Texas Curriculum for Nurse Aides in Long-Term Care Facilities

Texas Health and Human Services
January 2022

TEXAS
Health and Human Services

Course Objectives

To prepare nurse aides with the knowledge, skills and abilities essential for the provision of basic care to residents in long-term care facilities. After completing this course, participants will be able to:

- provide person-centered basic care to residents of long-term care facilities.
- communicate and interact therapeutically with residents and their families, with sensitivity to the physical, social, and mental needs of residents.
- assist residents in attaining and maintaining maximum functional independence.
- protect, support and promote the rights of residents.
- provide safety and preventive measures in the care of residents.
- demonstrate skill in observing, reporting and documentation.
- function effectively as a member of the health care team.

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Introduction to Person Centered-Care

1. Person-centered care is a care concept that recognizes that individuals have unique values, personal histories and personalities and that each person has an equal right to dignity, respect, and to participate fully in his/her environment.
2. The goal of person-centered care honors the importance of keeping the person at the center of his/her care and decision-making process.
3. In person-centered care, those providing the care must actively listen and observe to be able to adapt to each individual's changing needs, regardless of his/her condition or disease process.
4. In long-term care, the person-centered care model is extremely important to ensuring that everyone is treated as an individual with the focus not being placed on his/her illness, abilities, or inabilities.
5. Making sure that people are involved in and central to their care is now recognized as a key component of providing for a high quality of health care.
6. There are many aspects of person-centered care that should be accounted for:

   A. Respecting one's values and putting them at the center of their care;

B. Taking into account someone's preferences and expressed needs;

C. Coordinating and integrating care;

D. Working together to make sure there is good communication with the individual and that information and education is effectively passed along;

E. Making sure people are physically comfortable and safe;

F. Providing emotional support;

G. Involving the individual's family and friends;

H. Making sure there is continuity between and within the services that the person is receiving; and

I. Making sure people have access to appropriate care when they need it.

7. Person-centered care is about focusing care on the needs of the person in all areas of care, including:

   A. Activities of Daily Living (ADLs) by ensuring that the resident is allowed to make choices on what they want to wear, when he/she want to take/receive a shower, and how he/she want to have his/her hair done, just to name a few.

   B. Dining and Nutrition to ensure that the resident is provided with the food that he/she wants to eat, when to consume each meal, and whether or not to eat in the dining room or his/her personal room.

   C. Activities to ensure that a resident is provided with meaningful activities that he/she wants to do, when he/she wants to do them, and how he/she wants to do them (to the best of his/her abilities).

Introduction to OBRA

1. The Omnibus Budget Reconciliation Act (OBRA) of 1987 is a federal law that establishes regulations for nursing facilities and nurse aide training in facilities.

2. The intent of OBRA is to improve the quality of life for residents in nursing facilities.

3. OBRA facility regulations focus on:

   A. Resident rights, restorative care, psychosocial care and preventive care to maintain maximum physical and mental wellness of residents.

B. State inspection of facilities for compliance with regulations with penalties for noncompliance.

4. OBRA nurse aide training regulations include:

A. The facility must assure that nurse aides complete an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) and be placed on the Nurse Aide Registry within 4 months of their date of hire by the facility.

a. The first 16 hours of training must be completed prior to any direct contact with a resident.

b. After the first 16 hours, nurse aides can perform only those skills for which they have been trained and found to be proficient by the instructor.

B. An approved Nurse Aide Training Program must be at least 100 clock hours in length (including 60 classroom and 40 clinical training hours). The nurse aide must pass the training program to be eligible to take the state test.

a. The state test (CEP) includes:

(1) A written or oral exam.

(2) A skills test consisting of 5 randomly selected skills.

(3) The nurse aide must pass the skills and written test before being placed on the registry. The nurse aide has 3 opportunities to pass each test and must meet competency within two years of his or her training completion date.

b. State registry requirements include:

(1) Each individual listed on the registry must keep the department informed of his or her current address and telephone number.

(2) Nurse aide certification expires 24 months after being entered into the registry. Nurse aides must submit verification of paid employment prior to the expiration date to continue certification.

(3) Nurse aides renewing certification after September 1, 2013 must complete 24 hours of in-service education every two years.

5. HHSC does not recertify nurse aides that are listed on the Employee Misconduct Registry (EMR) or have been convicted of a criminal offense listed in Texas Health and Safety Code, §250.006.

A. A finding of abuse, neglect or misappropriation of resident property may be entered into the registry. If a finding is entered, the nurse aide will not be employable as a nurse aide in LTC facilities.

B. See Appendix D: Texas Administrative Code, Title 26, Part 1, Section 556.9 and Section 556.12.

Residents in Long-term Care Facilities

1. Purpose of LTC facilities
   A. Designed to meet the needs of persons who cannot care for themselves but do not need hospital care.
   B. LTC facilities meet the needs of those who may be:
      a. Alert and oriented
      b. Confused and disoriented
      c. Needing complete care
      d. Geriatric
      e. Disabled
      f. Physically
      g. Mentally
      h. Requiring skilled nursing care (short-term care)
      i. Pediatric
      j. Needing post-acute care
      k. Terminally ill needing hospice care
      l. Other
2. Needs common to residents
   A. Physical
   B. Psychosocial
   C. Privacy
3. Myths and feelings about aging

Nurse Aides

1. The nurse aide may work in various health care settings and is usually the primary "hands on" caregiver.
2. Where they started and possible progress to other health care professions
3. Importance of their job and the skills they provide are essential to improved quality of life for those they provide care to.

Qualities of an Effective Nurse Aide

1. Professional and compassionate attitude
2. Responsible nature
3. Ability to communicate effectively
4. Maintenance of high ethical standards

Responsibilities of Nurse Aides

1. To the resident – job description
2. To the facility – commitment to professionalism
3. To the staff – cooperation, dependability, and conflict resolution
4. All members of the health care team focus their efforts on a care plan devised to meet the needs of the individual.

Relationship of the Nurse Aide to the Residents

1. Appropriate professional relationships
2. Inappropriate relationships
3. The goal of person-centered care honors the importance of keeping the person at the center of his/her care and decision-making process.

Safety is Everyone's Concern

1. Some older individuals may not realize that some activities may be harmful to them.
2. The most common cause of accidents for LTC residents is falls.
3. Communicate with residents about his/her safety while maintaining his/her right to choices about his/her care and activities.
4. The resident has the right to a safe environment.
5. Think about safety first when you enter an area and last when you leave the area.

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1.1.3 Safety Measures

Notes to Instructor:

- Integrate the principles of safety throughout this course

6. Safety is integrated throughout this course.

Physical Changes in Residents that Increase Risks

1. Decreased vision.
2. Impaired hearing.
3. Tremors or shaking.
4. Dizziness when position is changed from lying to sitting or sitting to standing.
5. Slower reflexes.
6. Mental changes such as forgetfulness or confusion.
7. Weakness due to illness, injury, or shrinking of unused muscles.

Providing a Safe Environment

1. Recognize and report unsafe conditions that nurse aides are unable to correct.
2. Keep hallways and resident rooms clean, dry, and free of obstacles.
3. Keep equipment and supplies on one side of the hallway so that residents have an unobstructed path
4. Pick up any objects on the floor
5. Wipe spills immediately and place a wet floor sign
6. Keep beds in prescribed position and wheels locked.
7. Follow facility policy for use of side rails.
8. Maintain adequate lighting.
9. Report all equipment not in proper working order and use it according to facility policy and manufacturer's directions. Unsafe or broken equipment should be identified and removed from service according to facility policy.
10. Properly transport residents according to his/her plan of care. Properly transport equipment according to facility policy and manufacturer's recommendation.
11. Instruct residents to use handrails.
12. Check soiled linen for sharp or misplaced articles.
13. Set brakes on wheelchairs during transfers or when parking the chair.

14. Keep all chemicals in locked area legibly labeled and in their original container. Do not store chemicals in the same area as food products.
15. Keep hazardous materials, sharp objects and plants away from confused residents.
16. Ensure appropriate footwear is worn by staff and residents.
17. Provide call signals to all residents and remind resident to call for help.
18. Always identify residents before beginning care.
19. Follow recommended safety precautions for all procedures.
20. Report any change in condition such as loss of appetite.
21. Keep resident's preferred belongings within easy reach.
22. Avoid the use of any clothing that could cause residents to trip.
23. Use shower chairs in showers. Do not transport resident in shower chair or leave unattended in tub or shower.

Accidents and Incidents

1. "Incident" – An occurrence or event that interrupts normal procedures or precipitates a crisis
2. "Accident" – An unexpected, undesirable event
3. Role of the nurse aide in recognizing and reporting incidents and accidents
4. **Unsafe or broken equipment** should be "locked out" so that it cannot be used. The person who discovers broken equipment should "tag" is following facility policy.
5. **The Hazardous Communication Employee Right to Know** program is designed to make employees aware of the proper uses and hazards of chemicals in the workplace.

Answering Call Signals

1. Ensure that all residents have access to a call signal at all times and know how to use it.
2. The call signal may be the resident's only means of getting help in an emergency.
3. Know and follow facility policy for using call signals.

4. In general, all staff are responsible for answering call signals, even if it's not his/her assigned resident.
5. Know the various signals for resident rooms, bathrooms, etc. in your facility.
6. Know how to turn call signals off/on.
7. Know timelines for answering call signals.
8. Proper responses when answering call signals.

Identifying Residents

1. Resident identification systems:
   A. Identification bands
   B. Name on door
   C. Pictures
   D. Sensor bracelets for residents that wander
2. Follow facility policy and procedure for identifying residents.

Oxygen Safety

1. Types of oxygen delivery systems and how they are used:
   A. Cannula
   B. Mask
2. Know the liter flow ordered by the doctor, monitor liter flow when in the room and notify nurse of incorrect liter flow.
3. Safety precautions when oxygen is used:
   A. Post oxygen signs on door, over bed and follow facility policy.
   B. Check with nurse before using electrical equipment such as razors, fans, radios, televisions.
   C. Never use flammable liquids such as nail polish remover.
   D. Be sure that the oxygen cylinder is secured on base and/or chained to a carrier or wall.
   E. Immediately report smoking/smoking materials when oxygen is in use.
   F. Use only cotton blankets – not wool or synthetic.

G. If tank is empty report to nurse.

Fire Prevention and Safety

1. Fire Prevention
   A. Supervise smoking in designated areas/monitor for smoking materials in rooms.
   B. Allow no open flames near oxygen.
   C. Report frayed wiring or faulty electrical equipment.
   D. Report concerns of overloaded electrical outlets.
2. Fire emergency rules
   A. Stay calm and do not panic, run or scream.
   B. Follow the steps of RACE:
      a. R = Remove all residents from the immediate vicinity of the fire.
      b. A = Activate the alarm system.
      c. C = Contain the fire and smoke by closing all doors and windows.
      d. E = Extinguish the fire, if it is small enough to contain.
3. Remove combustible supplies and equipment from hallways.
4. Remember that smoke kills. In a smoke-filled area, stay close to the floor because smoke rises.
5. Know facility policy regarding fire emergency rules.

Natural Disasters

1. Tornado
2. Hurricane
3. Other natural disasters
4. Other Safety Regulations
   A. **The Safe Medical Device Act of 1991** requires that the Food and Drug Administration (FDA) be notified of any death or serious injury caused by any type of medical device.
   B. **The Texas Concealed Handgun Law** prohibits carrying a concealed weapon in a hospital, nursing home or other health care facility.

C. **The Occupational Safety and Health Administration (OSHA)** is mandated by the government to protect the employee.

   a. OSHA inspects LTC facilities for compliance with personal protective equipment, standard precautions, Material Safety Data Sheets (MSDS), and tuberculosis testing and exposure.

D. **OSHA** also requires each facility to have an eyewash station within a reasonable distance of where hazardous chemicals are used and a total body wash station. Facility shower rooms satisfy both requirements.

E. **Video recorders may be in use** – Audio Electronic Monitoring (AEM)

1.1.4 Emergency Measures

- State the general procedure to follow in an emergency in your facility
- Describe and/or demonstrate laboratory skills in emergency measures for:
  - Fainting/syncope
  - Falls and suspected fractures
  - Seizures
  - Vomiting and aspiration
  - Clearing the obstructed airway (Heimlich Maneuver)
- NOTE: Do not practice forceful abdominal thrusts on human subjects as part of training

General Measures for Emergency Care

1. Stay with the resident and call for help. Be sure the nurse is notified
2. Do not move the resident unless there is immediate danger
3. Remain calm and reassure the resident
4. Start emergency measures that you are trained to perform while waiting for help to arrive
5. Remain with the resident after help arrives to assist and answer questions as needed
6. Know facility procedure and phone numbers for reporting emergencies
7. Know where emergency equipment and supplies are located

Brain Health and Function

Dementia involves a decrease in brain function. Alzheimer's disease is the most common form of dementia and only one of many different types.

By 2050, nearly 14 million Americans may be living with Alzheimer's dementia. This is an increase from the estimated 5.8 million in 2019. As the population affected by dementia grows, it is beneficial for CNAs to be aware of, and acknowledge, the unique needs of people living with dementia.

To understand Dementia disorders, it is necessary to first understand how cognition (knowledge/learning) works in the human brain.

Aging and Nervous System Changes

Changes in the brain and the nervous system occur with the aging process.

Common changes to the nervous system may include:

- Loss of nerve cells;
- Slower response/reaction time (reflexes decrease);
- Decrease in hearing/vision;
- Reduction in blood flow to the brain;
- Dizziness (balance/blood pressure shifts);
- Changes in sleeping patterns;
- Sensitivity to pain; and
- Decrease in taste/smell.

While all these changes are normal as a person ages, the severity and the speed of onset can vary in a person living with dementia.

Normal age-related changes

Some of the ways that age-related changes may manifest include:

- Forgetting which word to use in conversation;
- Making an occasional bad decision;
- Forgetting the date but remembering later; and
- Misplacing items occasionally.

