Observation and Charting Crossword



ACROSS

2 Short for "bowel movement".
3 Short for "licensed vocational nurse".
6 A card file that summarizes information about the resident.
9 Short for "range of motion".
10 Using the senses to collect information.
13 A word element placed at the beginning of a word to change its meaning.
14 Short for "intravenous".
15 Means "every day".

DOWN

1 Means "lung".
2 Short for "bathroom privileges".
4 Shortened version of a word.
5 Short for "electrocardiogram".
7 Means "removal of".
8 Short for "emergency room".
11 Words or terms used in a particular science.
12 Means "nothing by mouth".
15 Every night at bedtime.
17 Near the middle or midline.
19 Means "before meals"

1 of 2

16 A word element placed at the end of a word that changes its meaning.
18 A word element that contains the basic meaning of the word.
19 To observe and make judgments.
20 Stands for "difficult" or "abnormal".
21 Short for "laboratory".
20 Short for "diagnosis".

Prefixes, Suffixes, and Roots

Prefix	Meaning
ab-	away from
ad-	toward
ante-	before, forward
anti-	against
auto-	self
brady-	slow
contra-	against, opposite
dys-	bad, difficult, abnormal
ecto-	outer, outside
en-	in, into, within
endo-	inner, inside
epi-	over, on upon
eryth-	red
hemi-	half
hyper-	excessive, high
hypo-	under, decreased
inter-	between
intra-	within
macro-	large
micro-	small
olig-	small, scanty
peri-	around
poly-	many, much
post-	after, behind
pre-	before, in front of, prior to
pro-	before, in front of
re-	again
retro-	backward

semi-	half
tachy-	fast, rapid
uni-	one

Suffix	**Meaning**
-algia	pain
-ectomy	excision, removal of
-genic	producing, causing
-gram	record
-graph	a diagram, a recording instrument
-graphy	making a recording
-iasis	condition of
-itis	inflammation
-logy	the study of
-lysis	destruction of, decomposition
-meter	measuring instrument
-oma	tumor
-pathy	disease
-phasia	speaking
-phobia	an exaggerated fear
-plasty	surgical repair or reshaping
-plegia	paralysis
-ptosis	falling, sagging, dropping
-scope	examination instrument
-scopy	examination using a scope
-stasis	maintenance, maintaining a constant level
-ostomy	creation of an opening
-otomy	incision, cutting into
-uria	condition of the urine

Charting Guides

Safety:

1. Note any safety measures done for patient to protect them from harm. If not written on chart, there is no record of it being done.
2. Restraints - note type of restraint, exact time in and out, activity done when out of restraint, condition of skin, and patient's response to care given.

Patient's Emotions:

1. Patient's mood: angry, withdrawn, crying, etc.
2. Description of unusual symptoms that might indicate anxiety like picking at bed sheets, stuttering, tenseness, restlessness, vital sign changes, and so on.
3. Quotation of any verbalized fears: patient states "I am afraid of going to sleep – I might die."
4. What decreases patient's anxiety: "Patient less tense after group activities and nap."
5. Any changes in degree of orientation: "Patient recognized nurse and knew what day it was."

Range of Motion:

1. Chart whether it is an active or passive exercise.
2. Chart problem areas as pain or restricted joint movement.
3. Chart progress made in ROM.

Positioning:

1. Time of position change.
2. What position is the patient put into.
3. Observations of the skin.
4. If there is a reddened area, chart what you did about it.
5. How patient tolerated position.

Pressure Sore:

1. Chart factual observations; examples: *location* - left hip, sacrum; *condition* - reddened area, bleeding, and green purulent drainage.
2. Chart any special treatment used such as bridging, positioning, or special equipment.

Transfer Activities:

1. Chart the level of the patient's ability to transfer unassisted or with assistance.
2. Chart how the patient tolerated the procedure (important when teaching new independent transfer activities).

Personal Hygiene:

1. Type of treatment or care given (bath, grooming, back care, lotion, makeup) or why care was not given.
2. Observations of patient's skin condition, mouth, hair, nails, and feet. Words to use for describing the skin include pale, red, discolored, clammy, cyanotic (bluish tinge), bruised, dry, scaly, excoriated (skin scratched or rubbed off).
3. How much patient is able to do for self.
4. Emotional state of patient (attitude or moods). Use patient's own words to describe how he or she feels.
5. Record patient's complaints of pain, discomfort, and so on, with factual statements of observation made concerning this.
6. Observe for any problem areas recorded in previous charting and make a factual statement of new observations made concerning it.

Nutrition and Fluid:

1. Amount of food eaten at every meal (percentage).
2. Type and amount of food *not* eaten at each meal.
3. Appetite if poor.
4. Whether patient must be fed.
5. How patient can be helpful to feed self.
6. Problems with eating.
7. Special diets, such as mechanical soft or diabetic.
8. Record intake for every patient with a catheter or on bladder training.