Cognitive Impairments: Delerium

Delirium is an acute onset (days or hours) of confusion caused by a serious disturbance that causes rapid brain changes.

Delirium and dementia can present similar symptoms, and input from a family member or caregiver is often needed to make an accurate diagnosis for an individual. Permanent physical changes causing confusion may be irreversible, but manageable.

Delirium may have multiple causes including:

- **D** rugs and medications
- **E** lectrolyte imbalance (thyroid issues, dehydration, etc.)
- **L** ack of drugs (inadequate pain medication or sudden withdrawal of medication)
- **I** nfection (Urinary tract infections can cause delirium)
- **R** educed sensory input (rapidly failing sight or hearing ability)
- **I** ntracranial issues (stroke, tumors, hemorrhage, etc.)
- **U** rogenital issues (inability to urinate or extreme constipation)
- **M** yocardial or lung conditions (CHF or COPD)

Cognitive Impairments: Depression

Depression is a mood disorder that may cause loss of interest and feelings of sadness.

Depression affects feelings, as well as thinking and behavior.

Combining treatments may be effective in treating depression, such as counseling and medication. However, responses will vary among individuals.

Depression may present the same behaviors that are common with dementia disorders.

Cognitive Impairments: Sustance Induced Cognitive Impairment

Certain medications can cause a resident to show signs of cognitive impairment suddenly.

It is important to know your resident's normal attitude and abilities so that you are better able to identify changes in behavior and personality.

Report any changes to the nurse on duty.

Mild Cognitive Impairment (MCI)

Mild Cognitive Impairment (MCI) is an intermediate stage between a normal age-related change and another more serious condition (such as a Dementia disorder).

Infection Control Introduction:

1. Residents of long-term care facilities are at risk of infection due to medications that reduce their resistance to microorganisms, the use of medical devices (such as urinary catheters), and the diagnoses of multiple diseases. These risk factors increase the severity of illness experienced by residents. Infections are a significant cause of illness, disease and death for residents that reside in long-term care settings.

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Chain of Infection

Susceptible Host
- Elderly
- Infants
- Immunocompromised
- ANYONE!

Pathogen
- Bacteria
- Virus
- Fungi
- Parasite

Portal of Entry
- Mouth
- Nose
- Eyes
- Cuts in skin

Reservoir
- People
- Animals
- Soil
- Food
- Water

Mode of Transmission
- Direct Contact
- Indirect Contact
- Vectors

Portal of Exit
- Coughing/Sneezing
- Bodily Secretions
- Feces

2. As a nurse aide one of your primary responsibilities is infection control. Infection control prevents or stops the spread of illness. It is one of the most important aspects of providing a safe environment for residents.
3. Nurse aides must understand and follow the facility's infection control policies and procedures. There are two levels of recommended precautions to prevent and control the spread of infections: Standard Precautions and Transmission-Based Precautions. Regulations require you to know how to use standard and transmission-based precautions.

Microorganisms

1. Only seen with a microscope
2. Found in our everyday environment
   A. Air
   B. On our skin
   C. In our bodies
   D. On surfaces
3. Have certain requirements to survive
   A. Oxygen (aerobic)
   B. No oxygen (anaerobic)
   C. Warm temperature
   D. Moist environment
   E. Darkness for growth
   F. Food – dead tissue or live tissue
4. Body defenses: Beneficial in maintaining balance in our bodies and in our environment
   A. Microorganisms may cause illness, infection and disease
   B. External defenses to prevent illness, infection and disease
   C. Skin as a barrier
   D. Intact mucous membranes
   E. Cilia
   F. Coughing/Sneezing

G. Acid in the stomach

H. Tears

I. Internal defenses

J. Inflammation

K. Fever

L. Natural Immune Response

Chain of Infection

1. A communicable disease is one that is transmissible from person-to-person, animal-to-person, or object-to-person. Many of the illnesses in long-term care facilities are caused by communicable disease. The chain of infection is a set of 6 intertwined links that allow for communicable disease spread. Each step of the chain is required to effectively transmit illness. Breaking any one of the 6 links prevents disease spread.

   A. Must have a causative agent (pathogen)

      a. Bacteria

      b. Viruses

      c. Fungi

      d. Protozoa

   B. Must have a reservoir for the pathogen: A reservoir serves as a place in the environment where a pathogen lives, replicates and thrives.

      a. Humans with diseases

      b. Symptomatic

      c. Asymptomatic

      d. Animals/insects

      e. Food/water

      f. Environment

      g. Inanimate objects such as clothing, bedding, mops, resident care devices

   C. Must have a point of entry: This is any route that a pathogen uses to enter the body.

a. Breaks in the skin

b. Mucous membranes that are not intact

c. Respiratory system

d. Gastrointestinal system

e. Urinary system

f. Reproductive system

D. Must have a point of exit: The portal of exit refers to any route that the pathogen can leave the reservoir or body.

a. Saliva/other respiratory secretions

b. Urine

c. Feces

d. Drainage from wounds

e. Reproductive secretions

f. Blood

g. Tears (minor risk)

E. Must have a mode of transmission

a. Direct contact – person to person transmission occurs when pathogens are transferred from an infected person to another person.

b. In nursing facilities, resident-to-resident direct contact transmission may occur in common areas of the facility such as the recreation room, rehabilitation area, and/or dining room.

c. Examples of direct contact include:

(1) Skin-to-Skin contact (like touching)

(2) Kissing

(3) Sexual contact

(4) Contact with oral secretions

(5) Contact with body lesions

d. Indirect contact – inanimate contaminated objects to person

e. Examples of opportunities for indirect contact transmission:

(1) Clothing, uniforms, laboratory coats, or isolation gowns used as PPE may become contaminated with potential pathogens after care of a resident.

(2) Contamination of high touch environmental surfaces (all phones, remote controls, kiosk screens, bedside table, bedrails, toilets, sinks, and handrails) contributes to indirect transmission.

f. Airborne: Inhaling small pathogens that float in the air

g. Examples of airborne illnesses:

(1) Measles (can remain in the air for up to 18 hours after the infected individual coughs, sneezes, or talks)

(2) Tuberculosis (can remain suspended for up to 6 hours)

h. Bloodborne: Microorganisms that are present in human blood and can cause disease

i. Examples of blood-borne illnesses:

(1) Human Immunodeficiency Virus (HIV)

(2) Hepatitis-B Virus

(3) Hepatitis-C Virus

j. Droplet: Drops of secretions put into the air through sneezing, coughing or talking

k. Examples of droplet illnesses:

(1) Strep Throat

(2) Influenza

(3) The common cold

l. Food and fluids

m. Vectors

(1) Mosquitoes, parasites

(2) Examples of vector illnesses:

(3) Mosquito: West Nile Virus

(4) Fleas: Bubonic Plague

(5) Ticks: Lyme Disease

F. Must have a host individual to harbor the infectious pathogen (last link in the chain of infection)

Preventing and Controlling Infections

1. Medical asepsis (Clean Technique): Practice(s) used to remove or destroy pathogens to prevent spread of infection from one person/place or object to another person/place or object.
2. Practices to promote medical asepsis
   A. Wash hands with soap and water according to the Centers for Disease Control and Prevention (CDC) guidelines (Procedural Guideline #6). This is the single most important practice to prevent the transmission of infection. List of some situations that require hand washing:
      a. Anytime hands are visibly soiled
      b. After personal use of the toilet
      c. Before and after caring for a resident's personal care, assisting to toilet, feeding and procedures
      d. Before and after eating or handling food
      e. After smoking
      f. After coming in contact with a resident's skin, mucous membranes or body fluid
      g. After contact with any infectious materials
      h. After removing gloves
      i. After blowing or wiping nose or covering mouth while coughing
      j. After handling any soiled materials
      k. After handling used linens, bedpans or urinals
      l. Before moving from work on a soiled body site to a clean body site on the same resident
      m. After contact with objects in the resident's room
      n. After removing PPE
3. Proper use of gloves (discussed under Standard Precautions)

4. Following CDC recommendations for Respiratory Hygiene/Cough Etiquette: Combination of measures designed to minimize transmission of pathogens via droplet/airborne routes
   A. Cover mouth and nose during coughing and sneezing
   B. Use tissues to contain any respiratory secretions/promptly dispose of tissue
   C. Wear a mask when coughing to decrease environmental contamination (follow facility policy)
   D. Turn head away from others when coughing, try to maintain a distance of 3 feet from others
5. Proper use of hand sanitizer (follow facility policy)
6. Wash resident hands before and after meals
7. Clean used equipment and place in approved storage, avoid cross contamination between clean and dirty (follow facility policy)
8. Methods to kill/control pathogens
   A. Disinfection
   B. Use of chemical disinfectants to clean equipment
   C. Decisions about product selection should be made in consultation with environmental services staff.
   D. Select and use disinfectants that are EPA-registered and labeled for use in healthcare settings. These will typically have "hospital-grade disinfectant" or "hospital disinfectant" on the product label.
   E. Kill claims, or information about which pathogens the disinfectant kills, are available on the product label.
   F. Environmental Protection Agency (EPA): Registered Disinfectants
   G. Sterilization: Process of killing all microorganisms
9. Caring for supplies and equipment
   A. Disposable equipment use once and discard in appropriate container
   B. Clean non-disposable equipment (follow facility policy)
10. Disinfectants
   A. Soap and hot water

B. Disposable wipes, cloths

11. Other measures of asepsis
    A. Keep equipment and supplies, linens, etc. from touching clothing
    B. Never shake linen, used or unused
    C. Always clean from cleanest area to the soiled area
    D. When cleaning, clean away from you to prevent contamination of clothing
    E. Pour contaminated liquids into appropriate places, designated hoppers, toilets (follow facility policy)
    F. Clean equipment used on multiple residents between each resident (follow facility policy)

Standard Precautions (CDC recommendations/takes the place of Universal Precautions)

1. Based upon the premise that every person is potentially infected or colonized with an organism that could be transmitted to others in a healthcare setting
2. The primary strategy for preventing healthcare associated transmission of infections among residents and healthcare personnel
3. The nurse aide must be knowledgeable about and closely follow the facility policies
4. Hand Hygiene
    A. Hands may be washed using friction with soap and warm water for all cases
    B. Hands are visibly soiled
    C. Before direct contact with residents
    D. After contact with blood body fluids or excretions, mucous membranes, non- intact skin, wound dressings
    E. Immediately after removing gloves
    F. Between resident contacts
    G. Between tasks and procedures on the same resident to prevent cross contamination
5. Personal Protective Equipment (PPE) (Procedural Guideline #4)

A. You are required to know:

a. How to select the correct PPE

b. Proper procedures for donning (putting on) and doffing (taking off) PPE

c. How to determine if the PPE is contaminated or damaged

d. **NOTE:** Decisions about what PPE to use should be determined by the type and level of contact you will have with the resident. Refer to your facility policy, infection preventionist, and nurse management for specific decisions regarding PPE

B. Consider the following:

a. Will I be touching the resident? Will I be touching potentially contaminated items in their environment?

b. Is it likely I will encounter splash from blood or bodily fluids?

c. Is the resident coughing? Sneezing? Vomiting? Do they have diarrhea?

d. What is the diagnoses of the resident's illness?

e. Are they infectious? What is the pathogen?

f. What is the mode of transmission of the pathogen?

g. Did you refer to your facility policy, infection preventionist, and nurse management for decisions regarding PPE?

C. Gloves

a. When touching blood, body fluids, secretions, excretions, mucous membranes, non- intact skin, contaminated items or contact with resident

b. The way YOU use gloves can influence the risk of disease transmission in your healthcare setting:

c. Do:

(1) Remove gloves after contact with a resident or surrounding environment including medical devices

(2) Perform hand hygiene before and after resident contact, even when gloves are worn.

(3) Work from clean to dirty.

(4) Perform hand hygiene after glove removal.

(5) Change gloves as needed during resident care activities (you may need to change gloves mid-procedure).

d. Do not:

(1) Wash or reuse gloves

(2) Touch yourself while wearing contaminated gloves. This limits opportunities for cross-contamination.

(3) Handle clean materials, equipment, or surfaces while wearing contaminated gloves.

(4) Wear the same pair of gloves for the care of more than one resident.

D. Gown Guidelines

a. During procedures/resident care activities when contact of clothing/exposed skin is anticipated from blood, body fluids, secretions and excretions

b. Gowns should fully cover the torso and have long sleeves. If fluid exposure is anticipated, a fluid-resistant gown should be used.

c. Do:

(1) Remove and properly dispose of gowns before leaving the resident care area.

d. Do not:

(1) Reuse or save gowns for later use, even during care for the same resident.

(2) Use clinical or lab coats as a substitute for isolation gowns.

E. Face Coverings: Medical/Surgical Mask

a. To be worn as a simple barrier to help prevent your respiratory droplets from reaching others.

b. For masks to be effective, they should fit snuggly and fully cover both your nose and mouth.

c. Do:

(1) Change a facemask if it becomes damaged or soiled.

d. Do not:

(1) Confuse facemasks with respirators.

F. Face Coverings: Respirators

a. Respirators (ex. N95 or higher-level filtration) are worn to prevent inhalation of airborne pathogens.

b. Respirators form a tight seal around your nose and mouth and requires a specific evaluation (fit-test) to ensure the safety, fit, and adequate protection.

G. Face Coverings: Goggles

a. Goggles provide protection to the mucous membranes in your eyes from blood and other bodily fluids.

H. Goggles should fit snuggly over and around the eyes.

a. Do not:

(1) Use personal prescription eye glasses as a substitute for goggles.

I. Face Coverings: Face Shields

a. Face shields protect the face, mouth, nose and eyes from blood and bodily fluids.

b. Can be used as an alternative to goggles if extensive splash or spray is anticipated.

c. Should cover the forehead, extend below the chin and wrap around the side of the face.

J. **NOTE:** These are the PPE guidelines to follow under normal circumstances. The CDC and local health department provide PPE optimization guidelines when PPE supplies are stressed, running low, or absent. Please refer to CDC for optimization strategies for optimizing the supply of PPE during shortages.