Elimination:

1. Intake and output must be recorded on all patients with retention catheters or on bladder training.
2. Record urine color, odor, amount, clarity, and presence of sediment, mucus, or other material.
3. Record time of voiding if it is more frequent than every two hours.
4. Record stool size, number, and character: soft, hard, liquid.
5. Unusual occurrences to chart and report
   a. Bright blood in urine or stool.
   b. Mucus in urine or stool.
   c. Very dark and strong-smelling urine.
   d. Voiding 30-50ml every one to two hours.
   e. Burning urination.
   f. Smeary or liquid fecal dribbling.
6. Guide for estimating volume of incontinent urine:
   a. Urine volume can be estimated from the size of the wet area on the linen:
      9in. diameter - 50-75 ml.
      12in. diameter - 100-125ml.
      18in. diameter - 150-175ml.
      24in. diameter - 200-300ml.
   b. These estimates vary depending on the type of linen. For instance: the stain on a thick diaper will be smaller than one on a thin sheet.

Vital Signs:

1. Temperature: *febrile* - have a fever; *afebrile* - not having a fever.
2. Pulse: *strong and regular* - good force, even rhythm; *weak and regular-* poor force, even rhythm; *thready* - very weak force, usually irregular; *irregular* - rhythm uneven.
3. Respirations: *regular* - both in depth and rate; *shallow* - little air taken in; *deep* - lots of air taken in; *irregular* - rhythm uneven, depth varies; *Cheyne-Stokes* (often seen as death approaches) - uneven rhythm, uneven rate, periods of no breathing; *dyspneic* - labored or difficult, usually with pain; *orthopneic* - ability to breathe only in upright position.
4. Blood pressure: *strong* - good volume, easy to hear; *weak* - poor volume, distant or hard to hear; *hypertension* - abnormally high blood pressure; *hypotension* - abnormally low blood pressure.
5. Pain: patient self-reports using pain scale.

Oxygen:

1. Note the exact times the patient is on or off oxygen.
2. Note how the oxygen is being administered; through mask, cannula, catheter, or tent.
3. Note number of liters flow meter is set: for example 4 liters.
4. Chart patient's condition and comfort level.
5. Chart care given to prevent irritation to skin, nose, and mouth.

Death:

1. Record the exact time of death and what you observed.

Postmortem Care:

1. Record time and date the body was taken to the morgue or by undertaker. Record what was done with the patient's valuables, and have a witness to this co-sign with you.

Module 16: Death and Dying
Minimum Number of Theory Hours: 2
Recommended Clinical Hours: 0

Statement of Purpose:
The Nurse Assistant is introduced to the various stages of the grieving process and physical signs of approaching death. This unit introduces death as a normal stage of life. The health care provider must recognize the physical, psychological, and spiritual needs of the patient/resident during this period to understand coping mechanisms and provide support to the patient/resident and family members.

Terminology

1. Acceptance
2. Advanced directives
3. Apnea
4. Anger
5. Artificial hydration/nutrition
6. Autopsy
7. Bargaining
8. Cachexia
9. Cheyne-stokes respirations
10. Denial
11. Depression
12. Do Not Resuscitate (DNR)
13. Durable power of attorney
14. Hospice
15. Living will
16. Morgue
17. Mottling
18. Palliative care
19. Patient Care Self-Determination Act
20. Postmortem care
21. Prognosis
22. Reminiscence
23. Reincarnation
24. Rigor mortis
25. Shroud
26. Terminal

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of the two hours of class plus homework assignments, the learner will be able to:

1. Define key terminology
2. Describe the five stages of the grieving process according to Dr. Kubler-Ross
3. Describe approaches to meet common emotional and spiritual needs of terminally ill patients/residents and their families
4. List the rights of the dying patient/resident
5. Differentiate between common signs of approaching death and biological death
6. Identify care and comfort measures for dying patients/residents
7. Identify the philosophy and goals of hospice and the Nurse Assistant's role when the patient/resident is cared for by a licensed hospice nurse
8. Describe procedures and responsibilities for postmortem care