Environmental Control Guidelines

1. Some pathogens can contaminate environmental surfaces and survive for long periods of time if proper cleaning and disinfection are not performed.
2. Example: Survival time of some common pathogens in healthcare settings on dry, inanimate surfaces:

A. C. Diff: 5 months

B. E. Coli: 1.5 hours to 16 months

C. Norovirus: 8 hours to 7 days

D. Staphylococcus: 7 days to 7 months

E. Hepatitis B: more than 1 week

3. Follow facility procedures for cleaning and disinfecting environmental surfaces and equipment

Textiles and Laundry Guidelines

1. Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids.
2. Always wear gloves and follow standard precautions
3. Wash your hands after handling soiled linen and before handling clean linen.
4. Contaminated linens and fabrics are placed into bags at the site of collection.
5. Handle soiled laundry as little as possible - never shake/agitate the dirty laundry
6. Keep linen away from clothing: Do not "hug" the soiled items - Always carry soiled laundry away from your body.
7. Place soiled linen in specified containers
8. Never mix soiled linen with clean linen
9. Bags containing contaminated laundry must be clearly identified with labels, color-coding, or other methods so that health-care workers handle these items safely
10. Do not use the same cart for both dirty and clean linens - If you must utilize the same cart, thoroughly disinfect the cart between clean and dirty transports.

Transmission Based Precautions (CDC recommendations/formerly Isolation Precautions)

1. Used for residents who are known to be or suspected of being infected or colonized with infectious microorganisms that require additional measures to prevent transmission. They are used in addition to standard precautions.

2. Airborne Precautions - Use in addition to Standard Precautions; use for residents with known or suspected infection that is spread by microorganisms dispersed by air currents.
    A. For example, illness such as (but not limited to):
        a. Tuberculosis (active cases)
        b. Measles
        c. Chicken pox
        d. COVID-19: COVID-19 is mainly transmitted through close contact (i.e., contact transmission and droplet transmission) and can sometimes also be spread via airborne transmission under special circumstances.
3. Resident Placement - Private room, keep doors closed at all times, explain to the resident the importance of remaining in the room
    A. Resident Placement - Private room or with resident with same disease
    B. Have the resident wear a mask when others are in the room.
4. Hand Hygiene - Wash your hands immediately before entering the room (before gloving) Wash your hands immediately after exiting the room (after removing gloves)
5. Mask - Wear a N95 or higher-level respirator prior to entry of the room
6. Respirators should be properly fit and seal-tested prior to room entry
    A. Respirators should only be removed upon exit of the room with the door shut behind you
7. Gowns - Must be worn when entering the room
8. Transport - Limit transport of residents outside of the room. Only move the resident when it is medically necessary.
    A. If transport or movement is necessary, instruct residents to wear a surgical mask, if possible, and observe cough etiquette
9. Droplet Precautions - Use in addition to Standard Precautions; use for residents with known or suspected infection that is spread by droplets generated by coughing, sneezing, talking
    A. Wear goggles or a face shield
    B. Wear a mask when working within 3 feet of resident

Considerations for Care

1. Effects of aging and institutionalization on resident rights and independence.
2. Effects of cognitive impairment on resident rights and independence.
3. Empathy and how we all value our rights.
4. Respect resident rights and promote resident independence in all aspects of the care you give.

The Resident's Care Plan

1. The resident's care plan is a working document that details all of the nursing care that the resident should receive.
2. The information that is in the resident's care plan comes from a comprehensive assessment that the Registered Nurse must complete within a specific timeframe from admission.
3. The care plan is designed to assist all those who are caring for the resident to provide the highest level of care and consistency possible.
4. All members of the care team, including the Nurse Aide, should be a part of the care planning process; as all members bring crucial information about the resident that will be considered in providing a high quality of care.
5. The Nurse Aide is required to provide all care to the resident that is listed on the care plan.

6. Depending on the resident, the care plan may include:
   A. What kind of personal or health care services are needed;
   B. What type of staff should provide the services needed;
   C. How often the services are needed;
   D. What kind of equipment or supplies may be needed to provide the services;
   E. The diet that the resident is prescribed (if there is a special one) or the resident's food preferences;
   F. The resident's health and personal goals; and
   G. How the care plan will help the resident reach his/her goals.

Rights of Residents

- Resident rights as stated in the Nursing Facility Requirements for Licensure and Medicaid Certification, 40 TAC §19.401 - §19.423.

Sexuality and Intimacy

1. Intimacy and physical sexual expression is a basic human right and need throughout the lifespan.
2. Intimacy is defined as an expression of the natural desire of human persons for connection; a state of reciprocated physical closeness to, and emotional honesty with another.
3. Sexual Activity includes sexual contact and other activities intended to cause sexual arousal.
4. There are many myths that are associated with the sexuality and the older adult. These include:
   A. Older people do not have any sexual desires or healthy sexual relationships;
   B. Older people are unable to engage in sexual activities;
   C. Any sexual activity among the elderly is perverse and embarrassing;
   D. Older people are fragile physically and might harm themselves;
   E. Older people are grateful for sexual contact;
   F. Elderly people who claim to be sexually active are fantasizing; and

G. Sex is only for the young.

5. The reality is older adults may still enjoy and be able to engage in sexual activity.
6. In order to respect the rights of the resident, residents that have the capacity must be allowed to have intimate relationships/engage in sexual activity.

Respecting and Promoting Resident Rights and Independence

1. Ensure person-centered care is provided in all instances.
2. Provide privacy.
3. Maintain confidentiality.
4. Communicate appropriately and allow resident to have personal choice whenever possible.
5. Accommodate individual needs and preferences.
6. Encourage residents to participate in care as much as possible.
7. Provide care and security of residents' personal possessions.
8. Maintain safety.
9. Report residents' complaints of grievances and disputes to nurse.

Proper use of technical devices.

1. Assist residents to vote.
2. Assist residents to attend and participate in activities they are interested in within and outside of the facility.
3. Support the resident's right to participate in a group of his/her choosing.
4. Provide care that is free from abuse, neglect, and misappropriation of resident property.
5. Attempt a variety of alternatives to avoid the use of restraints. All attempts must be documented along with the resident's response.

Abuse, Neglect, and Misappropriation of Resident Property

1. Abuse – the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.
2. Physical Abuse: non-accidental force against an individual that results in physical pain, injury, or impairment.
3. Emotional Abuse: speaking to an individual in ways that cause emotional pain or distress
4. Sexual Abuse: engaging in sexual contact with an individual without his/her consent.
5. Neglect – the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
6. Misappropriation of Resident Property – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.
7. Recognizing potential signs of abuse:
   A. Unexplained bruising, swellings, pain or other unexplained injuries.
   B. Sudden changes in resident's personality or behavior.
   C. Fear and anxiety.

Protecting Residents from Abuse, Neglect, and Misappropriation of Property

1. Recognize the different risk factors that may increase the risk of abuse, neglect, or misappropriation of resident property.
   A. Resident characteristics
   B. Facility Risk Factors
   C. Staff Risk Factors
2. Reporting abuse, neglect, or misappropriation of resident property:
   A. As members of the health team, nurse aides are legally and ethically responsible for reporting actual or suspected abuse, neglect, or misappropriation or resident property.

B. Report suspected findings to the nurse and provide factual information requested for filing reports.

C. The Complaint Hotline at HHSC is (800) 458-9858.

Responding to Abusive Behavior

1. Demonstrate personal restraint and control when dealing with an abusive resident or family member.
2. Recognize the underlying reason for the behavior as well as potential triggers.
3. Implement guidelines for dealing with angry residents and families.
4. Implement guidelines for dealing with combative residents.

Communication

1. "Communication" is the way we exchange information with others. Thus, it is the basis of our interpersonal relations.

Effective Communication

1. Sender – the person who wants to communicate information.
2. Message – the information the person needs to send.
3. Channel – the method of sending information.
4. Verbal – spoken or written words

5. Non-verbal – facial expressions, posture, hand/body movements, and appearance
6. Receiver – person to whom the message is sent.
7. Effective listening
8. Reading body language
9. Written – Communication boards, care plan
10. Confirmation – the way the receiver lets the sender know that the message has been received.
11. Recognizing differences in communication styles:
    A. Generation differences
    B. Use of technology
    C. Use of acronyms and slang

Importance of Communication

1. Communications and interpersonal relations are the most important part of life for most people.
2. The nurse aide may be the primary person that the resident communicates with on a regular basis.
3. Communication is an important part of the care that you give. Effective communication can improve your relationships with residents, make your job easier and save wasted time.
4. Communication is also an important part of your personal life. Effective communication can improve your relationships with your family, friends and co-workers.
5. Communicating with other members of the health care team.
6. **Interact stop and watch** – The nurse aide may identify important changes while caring for a resident. Please report any changes to the nurse immediately.

Communicating with Family and Friends of Residents

1. Remember that you are representing yourself and the facility to others.

2. Maintain an open, friendly and supportive relationship with residents' families and friends.
3. Protect resident privacy and confidentiality as required under the HIPAA Privacy Rule.
4. When asked, tell family and friends something about the resident's activities such as "He ate a good breakfast" or "She played Bingo last night."
5. Escort visitors to the supervisor for problems, complaints or reports on a resident's condition.

Answering the Telephone in a Long-term Care Facility

1. Speak clearly and courteously.
2. Identify the facility and your location per facility policy.
3. Identify yourself by name and title.
4. Politely ask who is calling and get contact information.
5. Determine what is requested and transfer call to the appropriate person or take a clear message and relay it to the appropriate person as allowed under HIPAA.
6. Thank the person for calling.

Changes Due to Aging that Affect Communication

1. Communication with residents who have sensory losses.
2. Communication with residents who have memory losses.
3. Communicating with residents who have vision loss.
4. Communicating with residents who have hearing loss.
5. Communicating with residents who have problems with speaking.
6. Communicating with residents who have problems with understanding.

Communication Styles and Goals

1. Communication should be goal-oriented. Think about what you are trying to accomplish and set your goal.
2. Select your communication style based on your goal.

3. Social conversation – goal is to create a comfortable, relaxing atmosphere.
4. Interviewing – goal is to conduct a question and answer period to determine resident needs.
5. Teaching – goal is for the resident to learn and understand.
6. Reporting – goal is to accurately communicate the facts.
7. Problem solving – goal is to help meet resident's needs.
8. Therapeutic communication – goal is to encourage resident to discuss feelings.

Techniques for Effective Goal-Oriented Communication

1. Use every contact with resident as an opportunity to communicate.
2. Talk courteously with residents during care, listening and responding appropriately.
3. Smile and speak when you pass in the hall.
4. Set aside time just to communicate with residents.
5. Continue to communicate with residents who are unresponsive as they may still understand and benefit from your communication.
6. Assure that your verbal and nonverbal communication match and send the same message.
7. Nonverbal messages tend to reflect your true feelings and are thought to be more powerful than what you say.
8. If there is a difference between the verbal and nonverbal messages, people will likely believe the nonverbal message.
9. Plan your message ahead of time as needed to assure it is clear and correct:
   A. Arrange main points in logical order.
   B. Omit unrelated and non-essential information.
   C. Get feedback to determine if message is understood.
10. Select the most appropriate method for sending the message:
   A. Verbal – most commonly used.
   B. Nonverbal – more powerful than verbal.

C. Written – may be useful for residents with hearing loss or memory loss. Also important in communication with health care team.

D. Interpreter – may be required to communicate with a resident in a foreign language.

E. Communication assistive devices – (e.g. picture boards, word boards) may be useful for residents with sensory loss.

11. Individualize your communications to the needs of the resident. The same communication techniques do not work for all residents or all nurse aides.
12. Be aware of what you are saying (verbally and non-verbally) and of the care you are giving.
13. Observe and evaluate the resident's response to what you are saying and doing.
14. Adjust your approach if you are not getting the desired response.
15. Then re-evaluate and re-adjust your approach as needed.
16. Report and discuss your observations and problems with communication to the nurse.

Techniques for Implementing Therapeutic Communication

1. Therapeutic Communication - the face-to-face process of interacting that focuses on advancing the physical and emotional well-being of a resident. Therapeutic communication is the basis of interactive relationships and affords the nurse aide the opportunity to establish rapport, understand the resident's experiences, formulate individualized or resident-centered interventions and optimize the care they provide to the residents.
2. Active Listening – Being attentive to what the resident is saying, verbally and non- verbally. Sit facing the resident, open posture, lean toward the resident, make eye contact, and relax.
3. Silence – Time for the aide and resident to observe one another, sort out feelings, think of how to say things, and consider what has been verbally communicated. The aide should allow the resident to break the silence
4. Providing Information – Relevant information is important to make decisions, experience less anxiety, and feel safe and secure.
5. Clarifying – To check whether understanding is accurate, or to better understand, the nurse restates an unclear or ambiguous message to clarify

Managing Physical Illness

1. Preventing physical illness is very important.
2. Use the Standard Precautions and infection control practices taught in this class to help protect yourself, as well as the residents, from infections and communicable diseases.

Preventing and Managing Injuries

1. The safety practices taught in this class will protect both the nurse aide and the resident from injury.
2. The most common causes of employee injury in long-term care facilities are slips and falls, and back injuries caused by improper body mechanics.
3. Use equipment according to manufacturing guidelines and facility policy.
4. Reporting injuries:
   A. Know and follow the facility policies for reporting injuries and emergencies of residents and staff.
   B. All injuries should be reported, and incident reports completed following facility policy.

Managing Your Time

1. Report for duty on time.
2. Listen to report and read the resident's care plans.
3. Set priorities to make the best use of your time.
   A. Rate each task in order of importance.
   B. Anything that must be done at a specific time is a high priority.
   C. Things that must be done by the end of the shift are next.
   D. Sometimes priorities change because of resident illness or new admissions. Be flexible.
4. The better organized you are, the more easily you will complete your tasks. Good organization also reduces stress.