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes	A. Have students select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Describe the five stages of grieving according to Dr. Kubler-Ross.** A. Denial B. Anger C. Bargaining D. Depression E. Acceptance	A. Lecture/Discussion B. Handout 13.2 Timeline of Life C. "The Death Exercise" in Instant Teaching Tools for the New Millennium by Michele Deck	A. Written test B. Class participation
Objective 3 **Describe approaches to meet common emotional and spiritual needs of terminally ill patients/residents and their families.** A. Emotional needs of the dying 1. Contact with loved ones	A. Lecture/Discussion B. Role play providing support to family of	A. Written test B. Displays supportive behaviors when caring

a. Encourage family members to visit b. Provide privacy 2. Communication: a. Listening b. Touching 3. Expression of emotions, i.e. guilt, anger, frustration, anxiety, depression 4. Reminiscence a. Recalling life experiences b. Listening important B. Cultural and spiritual needs of the dying 1. Beliefs are communicated and respected 2. Rites and rituals are encouraged 3. Respect for solitude vs. companionship are explored and respected 4. Beliefs and wishes regarding autopsy, funeral and post-mortem care discussed and respected C. Approaches 1. Respect for religious/cultural practices 2. Provide physical, emotional and spiritual comfort to patient/resident and family 3. Accept patient's/resident's emotions 4. Report to licensed nurse any emotional, social, or spiritual needs	dying patient/resident. Practice what to say. This is a difficult skill. Students can give suggestions for what words are most comforting/supportive	for terminally ill patients/residents and families
Objective 4 **List the rights of the dying patient/resident.** A. I have the right to be treated as a living human being until I die B. I have the right to maintain a sense of hopefulness, however changing its focus may be C. I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this may be D. I have the right to express my feelings and emotions about my	A. Lecture/Discussion B. Handout 13.4 Dying Person's Bill of Rights	A. Written Test B. Class participation C. Respects and supports the dying patient's/resident's rights

approaching death in my own way E. I have the right to participate in decisions concerning my care F. I have the right to expect continuing medical care and nursing attention even though "cure" goals must be changed to "comfort" goals G. I have the right to not die alone H. I have the right to be free from pain I. I have the right to have my questions answered honestly J. I have the right not be deceived K. I have the right to have help from and for my family in accepting my death L. I have the right to die in peace and dignity M. I have the right to retain my individuality and not be judged for my decisions which may be contrary to beliefs of others N. I have the right to discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others O. I have the right to expect that the sanctity of the human body will be respected after death P. I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death		
Objective 5 **Differentiate between common signs of approaching death and biological death.** A. Impending signs of death 1. Decreasing level of consciousness 2. Cold hands and feet 3. Diaphoresis 4. Pale skin 5. Loss of muscle tone 6. Labored or Cheyne-Stokes respirations	A. Lecture B. Discussion	A. Written test B. Class participation

7. "Death rattle" 8. Weak, irregular, or slow pulse 9. Blank, staring expression 10. Jaw drops 11. Mottling of skin 12. Peristalsis slows 13. Loss of sensation 14. Pain decreases B. Signs of biological death 1. No pulse 2. No breathing 3. No blood pressure 4. Pupils maybe fixed and dilated C. Hearing is the last sense to disappear 1. Be professional in all conversation 2. Talk to patient/resident normally 3. Explain procedures		
Objective 6 **Identify care and comfort measures for the dying patient/resident.** A. Monitor patient/resident, observe for signs, change of status 1. Notify licensed nurse in charge for any changes in condition 2. Determine patient's/resident's code status (DNR, no code, etc.) in order to act at appropriate level of care 3. Patient/resident can usually hear, even when they appear unconscious B. Care and comfort measures 1. Pain management 2. Hygiene 3. Oral hygiene 4. Communication/support 5. Positioning/turning 6. Provide comfort 7. Attend to psychosocial needs 8. Spiritual support	A. Lecture B. Discussion C. Case studies or scenarios on terminally ill clients	A. Written test B. Provides appropriate care/comfort measure for terminally ill patient/resident

Objective 7 **Identify the philosophy and goals of hospice and the Nurse Assistant's role when the patient/resident is cared for by a licensed hospice nurse.** A. History – The first modern hospice, St. Christopher's Hospice began in London in the 1960s B. Philosophy 1. To provide comfort, support and dignity to the dying patient/resident using a holistic approach 2. To provide comfort and support to family and friends of the dying person 3. Hospice care does not prolong life nor does it hasten death 4. Nurse on call to answer questions, provide support, make a visit, or problem solve C. Goals 1. To provide palliative care using a team approach with an emphasis on pain control and comfort, rather than recovery 2. Usually for patients with six months or less to live 3. Patient/resident encouraged to participate in family life and decision- making 4. Services and counseling available to family even after person's death D. Nurse Assistant's role – To provide care within scope of practice as identified by the multidisciplinary team E. Attitudes and skills useful in hospice care 1. Listening 2. Respecting privacy 3. Sensitivity to individual needs 4. Awareness of your own feelings 5. Recognizing stress 6. Care for yourself F. Role of the hospice nurse – To meet the physical, emotional and spiritual needs of terminally ill patient and his/her family	A. Lecture B. Discussion	A. Written test B. Class participation

Objective 8 **Describe procedures and responsibilities for postmortem care.** A. Assist with postmortem care as directed by licensed nurse B. Follow facility procedures C. Provide privacy, support and comfort D. Respect family member's beliefs in regard to postmortem care	A. Lecture B. Discussion C. Demonstrate and return demonstration post-mortem care D. Manual Skills 13.8-Postmortem Care	A. Written test B. Class participation

Sample Test: Module 16- Death and Dying

1. A patient/resident has terminal breast cancer and says she wants to live three more months to see her first grandchild. According to Kubler-Ross, in what stage of the grief process is this patient/resident?
   A. Denial
   B. Bargaining
   C. Depression
   D. Acceptance

2. A patient/resident is dying of a lung disease. He has been recently yelling at the staff. What stage of the grief process may this be?
   A. Anger
   B. Acceptance
   C. Depression
   D. Denial

3. The dying patient/resident has a right to:
   A. Read their facility record at any time they choose
   B. Refuse life-prolonging measures
   C. Refuse to pay for any services
   D. Request the Nurse Assistant to give him medications

4. Mr. Huang is terminally ill and has lost consciousness. The Nurse Assistant should:
   A. Tell his family that death is only a few hours away
   B. Turn and reposition him less frequently
   C. Keep the room very bright and noisy
   D. Remember that the patient/resident may still be able to hear

5. One of the signs of biological death would include:
   A. Bradycardia (slow heart beat)
   B. Hypertension (high blood pressure)
   C. Lack of respirations (patient/resident is not breathing)
   D. Agitation (patient/resident is active and jumpy)

6. Mrs. O'Leary always keeps her rosary and medals with her at all times. These objects should be:
   A. Ignored since it is better to avoid discussion about religion
   B. Placed on bedside table where she can't get to it
   C. Removed as soon as she goes to sleep so they are not lost
   D. Left with Mrs. O'Leary and handled as valuable items

7. One of the goals of hospice care is to:
   A. Help the patient/resident in making the dying process less painful physically and psychologically
   B. Prolong life above all else
   C. Provide an elimination of all disease symptoms and pain
   D. Provide an opportunity for death by giving too many drugs

8. Keeping the terminally ill patients/residents comfortable includes:
   A. Keeping the bed in a flat position
   B. Providing skin care and linen changes
   C. Discouraging any visitors
   D. Only turning the patient/resident every 6 hours

9. It is important for the Nurse Assistant to monitor the condition of the dying patient/resident, who has written an Advanced Directive not to resuscitate him, so that they can:
   A. Provide physical and emotional support
   B. Provide large serving of food frequently
   C. Notify the physician of the exact time of death
   D. Give medication

10. Usually the first task after the patient/resident has died and before the family comes to visit is to:
    A. Wrap the body in a shroud for transfer to a mortuary
    B. Notify the mortuary for immediate transfer of the body
    C. Just leave the patient/resident as is
    D. Prepare the body for viewing by family members

11. Postmortem care includes:
    A. Taping the eyes shut
    B. Bathing as necessary
    C. Removing dentures
    D. Removing prostheses

12. After a patient's/resident's death, the Nurse Assistant should support the family by:
    A. Trying to cheer them
    B. Encouraging the family to talk with the roommate
    C. Listening when the family wants to talk
    D. Assuring the family that the patient/resident is better off

13. When preparing a body for postmortem transfer, the Nurse Assistant should first:
    A. Cover the patient's/resident's body and head with a clean sheet
    B. Straighten the body in supine position
    C. Maintain the patient's/resident's body positions and elevate the head
    D. Provide bright lighting when the family members arrive

14. As part of the care of a patient/resident after death, the Nurse Assistant should:
    A. Dress the patient/resident in regular clothes
    B. Remove all patient's/resident's identification bands
    C. Remove all tubes and drains
    D. Position the patient's/resident's body in normal alignment

15. When caring for a dying patient/resident, the Nurse Assistant should expect:
    A. The patient/resident to be alert
    B. Vital signs to be normal
    C. Breathing to be irregular
    D. Temperature to be unchanged

16. To provide emotional support for the family members of a dying patient/resident, the Nurse Assistant should:
    A. Tell them not to cry
    B. Remind them that everyone dies
    C. Accept their expression of feelings
    D. Recommend that they limit their visits

17. Nurse Assistants who help with postmortem care of a patient/resident should:
    A. Wipe the body with alcohol to remove germs
    B. Be sure the body and clothing are clean and dry
    C. Be sure all jewelry is placed on the body
    D. Notify the nurse if there has been a bowel movement

18. The daughter of a patient/resident who has just died says to the Nurse Assistant, "My father can't be dead. It just isn't possible." Which of the following would be the best response for the Nurse Assistant to make?
    A. "Didn't you know that your father was very sick?"
    B. "Would you like me to call the mortuary for you?"
    C. "This must be very hard for you"
    D. "I will talk to the nurse in charge"