5. Plan your work for efficient use of your time.
   A. Estimate the time that each task will take.
   B. Identify tasks that you can group together, e.g., while the resident is in bathroom, you can make the bed.
   C. Plan your schedule around meal times.
   D. Plan ahead for tasks in which you will need an assistant or special equipment.
   E. Check on your residents before you begin your assignment.
   F. Take care of resident's immediate needs as this reassures them and makes them less anxious
   G. Check the activities calendar for events that the resident may enjoy
6. Anticipate and gather needed items before you go into a resident's room to avoid unnecessary trips.
7. Work while you are on duty. You are employed and paid to work the entire shift.
8. Take assigned breaks and return in a timely manner.
9. Try to improve your performance.

Protecting Yourself Legally

1. Follow all facility policies to protect your job and assure that you are functioning within the limits of the law. Check facility policy and procedure manuals if you are unsure of how to perform a procedure.
2. Do things the way you were taught.
3. Do not perform skills for which you have not been trained. Inform your supervisor if you
4. don't know how to perform a procedure or are unable to get it done.
5. Protect residents' rights and meet residents' needs in a timely manner. These are both legal obligations and ethical standards (things that are morally right). Follow HIPAA Privacy Rules.

Your Emotional Health

1. "Stress" is mental and physical tension or strain.

A. Working in a LTC facility and dealing with sickness and death can be stressful.

B. Your job may be physically and emotionally demanding.

C. Stress is unavoidable as you help others with their problems.

D. Stress can leave you feeling overwhelmed and out of control.

E. Your personal/family problems may also contribute to your stress.

F. If you are not physically or mentally in good health, stress may seem to worsen.

2. "Burn-out" is total mental, emotional, and sometimes, physical fatigue which can often times cause you to become so overwhelmed with the job routine that other aspects of your life begin to be neglected, such as your family.

3. Understand the signs of burnout.

   A. Chronic fatigue

   B. Insomnia

   C. Forgetfulness/impaired concentration and attention

   D. Physically feeling sick

   E. Increased irritability

   F. Feeling of dread when you have to go to work

   G. Not as engaged when you are at work

   H. Becoming insensitive to the residents

4. Learn ways to decrease burnout.

   A. Monitor extra shifts you are working

   B. Start saying no (to extra work)

   C. Invest in your own health

   D. Discuss concerns of burnout with your supervisor

   E. Identify where things could go wrong

   F. Request assistance as necessary to prevent or resolve burnout.

   G. Make time for downtime

5. Use stress-reducing techniques to cope with stress or sadness.

   A. Take your assigned breaks

B. Whenever possible, participate in relaxation activities that work for you.

C. Increase social interactions

D. Avoid unnecessary stress

E. Alter the situation if possible

F. Adapt to what is causing the stress

G. Make time for fun

6. It is your responsibility to understand your feelings, what may make you angry and how you behave.

   A. A sign of emotional intelligence is the ability to control your emotions.

   B. Ask yourself, "How will my actions affect my residents, my co-workers, my employer, and me?"

   C. Find acceptable ways of coping with these feelings – do not direct your anger towards residents.

   D. Do not take negative resident behavior or remarks personally.

   E. Try to understand why the resident is acting or be having this way. If the behavior is out of the ordinary for this resident, notify the nurse of the changes you are observing.

   F. Regardless of how the resident reacts towards you, you must respond professionally with courtesy and respect.

Personal and Vocational Adjustments

1. Health care rules and directives from supervisors should be followed in a timely manner even if you do not agree with them. (See D. 1 – 4 of this unit).

2. Nurse aide actions contribute to complete care of resident and function of the facility.

3. "Dependability" is one of the most important qualities of a nurse aide.

   A. Be dependable with your attendance by reporting for duty on time and when scheduled.

   B. Keep absences to a minimum. Residents depend on you to be at work when you are scheduled.

C. If you are unable to come to work, always notify the facility as far in advance as possible.

4. Complete your assignment.
5. Respect your co-workers and try to get along with them.
   A. Be available to help others and accept help if you need it.
   B. Treat other staff members with the same courtesy and dignity that you would residents.
   C. Care is best delivered when everyone works as a team.
6. Practice empathy, patience, courtesy, cooperation and emotional control.
   A. Everyone has a right to his/her own feelings. Don't judge other people's feelings as right or wrong.
7. A good attitude is a very important trait that you bring to your job.
   A. Attitude is developed throughout your lifetime and is a reflection of your experiences.
   B. Attitude is an outer reflection of your inner feelings.
   C. Others can see your attitude through your behavior.
   D. Your tone of voice and body language can change the message that you are trying to convey.
   E. Be positive about your job, your contribution to resident care and believe that you will succeed.
8. "Tact" is the ability to do or say things without offending or upsetting other people.
9. Continue to learn and grow.
   A. Health care is always changing as new information and technology become available.
   B. Your nurse aide class is just the beginning.
   C. You may learn much from nurses and other nurse aides.
   D. Attend 12 hours of in-service training per year that is offered by your facility. Attend other continuing education classes as possible.
   E. Read health-related books, journals.

Positioning Residents in Proper Body Alignment

1. Positioning and protective devices
   A. Pillows
   B. Foam wedges - bolster
   C. Handrolls/trochanter rolls
   D. Foot cradles/footboards
   E. Trapeze
   F. Specialized beds and mattresses
   G. Specialized equipment for heels and feet
2. Positioning Residents (Procedural Guideline #42)
   A. Fowlers
   B. Supine
   C. Semi-supine
   D. Prone
   E. Semi-prone
   F. Lateral
3. Beginning and Closing Steps
   A. Note the beginning and closing steps that appear at the beginning of Part 2 – Procedural Guideline.
   B. These standard steps are repeated in most procedural guidelines that are done at the bedside.
   C. Follow the beginning and closing steps as appropriate.
   D. Start with the beginning steps and end with the closing steps for each applicable procedure.
   E. Review the steps with each procedural guideline, as slight differences occur mainly in the sub-points.

Considerations for Care

1. Respect resident's room as private space
2. Respect resident's preferences and privacy
3. Respect resident's personal belongings as irreplaceable
4. Maintain a safe environment

Role of the Nurse Aide in Use and Care of Equipment and Supplies in Resident's Room

1. Bed
2. Side rails
3. Call signal
4. Privacy curtains/screens
5. Window curtains if applicable
6. Resident's belongings
7. Other items

Role of the Nurse Aide in Environmental Control

1. Respect resident's private environment. Share in the role of a homelike environment that is safe and clean.
   A. Cleanliness—team effort
   B. Control of odors
   C. Safety
   D. Comfort and convenience

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1. Basic nutritional needs
   A. Nutrients
   B. USDA MyPlate
2. Importance of food to residents
   A. Nutritional
   B. Psychosocial
3. Changes in nutrition due to aging
4. Common problems related to nutrition
   A. Problems with appetite
   B. Mechanical problems in putting food into mouth, chewing and swallowing
   C. Diabetes

Assisting Residents with Nutrition

1. Setting the stage for pleasant mealtimes
2. Guidelines and Precautions in feeding residents
3. Assisting with Meals (Procedural Guideline #9)
   A. Preparing the eating area
   B. Preparing residents prior to mealtime
   C. Serving (passing) trays
   D. Assisting residents with eating
   E. Monitoring mealtime
   F. Removing trays
   G. Assisting residents after meals
   H. Observing, reporting and documentation
4. Use of assistive feeding devices to maintain independence in eating
   A. Non-slip plate holders
   B. Utensils with built-up handles and other modifications
   C. Plate guards
5. Importance of resident receiving and eating special therapeutic diets ordered by a physician as treatments:
   A. Liquid, soft or easy-to-chew diets
   B. High calorie or high protein diets

C. Low salt, fat or calorie diets

D. Diabetic diets

E. Pureed

6. Feeding the Dependent Resident (Procedural Guideline #10)

Considerations for Care

1. Amount of fluids needed by body
2. Normal daily range of I & O
   A. Fluid intake = 2000 to 2500 cc
   B. Urine output = 1500 to 2000 cc
3. Importance of fluid balance
4. Problems with hydration due to aging or illness
5. How to recognize dehydration and fluid retention

Revised: 1/2022

Urinary Elimination

1. Normal function of urinary system
2. Changes in urinary function associated with aging
3. Common problems of the urinary system
   A. Urinary retention
   B. Urinary incontinence
   C. Urinary infection
   D. Kidney failure
4. Role of the nurse aide in preventing urinary problems
   A. Encourage fluid intake.
   B. Assist with toileting frequently, promptly and regularly as needed.
   C. Provide privacy
5. Indwelling Urinary Catheter Care (Procedural Guideline #35)
   A. Catheters must be ordered by physician.
   B. Catheters must be inserted by licensed personnel.
   C. Catheters must never be used for convenience of staff.
   D. Catheters should always be secured with tape or leg strap.
   E. Provide privacy bags
6. Observing and reporting urinary elimination

Bowel Elimination

1. Normal bowel function
2. Changes in bowel function associated with aging
3. Common problems of bowel elimination
   A. Constipation
   B. Diarrhea
   C. Incontinence
4. Role of the nurse aide in preventing constipation
   A. Encouraging fluid intake

B. Encouraging high fiber foods

C. Encouraging exercise and activity

D. Assisting with toileting promptly and at regular times

E. Providing privacy

5. Role of nurse aide in identifying fecal impaction
6. Role of nurse aide in managing diarrhea
7. Observing and reporting bowel elimination

Bladder and/or Bowel Incontinence

1. Definition and causes
2. Avoiding incontinence
   A. Incontinence is not a normal part of aging.
   B. Regular and prompt toileting is an important measure in avoiding incontinence for all residents, including confused residents.
3. Respect the resident's right to privacy when discussing the use of briefs or toileting.
4. Use of appropriate size of incontinent pads and briefs
5. Use of external catheters for males
6. Incontinent care (review Procedural Guidelines 20 & 21 as needed)
7. Bowel and bladder toileting
   A. Description
   B. Role of the nurse aide in bowel and/or bladder retraining program

Collecting Specimens

1. Urine Specimen Collection (Procedural Guideline #36)
2. Stool Specimen Collection (Procedural Guideline #37)

- OBRA states that residents have the right to be free from restraints which are unnecessary, inappropriate or not required to treat the resident's medical symptoms.

Requirements for Using Restraints

1. Restraints require written doctor's order and consent that specifies the reason for the restraint.
2. Restraints may be used only to treat or protect the resident—not for discipline or staff convenience.
3. The least restrictive type of restraint must be used for the least amount of time.
4. All person-centered approaches must be attempted/implemented prior to the use of restraints, except in the case of emergency restraints.
5. Restraints must be used only as a last resort when all other methods have failed.

Dangers of Using Restraints

1. Physical effects such as skin damage, circulatory impairment, incontinence, nerve/muscle injury, pneumonia, serious injury and death.
2. Emotional effects such as depression, frustration, anger, agitation, disorientation and loss of self-esteem.

Role of the Nurse Aide in Avoiding the Need for Restraints

1. General measures
   A. Keep environment calm, restful.
   B. Eliminate multiple stimuli.
   C. Speak in a calm, gentle manner.
   D. Provide kind, respectful care.
   E. Practice person-centered care principles.
   F. Meet residents' needs, e.g. elimination, positioning, activity.
   G. Frequent observation.

H. Adjust staff and environment to resident's individual needs—not vice versa.

2. Observation and problem-solving
   A. Make careful observations of resident to identify what:
      a. Causes the problem behavior.
      b. Calms or distracts the resident.
   B. Report your objective observations to the nurse to assist the nurse in care planning.
   C. Provide care (that you are trained to provide) following the instructions of the nurse, care plan, and person-centered principles to:
      a. Eliminate cause of behavior
      b. Calm or distract resident.
   D. Continue to report observations to the nurse to assist the nurse with evaluating the plan of care.

Role of the Nurse Aide in the Care of Residents when Restraints are Needed

1. Soft restraints (Mitt)
   A. Precautions
   B. Applying soft restraints (Mitt)
   C. Care of the restrained resident
   D. Observing and reporting
2. Geri chair
3. Pommel chair
4. Scoop mattress
5. Seat belt, lap buddy
6. Side rail

Temperature ("T")

1. Definition: "Temperature" is the amount of heat in the body.
2. Normal "T" and range to be reported
   A. Report below 96°F and above 99°F
4. Importance of accurate measurements.
5. Temperature (Procedural Guideline #14)
   A. Oral Temperature
   B. Axillary Temperature

Pulse (P)

1. Definition: The "pulse" is the rate of the heartbeat.
2. Normal rate and range to be reported
   A. Normal rate – about 76/minute
   B. Report P <60 & >100/minute
   C. Normal rhythm – regular
3. Pulse points
4. Factors that affect pulse rate and rhythm
5. Importance of accurate rate and description of pulse (irregular, bounding, weak, thready)
6. Pulse (Procedural Guideline #15)

Respiration (R)

1. Definition–respiration is inspiration (breathing in) and expiration (breathing out).
2. Normal rate and range to be reported
   A. Normal rate – about 16/minute
   B. Report R <12 & >22/minute
3. Factors that affect respiratory rate, rhythm and character
4. Importance of accurate rate and description (deep, shallow, noisy)
5. Respiration (Procedural Guideline #15)

Blood Pressure (BP)

1. Definition–blood pressure is the force of the blood against the artery walls as the heartbeats.

S 2

2. Normal BP and range to be reported
    A. Recorded as systolic/diastolic
    B. Normal – about 120/80 mmHg
    C. Report <100/60 & >140/90 mmHg
3. Factors that affect blood pressure
    A. Recheck a blood pressure no more than 3 times and wait at least 1 to 2 minutes before repeating the BP measurement on the same arm.
    B. Report to the charge nurse for assistance if you cannot hear the BP or are unsure of what you are hearing after 3 tries. Don't guess at the BP reading.
4. Importance of accurate BP readings
5. Blood Pressure (Procedural Guideline #16)

Height and Weight

1. Definition
2. Importance of accurate measurements
3. Height and Weight (Procedural Guideline #17)
    A. Ambulatory Residents
    B. Non-ambulatory Residents
    C. Contractures

Importance of Observing, Reporting and Documenting in LTC

Importance of the Nurse Aide in Observing and Reporting

Minimum Data Set – The MDS is a 52-page resident assessment document

1. Purpose
    A. Drives care
    B. Sets reimbursement
    C. Regulatory document
    D. Justifies staffing
2. CNA Impact

A. Documents ADLs
   a. Transfer
   b. Toileting
   c. Eating
   d. Bed mobility
   e. Behaviors
   f. Restorative

B. Reflects amount of assistance required in Self Performance (what resident does):
   a. Independence
   b. Supervision
   c. Limited
   d. Extensive
   e. Total
   f. Activity did not occur

C. Reflects amount of assistance required in Support (what staff does):
   a. No set-up upon assistance
   b. Set-up only
   c. 1 person physical assist
   d. 2 person physical assist
   e. ADL did not occur

Types of Observations

1. Objective observations
2. Subjective observations

Guidelines for Effective Observations

1. Develop the habit of making systematic observations as you work. Go from head to toe or use your own system.
2. Use your senses (sight, touch, hearing, smell).