19. While the Nurse Assistant is changing a patient's/resident's bed, the patient/resident just starts crying and says, "No one cares about me. I wish I could just die!" the Nurse Assistant should:
    A. Say nothing and continue to change the bed
    B. Tell the patient/resident that she is too busy to listen
    C. Ask if the patient/resident would like to talk for awhile
    D. Tell the patient/resident to stop being such a baby

20. A dying patient/resident tells the Nurse Assistant, "I'm having a lot of pain." The Nurse Assistant should:
    A. Try to change the subject
    B. Report the pain to the nurse in charge
    C. Talk to the family member about the pain
    D. Leave the room to provide privacy

MANUAL SKILL: Postmortem Care

EQUIPMENT:

Bath Towels
Bed Protector
Disposable gloves
Large container for personal belongings
Postmortem Kit (shroud, gown, or clean hospital gown, 2 tags)
Top Sheet
Valuable List
Wash Basin
Washcloth

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Identify patient/resident.
4. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
5. Gather equipment, if applicable.
6. Provide for privacy with a curtain, door, or screen
7. Apply gloves (standard precautions)

SKILL STEPS:

1. Raise bed to comfortable working height.
2. Place body on the back, with head and shoulders elevated on a pillow.
3. Close eyes by gently grasping eyelashes and pulling eyelids over eyes.
4. Place clean dentures in mouth (if applicable). Also, replace artificial eye(s) (if applicable).
5. Close mouth. Note: A rolled hand towel may be placed under the chin to keep jaw closed.
6. Remove soiled dressings; apply clean dressings as indicated, remove tubes or catheters according to policy.
7. Bathe soiled areas with plain water, comb hair, and straighten arms and legs.
8. Place a disposable bed protector underneath the buttocks.

9. Remove and discard gloves and wash hands.
10. If the family is to view the body:
    A. Put a clean hospital gown on the patient.
    B. Cover the body to the shoulders with a clean sheet.
    C. Make the room look neat and tidy.
    D. Remove soiled linens from the room.
    E. Adjust the light to subdued level and allow the family to visit privately.
11. Put the shroud on the patient/resident after the family leaves (if applicable). Note: May be done by the funeral home when they pick up the body.
12. Collect all belongings and make a list, store, and label or give to family.
13. Fill out identification cards and fasten to foot of patient/resident and one on each of the patient's/resident's belongings.
14. Follow facility policy if necessary to bring body to morgue.
15. Remove all linens and other supplies from room.
16. Report and record:
    A. Completion of procedure and time.
    B. Where the body was transported and by whom.
    C. What was done with the personal belongings.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

Timeline of Life

1. Write the timeline on the board as follows:

Birth ——————————————————————————— Death

2. Have the student make a similar timeline on a piece of paper and place a mark on the timeline that indicates approximately where they feel they are in their life.

   Example:

Birth	dance recital	Christmas 1988	graduation	marriage	**PRESENT**	RN	children	purchase home	travel	grandkids	Death

3. From “Birth” to where they placed their “present” mark, they should put highlights of their life, memories, accomplishments, etc. From “present” mark to “Death”, they should put their hopes and dreams for the future, goals, etc.

4. Ask for those students that wish to “share” their life, tell the class what they put down. (Maybe 3-4 students)

5. When the sharing has been completed, ask all students to pass forward their “lives”. Take all the lives, and show the class. Explain that you have all their memories, their hopes, and dreams for the future, and that they are sitting in a doctor’s office, and have just been told they have a terminal disease. Place their papers in a trash can.

6. After they have a moment to process what has occurred, ask them how they feel about the news and what you have just done. Some students may express anger, disbelief, sadness, etc. Discuss their feelings, and relate it to Dr. Kubler-Ross’ stages of grieving. Explain that the process of dying is very individual, and just as there are different reactions in class, there will be different reactions in the facility.

7. Begin Death and Dying Module.

The Dying Person's Bill of Rights

1. I have the right to be treated as a living human being until I die.
2. I have the right to maintain a sense of hopefulness, however changing its focus may be.
3. I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this might be.
4. I have the right to express my feelings and emotions about my approaching death in my own way.
5. I have the right to participate in decisions concerning my care.
6. I have the right to expect continuing medical and nursing attention even though "cure" goals must be changed to "comfort" goals.
7. I have the right to not die alone.
8. I have the right to be free from pain.
9. I have the right to have my questions answered honestly.
10. I have the right to not be deceived.
11. I have the right to have help from and for my family in accepting my death.
12. I have the right to die in peace and dignity.
13. I have the right to retain my individuality and not be judged for my decisions, which may be contrary to the beliefs of others.
14. I have the right to discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others.
15. I have the right to expect that the sanctity of the human body will be respected after death.
16. I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

Module 17: Patient/Resident Abuse
Minimum Number of Theory Hours: 6
Suggested Theory Hours: 7
Recommended Clinical Hours: 0

Statement of Purpose:
The purpose of this unit is to introduce the Nurse Assistant to patient/resident abuse. The module will focus on the nurse assistant role in preventing, recognizing, and reporting instances of patient/resident abuse.

Terminology:

1. Abuse
2. Advance Directive
3. Aiding and abetting
4. Assault
5. Battery
6. Choice
7. Chronic
8. Coercion
9. Confidential
10. Defamation
11. Defamation of character
12. Do Not Resuscitate (DNR)/ No Code
13. Ethical standard
14. False imprisonment
15. Financial abuse
16. Grievances
17. HIPAA
18. Informed consent
19. Involuntary seclusion
20. Laws
21. Legal standard
22. Libel
23. Mandated reporter
24. Neglect
25. Negligence
26. Ombudsman
27. Physical abuse
28. Policy and Procedure
29. Privacy
30. Psychological abuse
31. Resident council
32. Restraints
33. Scope of practice
34. Sexual abuse
35. Slander
36. Social services
37. Theft
38. Verbal abuse

Patient, resident, and client are synonymous terms referring to the person receiving care

Performance Standards (Objectives):

Upon completion of the six (6) hours of class plus homework assignments and one (1) hour of clinical experience, the learner will be able to:

1. Define key terminology
2. Identify and discuss types of elder abuse
3. Discuss the issues related to elder abuse
4. Explain the Nurse Assistant role in preventing elder abuse
5. Describe the Nurse Assistant role in reporting elder abuse

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology** A. Review the terms listed in the terminology section. B. Spell the listed terms accurately. C. Pronounce the terms correctly. D. Use the terms in their proper context.	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration. C. Encourage use of internet, medical dictionary, and textbooks. D. Create flashcards.	A. Have students select five words from the list of key terminology and write a sentence for each defining the term. B. Administer vocabulary pre-test and post-test. C. Uses appropriate terminology when charting and reporting to licensed personnel.
Objective 2 **Identify and discuss types of elder abuse** A. Define Abuse 1. An intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult who is someone age 60 or older 2. A crime and is one or more of the following elements: 1) Willful causing of injury 2) Unreasonable confinement 3) Intimidation, making someone afraid 4) Punishment 5) Refusal of goods or services needed for physical, mental or psychological well-being 3. Can happen to any older person, but often affects those who depend on others for help with activities of everyday life 4. Likely targets are older people who have no family or	A. Lecture/Discussion B. Arrange for tour of a long term care facility. C. Arrange for a guest speaker from a long term care facility.	A. Written test B. Class participation

friends nearby and people with disabilities, memory problems, cognitive problems, or dementia B. Forms or types of Elder Abuse (National Institute of Aging): 1. Verbal 1) Teasing 2) Profanity 3) Racial slanders 4) Threats 2. Physical 1) Battery: kicking, biting, hitting, shoving, pulling hair 2) Rough handling 3. Psychological **(**Emotional abuse) 1) Ridiculing or saying hurtful words 2) Ignoring repeatedly 3) Manipulating 4) Yelling at or threatening 4. Involuntary seclusion 1) Isolation 2) Keeping that person from seeing close friends and relatives 5. Abandonment 1) Leaving someone unattended 2) No planning for patient's/resident's care 6. Neglect 1) Failure to provide care that a reasonable person would provide 2) Not answering call light 3) Smells of urine and not being cleaned/changed 7. Sexual 1) Overtures or Innuendos 2) Inappropriate gestures 3) Inappropriate touching 4) Forcing an older adult to watch or be part of sexual acts 8. Financial 1) Stealing money or borrowing items		

2) Accepting gifts 3) May include forging checks, taking someone else's retirement and Social Security benefits, using another person's credit cards and bank accounts, changing names on a will, bank account, life insurance policy, or title to a house without permission from the older person 9. Healthcare Fraud 1) Overcharging 2) Billing twice for the same service 3) Falsifying Medicaid or Medicare claims 4) Charging for care that was not provided 5) Committed by healthcare providers or hospital staff C. Signs and Symptoms of abuse 1. Has new onset sleeping problems 2. Seems depressed or confused 3. Loses weight for no reason 4. Displays signs of trauma, like rocking back and forth 5. Acts agitated or violent 6. Becomes withdrawn 7. Stops taking part in activities that the patient/resident previously liked 8. Has unexplained bruises, burns, or scars 9. Appears unkempt or messy with unwashed hair or dirty clothes 10. Develops bed sores or other preventable conditions		
Objective 3: **Discuss the issues related to elder abuse** A. Abuse is a crime and is one or more of the following elements: 1. Willful causing of injury. 2. Unreasonable confinement. 3. Intimidation, making someone afraid. 4. Punishment. 5. Refusal of goods or services needed for physical, mental or psychological well-being.	A. Lecture/Discussion B. Handout 2.5- Abuse Reporting Form- SOC 341 C. Video "Your Legal Duty: Reporting Elder and Dependent Adult Abuse" Fax requests	A. Written test B. Class participation