3. Learn the usual/normal condition for resident, keeping in mind person-centered care principles (both physical and mental).
4. Then note any changes from the usual condition for that resident, such as: if a resident's usual BP is 170/100, then a "normal" BP of 120/80 may be unusual for that resident.
5. Document your observations on-the-spot and use for reporting.

How to Report

1. General reporting guidelines
2. Follow facility policy for reporting.
   A. Urgent reporting
   B. Routine reporting

Documentation

1. What is documentation
   A. Factual information about the resident
   B. Includes the needs and conditions of the resident and the care that is provided by the CNA
   C. Occurs on an on-going basis
   D. Firsthand record of any and all observations made by the care staff
2. Why document
   A. Documentation allows caregivers to communicate with one another
   B. It is used to ensure that services that were paid for, for each individual resident, are delivered
   C. Provides a picture of the resident's condition
   D. Details how the resident is responding to treatment
   E. It is a legal record of care that can be used in a court of law
3. When should you document
   A. Documentation should occur as soon as possible after the care and/or services are provided to the resident

B. It is **NEVER** okay to document that care/services were provided prior to being delivered to the resident

C. Each nursing facility will have its own policies and procedures related to documentation, which may include documentation by exception.

4. What is documentation by exception

A. This is the implication that all standards have been met with a normal or expected response unless otherwise documented.

B. Well-defined guidelines and standards for each resident must be in place

C. If 'normal limits' are used to indicate the need to document or not, then these normal limits must be clearly defined

D. When in doubt, it is better to be safe and document, as inadequate documentation can result in harm to the resident and possible legal consequences.

5. What should be documented

A. CNAs are responsible for documenting activities of daily living (ADLs) that are outlined in each resident's care plan

B. Any other activities in which assistance is provided

C. Useful information that the family provides about the resident

D. Any refusal of assistance by the resident

E. Observations that are made regarding the resident

How to Document

1. General documenting guidelines

A. Accurate and complete information must be provided

B. Documentation must be done on time

C. Done in a legal manner, ensuring that all information provided is factual, without any opinions

D. Professional (words spelled correctly and writing is legible)

2. Follow facility policy for documenting

A. On worksheets/flow sheets

B. In charts

C. Electronic systems

Consequences of Incomplete/Improper Documentation

1. When documentation is not completed properly, there can be serious consequences
   A. Legal consequences such as litigation, loss of job, and loss of licensure
   B. Changes in the resident's condition may be overlooked
   C. Resident's quality of care can suffer, potentially leading to injury, hospitalization, and even death
   D. The nursing facility may be subject to survey citations which may lead to fines or other penalties

Observing and Reporting Summary

1. Review and summarize guidelines for observing and reporting.
2. Signs of Infections
   A. Temperature elevation
   B. Chilling and sweating
   C. Skin hot or cold, color flushed or blue
   D. Inflammation (heat, pain, redness, swelling)
3. Respiratory Problems
   A. Noisy, labored, difficult respiration (dyspnea) shortness of breath (SOB), wheezing
   B. Coughing - dry or productive. If productive, describe sputum
   C. Change in color of lips or nails, usually blue
4. Cardiovascular Problems
   A. Chest pain
   B. Headache, dizziness, vomiting, weakness, paralysis
   C. Cold, blue, numb or painful feet or hands
5. Skin Problems

A. Skin changes such as rash, redness, irritation, bruising, discoloration, swelling, skin breakdown, drainage, foul odors

B. Skin complaints such as burning, itching, tingling, numbness, pain

C. Skin infections d. Pressure areas

D. Skin growths (benign and malignant)

6. Bowel or Abdominal Problems

A. Unusual appearance of stool. Presence of unusual substances such as blood, mucus

B. Bowel complaints such as pain, constipation, diarrhea, bleeding

C. Indigestion

D. Nausea and vomiting

E. Abdominal pain

F. Abdominal bleeding (digested blood causes vomitus and stool to look like "coffee- grounds")

7. Urinary Problems

A. Unusual appearance of urine -- such as dark, red, cloudy instead of yellow or straw colored. Presence of unusual substances such as solid particles, blood, odor

B. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain

C. Changes in mental status

8. Fluid Balance Problems

A. Signs of dehydration such as low fluid intake, low output of dark urine with strong odor, weight loss, dry skin, dry mucous membrane (lips, tongue, eyes), drowsiness, confusion

B. Signs of fluid retention such as edema, weight gain, respiratory difficulties

C. Changes in mental status

9. Mental status changes

A. Changes in level of consciousness/alertness

B. Changes in behavior or communication

C. Changes in mood or emotional status

D. Changes in memory or confusion

E. Threats of suicide or threats of harm to others

1.3.4 Admission, Transfer and Discharge

[redacted]

Types of Admissions/Discharges/Transfers

Effects of Admissions/Discharges/Transfers on Residents

Role of the Nurse Aide in Admitting, Discharging and Transferring Residents

1. Follow the policies and procedures of your facility, as variations exist in methods, roles and responsibilities.
2. Request and follow instructions from charge nurse.
3. Set aside adequate time for the procedure and have the room and needed supplies available.
4. Transport the resident following facility policy.
5. Use effective Communication and Interpersonal Skills (Procedural Guideline #8). Be a good listener and develop supportive relationships with residents.
6. Provide person-centered assistance and support to reduce the resident's stress and anxiety. Even under the best circumstances, these procedures represent changes that may result in increased stress and anxiety for the resident.
7. Take baseline TPR, BP, Height and Weight following facility policy and Procedural Guideline #14 thru #17.

The Interdisciplinary Restorative Team

The Importance of The Nurse Aide in Restorative Care

Guidelines for Restoration

1. Restoration is a resident's right.
2. Restoration is a team effort.
3. Restoration should be based on the resident's specific needs, following person-centered principles Promote optimal physical and psychosocial wellness.
4. Prevent complication through proper care.
5. Maximize self-care within limitations.
6. Provide support, empathy, patience, encouragement, enthusiasm, and praise.
7. Acknowledge success, however small.
8. Emphasize strengths and abilities—not weakness and disabilities.
9. Emphasize independence—not helplessness.
10. Convey a positive attitude of hope.
11. See the resident as a whole, complex person—a unique individual, implementing person-centered care principles. Realize that problems in one area of life may affect other areas or overall functioning.

1.4.2 Role of The Nurse Aide in Restoration Care

[redacted]

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Review of General Restorative Measures

1. Restorative measures related to the activities of daily living (ADL's):
   A. Hygiene and grooming
   B. Activity
   C. Nutrition and hydration
   D. Elimination
   E. Communication
   F. Mobility and bed mobility
2. Role of the nurse aide in applying general restorative measures and promoting self-care
   A. Use a restorative approach in the care of all residents, with a focus on independence and the quality of life.
   B. Prevent complications and promote wellness by:
      a. Encouraging activity, exercise and good alignment
      b. Offering adequate food and fluids
      c. Providing proper skin care
      d. Practicing safety and infection control
   C. Explain procedure and encourage resident's participation to his/her level of ability. (standard beginning steps of Procedural Guidelines).
   D. Allow adequate time for residents to complete self-care tasks.
   E. Always replace call signal and needed items within resident's reach (standard closing step of Procedural Guidelines).
   F. Encourage resident to use strengths to overcome weaknesses. Look for things the resident can do and build on the abilities.
   G. Encourage residents to function as independently as possible—but not beyond his/her capabilities.
      a. Independence can be physical such as walking or mental such as decision- making.
      b. Seek help from nurse in understanding residents' abilities and disabilities.

c. Find the right balance for each resident.

d. Generally, stop short of resident becoming frustrated, discouraged or giving up.

H. Make careful observations to prevent complications and to monitor the resident's progress.

I. Be sensitive to residents' needs and responses.

a. Identify what works and what doesn't work for residents.

b. Report your observations to the nurse (standard closing step of Procedural Guidelines).

Specific Restorative Programs

1. Restorative care planning begins on the day of admission and is:
   A. Based on needs of individual residents
   B. Developed and implemented by the restorative team
   C. Written in the resident care plan
2. Specific restorative programs
   A. Hygiene and grooming program
   B. Exercise program
   C. Ambulation program
   D. PROM program
   E. Pressure sore prevention program
   F. Dining program
   G. Bowel/bladder program
   H. "Alternatives to Restraints" program
   I. Communication program
   J. Behavior management program
3. Role of the nurse aide in assisting with specific restorative programs
   A. Make careful observations of residents' problems and/or restorative needs.

B. Report your objective observations to assist the nurse in assessing, planning care and the document programs.

C. Review and become familiar with the specific restorative plan of care.

D. Understand exactly what your role and responsibilities are.

E. Request information and assistance from the nurse.

F. Follow the restorative care plan and instructions of the nurse, keeping in mind the principles of person-centered care.

G. Report changes in improvement or decline to the nurse.

H. Work with the restorative team as appropriate. Your participation can be valuable to the success of the program and can be a valuable learning experience for you.

Assisting Resident with Adaptive or Assistive Devices

1. Grooming devices
2. Ambulation devices
3. Feeding devices
4. Communication devices

Assisting Residents with Prosthetic Devices

1. Eyeglasses
2. Hearing aids
3. Artificial eyes
4. Artificial limbs
5. Braces and splints
6. Dental devices

Maintaining PROM

1. Range of motion refers to the distance a joint will comfortably move.
2. Types of PROM
   A. Active

Hierarchy of Needs

1. Abraham Maslow, a psychologist, studied the basic human needs that motivate people.
   A. He identified 5 basic human needs and arranged them in a pyramid to show their order from the most basic to the highest level needs.
   B. Maslow's theory is that people strive to meet their unmet needs, but the most basic needs must be met before the person is free to meet the needs at the next higher level.
   C. Individuals move up and down the pyramid of needs on an on-going basis, often meeting many needs with one activity.
   D. The needs are interactive, that is, changes in one's needs will cause changes in other needs.
2. The resident is a person with basic human needs. Use effective Communication and Interpersonal Skills (Procedural Guideline #8). Be a good listener and develop supportive relationships with residents. Be constantly aware of how the resident is responding, and adjust your approach and methods to achieve the desired results. Request help from the nurse as needed to assist in meeting psychosocial needs.
3. Physical or physiological needs of residents are the most basic needs related to body function.
   A. Meeting the physical needs of residents is covered in Sections I thru IV of this course.
   B. If physical needs are not met, the higher needs cannot be met.
4. Security needs of residents are both physical and psychosocial.
   A. The physical aspects are related to the resident receiving care in a safe manner. Provide safe care to residents (covered throughout this course). Perform care in an organized, consistent and confident manner. Answer call signals promptly and be available to help residents who need help.
   B. The psychosocial aspects are related to the resident trusting the caregiver and "feeling" safe and secure. Develop trusting relationships with residents. Check in on residents and offer assistance even before they ask for help. Follow-through on commitments you make to the resident.
5. Sexual needs of residents are both physical and psychosocial in nature.

A. Sexuality includes physical sex, as well as sensual pleasures related to physical appearance, touch, intimacy, caring and love. Use praise and touch as appropriate to help meet needs for love and caring. Assist residents to feel good about his/her physical appearance by:

   a. Providing care that includes occasional extras such as a new hairstyle.

   b. Complimenting resident on appearance emphasizing his/her best features.

B. Sexual needs and practices are highly individual.

C. Sexual behavior of older adults

   a. Myths

   b. Facts

D. Managing sexual behavior of residents

   a. Appropriate sexual behavior. Provide privacy for appropriate sexual behavior of residents such as closing doors and knocking before entering.

   b. Inappropriate sexual behavior. Manage inappropriate sexual behavior by calmly directing resident to a private place and notify a nurse. Follow instructions given by the nurse and as included in the care plan.

6. Love or social needs of residents are met through interpersonal relations that result in a sense of belonging, acceptance, and affection. For some residents, you may be the major social contact and/or the major source of assistance in making social contacts with others.

   A. Listen carefully and express genuine interest in residents/activities.

   B. Encourage and assist residents to maintain relationships with family/friends.

   C. Assist residents to prepare for visits or outings with family/friends.

   D. Help family/friends feel welcome at the facility and encourage visits.

   E. Work with the nurse to refer the resident to a social worker, activity director and/restorative team to meet social needs.

      a. Support and assist residents with unplanned social contacts such as:

      b. Introducing the resident to other people.

c. Arranging the environment to promote socialization and avoid conflicts between residents.

d. Informing residents of social activities that they may enjoy.

e. Assisting residents to prepare for and arrive on time for social activities.

f. Respecting resident wishes regarding participation in activities.

7. Self-esteem or status needs of residents are the psychological and emotional need to feel good about one's self.

   A. Respect each resident as a unique individual.

   B. Identify each resident's strengths and reward independence with positive feedback.

   C. Use rewards appropriate to the residents' preference such as positive feedback, praise, compliments, congratulations, a handshake, a pat on the back, or a hug.

8. Self-actualization is the highest level psychosocial need that can only be met if all of the other needs are met.

   A. It is the need to fulfill one's own unique potential.

   B. Being "the best that you can be" at whatever you strive to be is a self-actualizing experience. There are limitations to assisting another with self-actualization, as this process is highly personal, internal and unique to each individual.

   C. Assure that basic needs are met and encourage and support residents in achieving goals and independence.

9. Spiritual needs are psychosocial in nature.

   A. Self-actualization is often attained through spiritual or religious activities.

   B. Know and respect the spiritual beliefs of each resident and handle with care and respect.

   C. Spiritual needs include:

      a. Personal values - Encourage residents to discuss spiritual beliefs and personal values.

      b. Religious beliefs - Inform residents of available spiritual/religious activities. Assist residents to participate in spiritual activities of his/her

choice. Provide privacy for religious visits and practices as requested. If a resident asks to see a clergy, report request to nurse promptly.

Major Losses and Changes Associated with Aging.

1. Most older adults suffer at least some of these losses/changes. They may occur in rapid succession over a short period of time following a change in condition. The losses and changes (like the basic human needs) are interactive, that is one loss will be intensified by another loss.
   A. Loss of health and fitness may occur through the onset of sensory impairments, short-term memory loss and chronic disease.
   B. Loss of economic security may occur through loss of job, income, home, belongings and other losses.
   C. Loss of relationships may occur through death or loss of spouse, family, friends, and pets.
   D. Loss of independence and control over own life may occur as a result of other losses.
      a. Admission to a nursing facility or other health care institution maybe necessary due to one or more losses.
      b. Relocating to an unfamiliar environment and giving up an established lifestyle represents the ultimate loss of independence to many.
2. Effects of losses and changes on basic human needs.
   A. The loss of health may decrease the person's ability to meet own needs.
   B. The loss of health may increase the complexity of physical care, medical care and the need for assistance. This will affect physical as well as self-esteem and independence needs.
   C. The loss of a spouse or other family and friends may occur, leaving the person alone (without a support system) to deal with health, as well as security problems. This will affect the need for security, love, self-esteem and independence.
   D. If these events require relocation to a nursing facility, the resident's ability to adjust may be overwhelmed. This will affect all of the basic human needs (including independence) and the way in which all of the needs will be met.

E. Respect the resident's individuality and dignity by encouraging independence, decision-making, and promoting resident rights and self-esteem.

F. Assist residents to establish and maintain a daily schedule of activities as similar as possible to his/her prior life style.

G. Encourage residents who are sad or grieving to express feelings. Allow them to cry to express his/her feelings. Avoid saying "Don't cry".

H. Listen to residents who feel helpless, useless, or hopeless; try to involve them in useful activities of his/her choosing such as helping someone or reading.

I. If a resident verbalizes fear and anxiety report to a nurse and follow guidelines given by the nurse and in the care plan.

J. Allow residents who are frustrated or angry to talk about his/her anger. Don't take the behavior personally.

Developmental Tasks Associated with Aging

1. Erik Erikson, another psychologist, studied the "developmental tasks" or tasks to be accomplished at the different stages of the life cycle. A brief summary of these developmental tasks follows:

   A. Infant – Develops basic trust (security). Receives care.

   B. Toddler – Develops autonomy (self-identity). Learns self-control.

   C. Preschool – Develops initiative (ambition/drive). Explores world.

   D. School Age – Develops industry (work). Gains skills.

   E. Teenage – Develops identity (individuality and sexuality).

   F. Young Adult – Develops intimacy (close relationships). Starts family.

   G. Middle Adult – Develops generativity (productivity). Pursues career.

   H. Older Adult – Develops ego integrity (mature identity). Reviews own life and accepts own mortality.

2. The developmental task of older adults (age 65 and above) represents a major change in focus.

   Like self-actualization, there are limitations to assisting with this developmental task, as the process is highly personal, internal and unique to each individual.

Developmental tasks may include:

A. Adjusting to the many losses and changes associated with aging

B. Reviewing own life experiences (reminiscing)

C. Accepting being old

D. Resolving remaining life conflicts

E. Realizing the continuity of life beyond own mortality

F. Integrating life experiences into a meaningful whole

G. Becoming comfortable with own life and own self

H. Accepting own life and inevitable death (mortality) without despair or fear

I. Allow resident time to recall and review life experiences as desired.

J. Listen carefully and point out resident's strengths, successes and positive experiences. Validate where they are – discuss ***Validation Therapy developed by Naomi Feil.***

K. Assist resident to contact and interact with family/friends as desired.

L. Encourage and assist resident to review family pictures, records and other items.

Normal Responses to Losses and Changes Associated with Aging.

1. Psychological responses of residents to losses/changes. These are normal responses commonly used by people adjusting to loss/change.

   A. Sadness and grief are normal and even psychologically necessary responses to losses and changes—not only loss of family/friends, but also losses such as mobility/independence/health.

   B. Fear and anxiety are normal responses that can become generalized as a result of past losses, fear of future losses and the feeling of vulnerability.

   C. Helplessness, uselessness, and hopelessness are normal responses that occur with the realization that past losses can't be reversed, and future losses can't be avoided. d) Frustration and anger are also normal responses. Anger may be internalized, but it is difficult to maintain self-esteem and be angry at one's self. Anger may be directed outward at

family, friends or caregivers. This misplaced anger is difficult to deal with, but it is a better solution for the resident's mental health.

2. Coping or defense mechanisms used by residents adjusting to loss/change. These are normal methods commonly used by people to cope with stress and protect self-esteem. How a person copes with loss/change is largely determined by how well the person has mastered the developmental tasks.

   A. "Compensation" is using a strength to hide a weakness, e.g. a person with hearing loss may attend a discussion group and do all of the talking to hide his/her inability to hear.

   B. "Rationalization" is providing an acceptable but untrue reason for one's own

   C. behavior, e.g. "I'm too sick to go to the discussion"

   D. "Projection" is placing the blame for one's own problem on someone or something else, e.g. "I can't hear you because you mumble."

   E. "Denial" is refusing to admit that a problem exists, e.g. "I do not need a hearing aide.

What is Culture Change?

1. The purpose of culture change philosophy is to promote a new way of thinking relating to people living in nursing facilities. The "old" culture was task-oriented and schedule driven and the new culture is focused on the person living in the facility and building relationships between that person and the people working in the facility. It is a change of perspective from viewing the nursing home as a work site controlled by nursing facility employees to viewing it as the residence of people with disabilities, regardless of age, living in his/her own home.

Cultural Influence on Residents' Needs:

1. Culture is the customs, beliefs, social practices, and traits of a racial, religious or social group.
2. Culture is not a basic human need but has a strong influence on needs.
3. Know and respect the cultural background of residents.
4. Talk to residents and/or family about his/her cultural background and practices and support the resident as appropriate.
5. Report special needs verbalized by the resident to the nurse so they can be included in the care plan.

Major Characteristics of Culture Change Include:

1. An environment of home and community within long-term care facilities;
2. A vision of leadership committed to cultivating living environments that nurture, inspire and create a home-like setting and ambiance for the people who live there;
3. A paradigm of person-centered and person-directed care practices;
4. Emphasis on the dignity and worth of an individual's preferences related to routine tasks (e.g., bathing times, set bed-time hours, flexible dining choices);
5. Consideration of the voices of people with disabilities regardless of age, medical condition or limitations; and
6. The empowerment and support of direct care workers.

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Purpose of Culture Change (Changing Routines and Organizational Approaches to Individualize and De-Institutionalize Care)

1. Person-directed care
   A. Care is directed by and centered on the person receiving care
   B. Meaningful relationships for those who live and work in the facility as well as involving families and friends to create a community
2. Person-directed care values:
   A. Dignity
   B. Respect
   C. Purposeful living, self-determination
   D. Freedom to make informed choices about daily life and health care) Meaningful relationships for those who live and work in the facility
3. Residents control his/her schedule for:
   A. Waking
   B. Bathing
   C. Going to bed
   D. Eating – what and when they want to eat
4. Residents can create living spaces that are more private, comfortable and personalized
5. Residents have a say about the environment of common areas in the facility.
6. Meaningful involvement of the residents' family, friends and the greater community outside the facility walls.
7. Quality of life and quality of care are equally important.

Long-Term Care and Culture Change

1. The same staff takes care of the same residents
2. Good relationships develop between staff and the residents
   A. Motivates staff to provide better quality of care
   B. The resident feels more secure, content and happy

3. Lower staff turnover
4. Formation of "neighborhoods"
    A. Smaller groups of residents
    B. Consistent staff assignment

Language

1. Patronizing language
    A. What is it?
    B. The words we use and how they affect the relationship
    C. How elderly people react to patronizing language
    D. How the elderly regard those who use it
2. Language that bothers some people
    A. High pitched voice
    B. Loud voice
    C. Slow talk
    D. One-sided conversation
    E. Calling someone "dear", "sweetie", etc.
    F. Using first name
    G. Saying, "it's time for our ...."
        a. Using "we" or "our" when speaking to an older person
        b. It confuses the difference between you and me and implies that the person cannot make independent decisions.

1.5.3 Specific Behavior Problems

Student Objectives:

- Describe how an unmet need might cause you to behave in a certain way.
- Describe the unmet basic human needs that are most likely to cause behavioral problems in:
    - An alert, orientated resident

    - A confused resident
- Psychosis, dementia and combative residents
- State the steps of behavior management.
- Discuss how the nurse aide functions with the health care team for behavior management.
- Describe 1 step for increasing appropriate behavior and 1 step for reducing inappropriate behavior.
- Discuss NCSBN Professional Boundary Guide
- Have students participate in role play to learn how to react to different situations.
- Give 2 examples of a verbal and nonverbal reinforcer.
- Describe and/or demonstrate skill in assisting residents with specific behavior problems
    - Sleep problems
    - Depression
    - Complaining or demanding
    - Yelling or screaming
    - Verbal or physical aggression

Considerations for Care

1. All behavior has a meaning.
2. Many experts believe that the purpose of behavior is to satisfy unmet needs.
3. Patterns of behavior are developed throughout a lifetime based on heredity and environment (life experiences).
4. Most older adults continue to use the same behavioral responses that they learned throughout his/her life.

Causes of Behavioral Problems

1. Remember that a resident's behavior may be a response to an unmet need.
    A. In an alert, orientated resident the unmet need is usually psychosocial.
    B. In a confused resident, the unmet need is usually physical.

2. Behavioral problems occur when the stresses associated with aging exceed the resident's ability to cope with stress.
3. Behavioral problems vary widely. Those included here are some of the more common behavior problems seen in nursing facilities.

Behavior Management

1. ABCs of behavior management
   A. A is the Antecedent (cause) of the behavior.
   B. B is the Behavior.
   C. C is the Consequences (effect or results) of the behavior.
2. Three steps of behavior management
   A. Step 1 – determine the cause of the behavior.
   B. Step 2 – eliminate the cause of the behavior. If the cause is eliminated, the behavior should stop or change.
   C. Step 3 – sometimes the consequences of the behavior may also have to be eliminated in order to eliminate the behavior, especially if the behavior has been rewarded over a period of time.

Role of the Nurse Aide in Assisting with Specific Behavior Management Plans. Behavior Management is Restorative Care.

1. Know and understand the residents in your care. Know at least one effective measure to comfort and/or distract each resident such as:
   A. Objects such as a favorite pillow, doll, or something new and interesting.
   B. Activities such as a favorite topic, music, TV, rocking chair, holding hands.
   C. A favorite caregiver who is effective in calming the resident.
2. Report your objective observations to assist the nurse in assessing and planning care.
3. Review and become familiar with the specific behavior management plan.
4. Understand exactly what your role and responsibilities are.
5. Request information and assistance from the nurse.

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6. Continue careful observations and objective reporting to assist the nurse in evaluating the plan of care. Share your observations of comfort measures and the resident likes and dislikes with the nurse to assist others in working with the resident.
7. Increase the resident's appropriate behavior by reinforcement (rewards) as specified in the care plan. Rewards must be acceptable to the resident and sincere.
   A. Verbal reinforcement may include positive feedback such as approval, praise, compliments, congratulations.
   B. Nonverbal reinforcement may include touch that is acceptable to the resident such as a pat, hug, handshake, or other rewards (a smile, snack, public recognition).
8. Reduce the resident's inappropriate behavior by:
   A. Ignoring it, if you can safely do so
   B. Continuing to reinforce appropriate behavior
   C. Other non-punitive responses as specified in the plan of care
9. Share your experiences with the resident, with the nurse and the behavior management team as appropriate. Your participation can be valuable to the success of the program and can be a valuable learning experience for you.

The Behavior Management Plan May Require that You Modify Your Behavior in Response to a Resident's Behavior.

Specific Behavior Problems:

1. Assisting Residents with Sleep Problems
   A. If resident has difficulty falling asleep at night:
      a. Promote sleep by offering P.M. care, controlling noise, dimming lights and other measures.
      b. Allow resident to remain up and provide appropriate activity that won't disturb others. Don't set a specific bedtime.
   B. If resident wakes up in middle of the night:

a. If resident is frightened, provide reassurance and comfort measures.

b. If resident is confused, provide orientation to time, place and person.

c. If resident wants to get out of bed, assist to location close to nurse's station and provide diversional activities as appropriate.

C. Follow guidelines provided by the nurse and in the care plan to decrease environmental problems, anxiety, fear, pain, too much sleep or caffeine, too little exercise and unmet needs, such as elimination of fluids.

D. Provide care to eliminate cause(s) of the behavior as instructed by the nurse and behavior management plan.

2. Assisting Residents who have Depression

A. Depression is a mental disorder

a. It may occur following stress or losses such as death of a spouse, or as a natural consequence of aging.

b. Signs and symptoms include sadness, fatigue, decreased concentration, memory loss, sleep/eating disorders, crying, lack of interest, low self- esteem.

B. Develop an honest, caring and supportive relationship with the resident.

C. Listen and encourage the resident to express feelings. Use open-ended statements like "Tell me why you are sad?"

D. Do not interrupt or change the subject. Follow communication guidelines. Do not use phrases like "cheer up," "stop crying" or "things could be worse."