B. Elder abuse has been: 1. Poorly or imprecisely defined 2. Defined specifically to reflect the unique statutes or conditions present in specific states, counties, or cities 3. Defined specifically for research purposes C. All states require the reporting of elder abuse or child abuse D. Forms of elder abuse (refer to objective 2) 1. Physical abuse 2. Verbal abuse 3. Involuntary seclusion 4. Financial abuse 5. Psychological abuse (emotional/mental abuse) 5. Sexual abuse 6. Neglect 7. Abandonment 8. Healthcare Fraud D. Recognizing the evidence and observation of elder abuse 1. Living conditions are unsafe, unclean or inadequate 2. Personal hygiene is lacking. 3. Weight loss 4. Frequent injuries 5. Old bruises 6. Quiet and withdrawn attitude 7. Anxious to please caregiver 8. Private conversations not allowed 9. Medications not taken properly 10. Frequent Visits to ER, hospital, or clinics 11. May go from one doctor to another E. Evaluate how a series of actions and reactions might lead to abuse F. Define local, state, and federal regulations regarding abuse (mandated reporter)	to Bureau of Medi-Cal Fraud and Elder Abuse. FAX: 916-263-2565. Downloadable publications from CA Attorney General's office available at www.safestate.org/publi cations D. Bureau of Medi-Cal Fraud and Elder Abuse http://ag.ca.gov/bmfea/el der.php	
Objective 4: **Explain the Nurse Assistant role in recognizing and preventing elder abuse**		

A. Explain the difference between negligence and abuse B. Recognize the evidence of elder abuse 1. Living conditions are unsafe, unclean or inadequate. 2. Personal hygiene is lacking. 3. Weight loss 4. Frequent injuries 5. Old bruises 6. Quiet and withdrawn attitude 7. Anxious to please caregiver 8. Private conversations not allowed 9. Medications not taken properly 10. Frequent Visits to ER, hospital, or clinics 11. May go from one doctor to another C. Explain Nurse Assistant role in preventing abuse 1. Identify combination of individual, relational, community, and societal factors contribute to the risk of abuse 2. Current diagnosis of mental illness 3. Current abuse of alcohol 4. High levels of hostility 5. Poor or inadequate preparation or training for care giving responsibilities 6. Assumption of caregiving responsibilities at an early age 7. Inadequate coping skills 8. Exposure to abuse as a child 9. High financial and emotional dependence upon a vulnerable elder 10. Lack of support 11. Unsympathetic or negative attitudes toward patients/residents 12. Chronic staffing problems 13. Lack of administrative oversight, staff burnout, and stressful working conditions D. Identify patient/resident safety and abuse prevention techniques 1. Effective monitoring systems 2. Institutional policies and procedures regarding patient care 3. Training on elder abuse and neglect for employees 4. Education and clear guidance on durable power of attorney	A. Lecture/Discussion B. Locate facility policies and procedures and patient/resident rights documents. C. Role-play a situation that involves a threat to patient/resident rights	A. Written test B. Class participation C. Locate facility policies, procedures, and patient/resident rights documents. D. Consistently promotes patient/resident rights

and how it is to be used 5. Promoting regular visits by family members, volunteers, and social workers 6. Coordination of resources and services among community agencies and organizations E. Explain how to prevent violations of elder abuse and discuss techniques to rectify situations that could possibly lead to abuse 1. Provide services to relieve the burden of caregiving, such as housekeeping and meal preparation, respite care, education, support groups, and day care 2. Estate planning including a. Living will b. Revocable trust c. Durable power of attorney for healthcare and/or asset management 3. Not signing documents without first consulting an attorney or family member you trust 4. Not provide personal information (e.g. social security number, credit card) 5. Tear up or shred credit card receipts, bank statements, and financial records before disposing of them 6. If you hire someone for personal assistance services, in home care services, etc. ensure that they have been properly screened with criminal background checks completed F. Review Mandated Reporter Role 1. Define facility, state, and federal policies and procedures related elder abuse G. Identify Self-care Techniques (Caregiver) 1. Caregiver may need to be available around the clock to fix meals, provide nursing care, take care of laundry and cleaning, drive to doctors' appointments, and pay bills, which contributes to caregiver stress 2. Make sure you have time to rest and take care of your needs 3. Ask a family member or friend to help out for a weekend, or even for a few hours, so that you can take some time for yourself		