E. Encourage physical activity as tolerated.

F. Encourage resident to participate in meaningful activities.

G. Encourage family/friends to provide support and activities.

H. Promptly report changes in behavior (both increased and decreased sadness) and threats of suicide to the nurse immediately.

I. Follow instructions of the nurse and behavior management plan as appropriate.

3. Assisting Residents Who Are Complaining or Demanding

A. Talk with the resident to determine the nature of the complaint/demand and report objective observations to the nurse.

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B. Correct or meet justified complaints or demands as instructed by the nurse.

C. If complaint/demand is not met, tell the resident that you are reporting it to the nurse.

a. Listen and provide support.

b. If complaints are related to the care, do not take it personally. Do not become defensive, take sides or argue with the resident.

c. Give the resident as much control as possible over daily life and routines.

d. Try to distract the resident with a favorite object or activity as appropriate.

e. Assist the nurse in identifying the cause of unjustified complaints such as boredom; need for attention, anger, long standing behavior patterns, or unmet needs.

D. Follow the instructions of the nurse and behavior management plan as appropriate.

4. Assisting Residents Who Are Yelling or Screaming

A. Try to distract the resident.

B. Listen to what the resident is saying and provide care as indicated to alleviate the cause of anger.

C. Report the behavior to the nurse immediately.

D. Follow the instructions of the nurse and behavior management plan as appropriate.

5. Assisting Residents Who Are Verbally or Physically Aggressive

A. Verbal aggression is arguing, threatening or accusing, usually in a loud and angry voice. Physical aggression or combative behavior includes hitting or kicking or other physical gestures.

B. Remain calm, reassuring and use non-threatening body language.

C. Do not become defensive, argue or try to reason with the resident.

D. Move the resident into a private space or move other residents to safety.

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a. If the attack is directed at you, leave if you can safely do so, or call for assistance of a caregiver to help calm the resident and control the behavior.

b. If the attack is directed at another resident, request assistance and remove both residents to separate areas.

E. For physical aggression, use the following safety precautions:

a. Notify the nurse promptly and obtain needed assistance.

b. Protect yourself following facility policy.

c. Take threats seriously and keep your distance.

d. Do not try to touch or turn your back on the combative resident.

e. Don't back the resident into a corner.

F. Try distraction or have the resident's favorite caregiver assist in calming the resident.

G. Report behavior immediately to the nurse.

H. Follow the instructions of the nurse and behavior management plan as appropriate.

1.5.4 Cognitive Impairment

Student Objectives:

- Define cognitive impairment, dementia and Alzheimer's Disease.
- State the major difference between acute and chronic dementia.
- Describe the three main types of Dementia
- Explain the three stages of Alzheimer's Disease
- Describe the effects of Alzheimer's Disease.
- Describe the behavioral responses to cognitive impairment.
- List the different behaviors that may be seen in Dementia.
- Discuss the special needs of cognitively impaired residents (e.g., as in early, middle and late stages of Alzheimer's Disease).
- Discuss the importance of using verbal and non-verbal communication inworking with cognitively impaired residents.

- Discuss pitfalls to avoid.
- Describe and/or demonstrate skill in assisting cognitively impaired residents:
  - By using communication
  - With memory loss/confusion
  - By using reality orientation
  - By using validation therapy
  - With wandering
  - With resistance to care
  - With self-control
  - With catastrophic reactions

Definitions

1. Cognitive impairment means impaired or damaged thinking.
   A. The main symptoms are memory loss and confusion.
   B. Cognitive impairment is not a normal part of aging.
2. Dementia is an umbrella term for a group of symptoms that describe a decline in a person's mental ability that is severe enough to interfere with his/her daily life. In addition to dementia, there are a significant number of other diagnoses that can cause the same symptoms. It is important that you understand the difference in how the symptoms present themselves in the resident.
   A. Delirium (known as acute dementia): is a medical condition that results in confusion and other disruptions in thinking and behavior, including changes in perception, attention, mood and activity level. These symptoms may mirror those of Dementia; however, the cause of the delirium is often treatable and reversible. In residents with delirium, there is an abrupt confusion, emerging over days or weeks, and represents a sudden change from the person's behavior or level of functioning.
   B. Chronic dementia: a medical condition, caused by any number of different disease processes that causes a progressive, subtle decline in memory and at least one other cognitive area in a resident who was previously alert. Dementia is a non-curable disease process that will ultimately result in death.

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Dementia in Long-term Care

1. Dementia is an umbrella term for a group of signs and symptoms that describe decline in a person's mental ability that is severe enough to interfere with his/her daily life.
2. There are over 100 different types of dementia, with the most common types of dementia being:
   A. Alzheimer's Disease: the most common type of dementia, accounting for 60%- 80% of all cases of dementia. The abnormalities seen in Alzheimer's Disease include deposits of protein fragment beta-amyloid (plaques); twisted strands of protein tau (tangles); and evidence of nerve cell damage and death in the brain.
   B. Vascular dementia (also known as multi-infarct): the second most common type of dementia, accounting for approximately 10% of all dementias. This type of dementia shows, in brain imaging that there are blood vessel problems.
   C. Dementia with Lewy Bodies: the third most common type of dementia that shows Lewy bodies, which are abnormal clumps of the protein alpha-synuclein that develop in the cortex of the brain.
3. Knowing how the different types of dementia affect the brain will help you to understand why some people with dementia behave in the ways that they do.
4. A resident may present with different signs and symptoms, depending on the area of the brain that is being affected. The different signs and symptoms may include (not all- inclusive):
   A. Trouble remembering things;
   B. Impaired communication;
   C. Poor judgment;
   D. Disorientation;
   E. Confusion;
   F. Behavior changes;
   G. Problems with planning;
   H. Sleep disturbances; and

The Different Types of Dementia:

1. There are over 100 different types of dementia. The following are the most common types of Dementia, including:
   A. Alzheimer's Disease (AD) is the most common type of dementia which accounts for approximately 60-80% of all cases. AD is a chronic, progressive brain disease with damage most commonly seen in the hippocampus and its connected structures. In addition, the cortex of the brain becomes thinner with damage also noted to the left hemisphere as well as the temporal lobe and potentially the right parietal lobe. The symptoms noted in AD include: having trouble remembering things (including conversations, names, familiar objects, etc.); impaired communication; poor judgment; disorientation; confusion; behavior changes; and difficulty speaking, walking and swallowing.
   B. Vascular Dementia (also known as multi-infarct): a less common form of dementia, accounting for 10% of the dementia cases. In Vascular Dementia, the damage is caused by diseases of the blood supply to the brain. Often this form of Dementia occurs after a resident suffers from a stroke, due to the brain dying when the blood supply is suddenly cut off. Residents with Vascular Dementia often experience symptoms such as impaired judgment and problems with planning, concentrating, and thinking.
   C. Dementia with Lewy Bodies: a far less common form of dementia, accounting for approximately only 4% of cases. In Dementia with Lewy Bodies, there is often less shrinkage of the brain; however, tiny deposits of protein (Lewy Bodies) are seen in several areas of the brain, such as the cerebral cortex, the limbic system, and the brain stem. For those residents who suffer from this form of dementia, they may have symptoms such as memory loss, thinking problems, sleep disturbances, visual hallucinations, and muscle rigidity.

The Developmental Stages of Alzheimer's Disease:

1. Early: In the early stages of Alzheimer's, a resident may function independently. He or she may still be able to drive, work and be part of social activities. Despite this, the resident may feel as if he or she is having memory lapses, such as forgetting familiar words or the location of everyday objects.

2. Middle: You may notice the resident with Alzheimer's confusing words, getting frustrated or angry, or acting in unexpected ways, such as refusing to bathe. Damage to nerve cells in the brain can make it difficult to express thoughts and perform routine tasks.
3. Late: In the final stage of this disease, residents lose the ability to respond to his/her environment, to carry on a conversation and, eventually, to control movement. They may still say words or phrases, but communicating pain becomes difficult. As memory and cognitive skills continue to worsen, personality changes may take place and residents need extensive help with daily activities.

Effects of Alzheimer's Disease

1. Progressive deterioration of behavior and personality
2. Impaired learning
3. Impaired thinking
4. Impaired judgment
5. Impaired memory
6. Impaired impulse control

Abilities that are Spared (Not Lost) in Alzheimer's Disease

1. Emotions and feelings
2. Physical strength
3. Senses such as vision, hearing, taste, smell and touch
4. Habits such as piano playing and cycling

Some Behavioral Responses to Cognitive Impairment

1. Memory loss
2. Confusion and disorientation
3. Lack of self-control

Different Behaviors Noted in Dementia

1. There are many different behaviors that may be seen in an individual with dementia. It is important to understand that these behaviors are a result of the disease process and not an intentional act by the resident. These behaviors include:

   A. Aggression and Anger: Aggressive behaviors may be verbal or physical. They can occur suddenly, with no apparent reason, or result from a frustrating situation. The cause of the aggression or anger may be due to physical discomfort such as pain, being tired, or the result of medication side effects. In addition, there may be environmental factors that are causing the behaviors. These environmental factors include: overstimulated by loud noises, an overactive environment or physical clutter.

   B. Anxiety and Agitation: A resident with dementia may feel anxious or agitated. He or she may become restless, creating a need to move around or pace, or become upset in certain places or when focused on specific details. The possible cause of these behaviors include moving to a new residence or nursing home; changes in environment, such as travel, hospitalization or the presence of houseguests; changes in caregiver arrangements; misperceived threats; fear and fatigue resulting from trying to make sense out of a confusing world.

   C. Hallucinations: When a resident with dementia experiences hallucinations, he or she may see, hear, smell, taste, or feel something that isn't there. These hallucinations are the result of changes within the brain resulting from the dementia and usually occur in the later stages of the disease.

   D. Repetition: As with many of the behaviors noted in dementia, the underlying cause is due to the deterioration of the brain cells that cause the resident to not be able to make sense of the world around them. In the case of repetition, a resident may not remember that he or she has just asked a question or completed a task.

   E. Sleep Issues and Sundowning: Sleep changes in residents with dementia are somehow the result of the impact of dementia on the brain, often causing residents to have problems sleeping or an increase in behaviors that begin at dusk and last into the night. The factors that may contribute to these behaviors include: end-of-day exhaustion (both mental and physical); an upset in the "internal body clock," causing a biological mix-

up between day and night; reduced lighting and increased shadows causing residents with dementia to misinterpret what they see, and become confused and afraid; reactions to nonverbal cues of frustration from caregivers who are exhausted from his/her day; disorientation due to the inability to separate dreams from reality when sleeping; less need for sleep, which is common among older adults.

Special Needs of Cognitively Impaired Residents

1. Physical care
   A. Provide for the resident's physical needs.
   B. Establish a routine for care and try to adhere. Be flexible if needed.
   C. Provide direction and encourage the resident to assist with care as much as possible.
   D. Ask resident if they have pain and report to nurse.
2. Safety needs
   A. Provide a safe environment to avoid risks as directed by the nurse and according to the care plan.
3. Supportive needs
   A. Always approach in a calm, respectful manner.
   B. Recognize when the resident is becoming frustrated and offer assistance.
   C. Limit decision making based on the resident's ability according to direction from the nurse and according to the care plan.
   D. Do not attempt to force the resident to think or remember.
   E. Orient the resident to name, place and day and time.
   F. Use calendars, clocks and other devices to assist the resident.
4. Communication needs
   A. Use positive body language as it may be the only message the resident can receive.
   B. Watch the resident's body language as it may be the only message the resident can send.
   C. Speak slowly and calmly.
   D. Greet by preferred name making eye contact.

E. Identify yourself by name and title. Always explain what you are going to do.

F. Give simple easy to follow instructions.

G. Ask only simple questions and wait for a response. Repeat if necessary.

H. Avoid using "NO" and DON'T".

5. Behavior management

   A. Reorient resident to name, place, day and time.

   B. Do not validate false thinking which may result in increased confusion.

   C. Do not correct resident with a negative message that may result in withdrawal or anger.

Guidelines for Assisting Residents Who Wander

1. Allow the resident to wander if it is not harmful to resident or others.
2. Ensure that the resident who wanders wears appropriate identification.
3. Ensure that appropriate doors and windows are locked and alarms are turned on.
4. Try to distract the resident with an interesting object or favorite activity.
5. Look for the cause(s) of wandering, which may include seeking an exit, restlessness, stress, boredom, or unmet needs.
6. Follow instructions of the nurse and behavior management plan as appropriate.

Guidelines for Assisting Residents Who Resist Care

1. Remember the principles of person-centered care, even when providing care to someone who resists it.
2. Keep care simple and routine. Give care in a calm, patient manner. Don't rush.
3. Resisting care often occurs when the caregiver activities require skills that the cognitively impaired resident no longer has.
4. Match the demands of the care to the resident's abilities.

5. Observe for signs of anxiety and body language that indicate early resistance to care such as restlessness, shifting position, clenching fists, wringing hands, or moaning.
6. At the first sign of distress, stop the care as soon as you can safely do so.
7. Report the behavior to a nurse. The caregiver (who has to get the job done) may be expecting too much of the resident, rushing the resident, communicating his/her own anxiety or impatience to the resident, or sending mixed messages.
8. Provide care following the person-centered instructions from the nurse and according to the care plan to eliminate the cause such as meet unmet needs. Delay care until the resident is no longer exhibiting signs of distress. Simplify the task, provide additional assistance, slow down, and adjust your approach.
9. Follow instructions of the nurse and the resident's person-centered behavior management plan as appropriate.

Guidelines for Assisting Residents with Self-Control Problems

1. Allow the resident to do as much as possible but assist as requested before anxiety and frustration occurs (help, but don't do).
2. Know and avoid situations that lead to loss of self-control for the resident.
3. Redirect the resident's thoughts and/or activities before they become agitated.
4. Use measures to comfort or distract the resident.
5. Remove the resident to a private space before self-control is lost, keeping in mind person- centered care.
6. Provide care as indicated to eliminate the cause(s) of the behavior.
7. Follow instructions of the nurse and the resident's behavior management plan as appropriate.