4. ARCH National Respite Network and Resource Center's National Respite Locator to find respite services in your area 5. Caregiving support groups may also help 6. Exercise could even help with stress H. Identify and discuss specific techniques for preventing escalation of potential abuse situations		
Objective 5: **Describe the Nurse Assistant role in reporting elder abuse and/or patients'/residents' rights violations** A. Review types of elder abuse and/or patients'/residents' rights violations (refer to objective 2 &3) B. Reporting 1. Discuss your observations with a licensed nurse and/or other appropriate personnel 1) If Nurse Assistant observes the abuse incident, the Nurse Assistant is responsible for reporting; mandated reporter 2) LVN or RN may assist the Nurse Assistant in completing mandated forms and in submitting required forms to reporting agencies 2. Report observations as a mandated reporter, following federal mandate for reporting suspected or actual elder abuse and/or patients'/residents' rights violations 3. Follow agency policies regarding abuse reporting 4. Follow up on reported incident with licensed personnel 5. Reporting Resources 1) Adult Protective Services (APS) 2) Long-Term Care Ombudsmen 3) Eldercare Locator 4) National Center on Elder Abuse (NCEA)	A. Lecture/Discussion B. Handout 2.5-Abuse Reporting Form- SOC 341. C. Video "Your Legal Duty: Reporting Elder and Dependant Adult Abuse" Fax requests to Bureau of Medi-Cal Fraud and Elder Abuse. FAX: 916-263-2565. Downloadable publications from CA Attorney General's office available at www.safestate.org/publi cations D. Bureau of Medi-Cal Fraud and Elder Abuse http://ag.ca.gov/bmfea/el der.php E. Red Flags of Abuse located at https://ncea.acl.gov/NCEA/media/docs/Red-Flags-of-Elder-Abuse-English.pdf	A. Written test B. Class participation

Sample Test: Module 17 Elder Abuse

1. The following statements about abuse are true except:
   a. Abuse is making judgements before knowing the patient/resident situation.
   b. Abuse is a punishable crime.
   c. Abuse is a willful act that causes harm or injury to the patient/resident.
   d. Abuse is depriving a person of goods and services needed to maintain health.

2. Threatening to touch the person's body without the person's consent is:
   a. Assault
   b. Battery
   c. Defamation
   d. False Imprisonment

3. Restraining a person's movement is:
   a. Neglect
   b. Invasion of privacy
   c. Defamation
   d. False Imprisonment

4. Sharing a person's photos on a social media site is:
   a. Fraud
   b. Allowed with the family's consent
   c. A HIPAA Violation
   d. Allowed if you obtained consent

5. Who is most at risk for being wounded, attacked, or assaulted?
   a. A teenager
   b. A single mother
   c. A caregiver
   d. An older adult

6. You scold an older person for not eating their dinner. This is a form of:
   a. Physical abuse
   b. Neglect
   c. Battery
   d. Verbal abuse

7. You leave your patient before completing your assignment and the patient's/resident's care. This is abuse by:
   a. Abandonment
   b. Neglect
   c. Involuntary seclusion
   d. Battery

8. You fall asleep at work. This is:
   a. Abandonment
   b. Neglect
   c. Malpractice
   d. Emotional abuse

9. Which is a sign of elder abuse?
   a. Stiff joints and joint pain
   b. Weight gain
   c. Poor personal hygiene
   d. Forgetfulness

10. An older adult has a black eye, bruises on their face, bite marks on on their arms. These are signs of:
    a. Physical abuse
    b. Sexual abuse
    c. Neglect
    d. Verbal abuse

11. You suspect a patient/resident has been abused. What should you do?
    a. Tell the nurse

b. Call the police
c. Tell the family
d. Ask the person about the abuse

12. Failure to exercise the degree of care considered reasonable in a given situation is:
    a. Malpractice
    b. Neglect,
    c. Coercion
    d. Physical abuse

13. You overhear another nurse assistant raise their voice loudly in a threatening manner when speaking to their patient/resident. The nurse assistant is guilty of:
    a. Neglect
    b. Physical abuse
    c. Verbal abuse
    d. Invasion of privacy

14. Your patient/resident offers you a dollar to thank you for picking up a newspaper for him. Your best response would be to:
    a. Ignore the money and pretend not to see it
    b. Take the money as you earned it
    c. Report the event to the doctor
    d. Politely refuse because tipping is not allowed

15. T F A patient may not refuse any treatment prescribed by the doctor
16. T F Every patient/resident has the right to considerate and respectful care
17. T F Anxiety can make a patient/resident very demanding
18. T F You fail to follow an order to encourage fluids for your patient/resident. You are guilty of neglect.
19. T F If an error occurs as the nurse assistant gives care, the nurse assistant should report it when they think about it
20. T F A patient/resident gives up their right to privacy when they are admitted to a healthcare facility