During daily checks of the resident, we can identify any changes that may indicate a new, or progression of, diseases and disorders.

We can identify changes that may indicate:

- Infection
- Respiratory diseases or disorders
- Cardiovascular diseases or disorders
- Skin diseases or disorders
- Gastrointestinal diseases or disorders
- Urinary tract diseases or disorders
- Changes in cognition and behavioral change

The changes observed in a resident can sometimes point us to the cause of the infection.

Let's review the difference in signs and symptoms.

The following slides will visit some commonly observed signs and symptoms for illnesses found in long-term care facilities. It is important to be watchful for changes in the resident as these may indicate infection.

Indication of Disease or Disorder: Respiratory

Signs of respiratory issues may include:

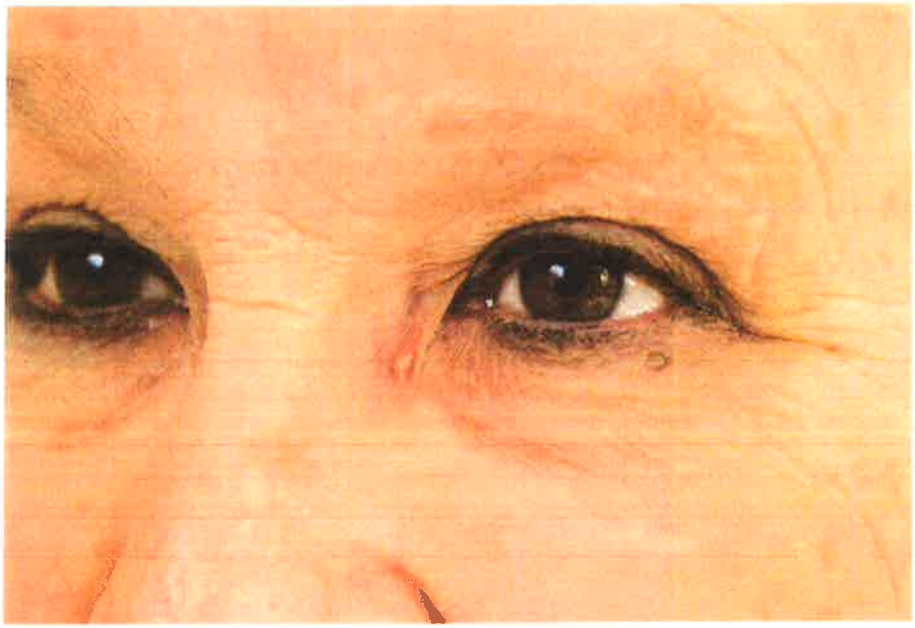
1. Noisy and/or labored breathing
2. Dyspnea (shortness of breath)
3. Wheezing
4. Coughing (dry or productive)
5. Blue color of lips or nails.
6. Fever

Indication of Disease or Disorder: Cardiovascular

Signs for cardiovascular problems may include:

1. Chest pain
2. Headache and/or dizziness
3. Weakness and/or paralysis Pop Up: definition
4. Vomiting
5. Cold, blue, numb or painful feet or hands

Indication of Disease or Disorder: Skin



Signs for skin problems may include:

Indication of Disease or Disorder: Gastrointestinal

Signs for bowel and abdominal problems may include:

1. Unusual appearance of stool
2. Presence of unusual substances
    - Blood and/or mucus
3. Bowel symptoms
    - Pain, constipation, diarrhea, and/or bleeding
4. Abnormal indigestion
5. Nausea and/or vomiting
6. Abdominal pain
7. Abdominal bleeding
    - Digested blood causes vomitus and stool to look like "coffee grounds"

Indication of Disease or Disorder: Urinary Tract

Signs for urinary problems may include:

1. Unusual appearance of urine
    - Dark, red, cloudy or straw-colored
2. Unusual substances present
    - Solid particles, blood or odor
3. Urinary complaints
    - Painful, difficult, burning, urgency, frequency and/or flank pain
4. Change in mental status
5. Signs of dehydration
    - Low fluid intake, dark urine with strong odor
6. Weight loss, dry skin, dry mucous membranes on lips/tongue/eyes
7. Drowsiness or confusion

Signs for fluid balance problems may include:

1. Signs of dehydration
    - Low fluid intake, dark urine with strong odor
2. Weight loss, dry skin, dry mucous membranes on lips/tongue/eyes
3. Drowsiness or confusion

Indication of Disease or Disorder: Cognition and Behavioral Changes

Signs for behavioral changes often include observed changes in:

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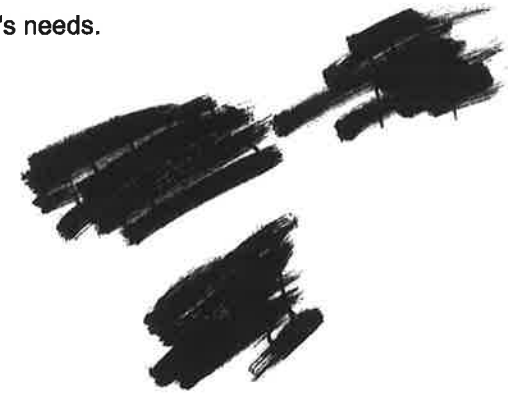
Steps a CNA can take to prevent or influence challenging behaviors from a resident are:

- Approaching with a calm, patient, gentle manner;
- Taking one step at a time;
- Using a non-confrontational/nonjudgmental communication style;
- Maintaining a routine whenever possible; and
- Modifying the approach according to the individual's needs.



Gather

Seeking more information in any situation can prevent or influence the resident's challenging behaviors that may occur.

Ways to gather more information include:

- Learning the resident's preferences;
- Collecting information on what may cause a resident stress;
- Talking with family members;
- Observing in the moment when a resident is triggered; and
- Attempting to isolate the trigger

A.C.T.

Step three is acronym designed as a reminder to follow three important action steps:

- **A** sk questions;
- **C** ollect information; and
- **T** reat the behavior(s).

Redirect

Finally, CNAs can avoid or delay a challenging behavior from a resident by:

- Creating a gentle distraction;
- Providing food (if the resident's diet allows); or

- Offering a new conversational topic.

These are all potentially effective methods for redirecting undesirable behavior. Tone of voice is also important and communication techniques will vary for each individual.

Behaviors as Unmet Needs

In addition to triggers, a resident may show change in behavior due to an unmet need. Someone living with dementia has a limited understanding of the world around them.

The more advanced the dementia, the more limited the understanding.

Because communication may be limited due to dementia, how will you determine what a resident living with dementia needs?

To determine the needs of a resident living with dementia, you must first recognize the challenging behaviors that may occur.

Dementia and Restlessness

Dementia excites a person, both physically and mentally.

A person who is overly excited or stimulated may manifest their feelings by pacing or fidgeting.

Restlessness may be caused by:

- Pain
- Communication problems
- Feelings of depression or loneliness
- Medication changes
- A basic need like thirst or hunger

Use these techniques to calm an agitated person:

- Move to a quiet area.
- Maintain a routine whenever possible.
- Decrease confusion by reducing noise, new people or places.
- Approach an agitated person slowly and calmly.
- Encourage routine exercise.

Dementia and Sundowning

Sundown Syndrome (sundowning) refers to late afternoon/early evening sensitivity to stress. While this can occur at any stage of dementia, it tends to peak at the middle stages of the disease and decreases as dementia progresses.

Sundowning is thought to occur due to:

- Being tired at the end of day which can lessen the ability to cope with stress.
- Low natural light and the creation of more shadows.
  - This can cause confusion and hallucinations.
- Disruption of the sleep/wake pattern because of the dementia.
  - The person cannot distinguish day from night.
- Not as much or no activity in the afternoon compared to the morning.
  - This can lead to restlessness later in the day.

To lessen the effects of sundowning and prevent challenging behaviors consider the following techniques:

- Schedule activities in the early part of the day for the resident.
- Reduce level of mental stimulation for the resident
  - This includes overstimulation from tv and radio.
- Provide adequate light for the resident as it begins to get dark.
  - Consider using a night light in the resident's environment.
- Offer companionship support to ease the resident's anxiety level.
- Plan toileting, food and a nap for the resident in the early afternoon.
- Maintain a routine at bedtime for the resident.

Case Study

Mr. Clarence Vinkle suffers from dementia, and routinely becomes more anxious around 4pm each day. He usually appears extremely tired and will act nervous or afraid. What behavior is Clarence displaying? What can you do to help him?

Click here to check your answer!

Dementia and Aggression

Physical/verbal combative behaviors are often a result of anger. Behavioral warning signs from the resident can be monitored to prevent escalation, such as:

- Muscle changes like clenching their jaw;
- Body movements like rocking, kicking or pacing;
- Changes in speech patterns like yelling or talking rapidly;
- Shifts in posture like stiffening the body into a rigid stance; and
- Eye appearance like a strong glaring expression.

Aggression may be caused by:

- Pain
- A basic need like thirst or hunger

- Frustration due to inability to communicate effectively
- An uncomfortable environment
- Too little, or too much, stimulation

To ease aggression, use a soothing tone of voice to explain what you are doing. Do not respond to angry behavior with more anger.

Dementia and Wandering

60% of people living with dementia will wander at some point. Wandering is a common behavior with Dementia and is often goal-directed. Anyone with dementia can wander as it is not specific to mid- or late-stage progression.

It is important to note that sleep disruption can cause night-time wandering.

When caring for residents who wander, it is important to:

- Maintain a regular activity/exercise program for the resident.
- Work to identify the resident's triggers for the wandering behavior.

Dementia and Hiding/Hoarding

These behaviors indicate feelings of insecurity. Residents who grew up with a "waste not, want not" mentality may hoard or hide items more than others.

Helpful techniques for working with residents who hide/hoard include:

- Providing a special "rummage" drawer for his/her use;
- Scheduling activities that require residents to work with their hands;
- Refraining from whispering or communicating in a secretive manner;
- Checking the trash can before emptying it; and
- Keeping extra keys, glasses, etc. on hand as replacements if items are frequently missing.

Dementia and Paranoia, Hallucinations, and Delusions

Paranoia

The resident may feel insecure when demonstrating suspicious/paranoid behaviors or when reacting to the behaviors of others.

Paranoid/suspicious behaviors may include:

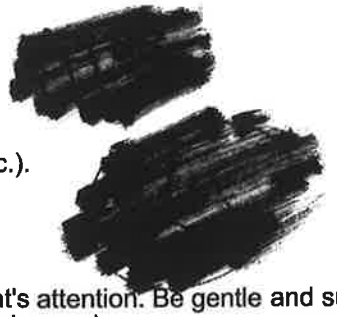
- Watchful scanning of his/her environment
- Hypersensitive reactions in conversations
- Expressing fear of immediate danger; and/or
- Secretive behavior (e.g., whispering).

Use a reassuring, calm approach when communicating with the resident. Some of the same care approaches for hiding/hoarding can also be used for paranoia or suspicion.

Hallucinations

Hallucination may cause a resident to:

- See, hear, taste, touch or smell things that do not exist.
- Hallucinations can include multiple elements (people, animals, places, etc.).



No response is necessary if the hallucination is not disturbing the resident.

When hallucinations occur that disturb the resident, calmly redirect the resident's attention. Be gentle and supportive. Inform the nurse so the hallucinations are documented in the resident's medical record.

Delusions

A delusion is a false idea or a misinterpretation of a belief.

Delusional behaviors may include the resident:

- Speaking about an infestation of pests like mice or insects that are not there;
- Verbally expressing that people are "out to get me"; or
- Reporting that a person is trying to break into his/her room who isn't there.

Using a calm, gentle approach to divert attention away from the resident's delusional behavior(s) will help diffuse these situations.

Dementia and Outbursts

These behaviors indicate that the resident is feeling an emotional or sensory overload.

Residents reactions can be influenced by a caregiver's response.

Helpful care tips include:

- Approaching the resident slowly, gently and calmly
- Providing space/time to recover from the resident's emotional reaction
- Giving reassurance to the resident
- Diverting the resident to a calmer activity or quieter area
- Reducing stimulation of any kind for the resident (noise, activity, people, etc.)

Dementia and Repetitive Actions

Repetitive behaviors from a resident can result from medication side effects, stress, or the disease process associated with dementia.

Repetitive behaviors may include:

- Clapping the hands;
- Repeating a question;
- Moving the body in a specific pattern; or
- Singing the same song.

An effective technique for a caregiver working with a resident with repetitive behaviors is to calmly approach the resident and divert his/her attention away from the repetitive behavior.

Dementia and Inappropriate Actions

These behaviors may occur when the resident is confused and/or disoriented. Behaviors are often public and may include:

- Removal of clothing;
- Self-exposure;
- Masturbation; and
- Touching himself/herself or others.

A calm approach to distract or prevent a resident from acting out these behaviors.

Quality of Care: Safety

Facility environments for people living with Dementia need regular safety monitoring and a home-like setting.

Checklists shown in this training are examples intended to raise safety awareness.

Use the lists to think about the facility areas you work in.

Always inform your supervisor of any areas that may be unsafe for a resident.

***Actual checklists will vary depending on your facility and facility policies.**

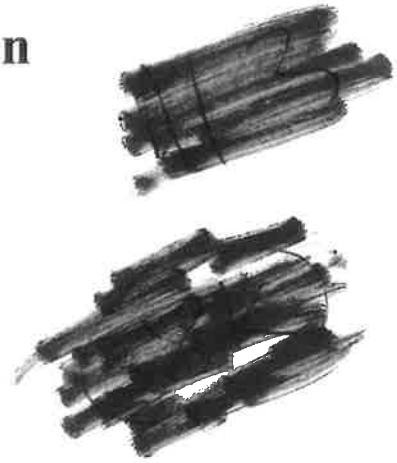
Quality of Care: Safety for General Areas

General safety sample checklist:

- Outlet covers
- Smoke detectors
- Secured hot water heater
- Medical devices used
- Storage of chemicals, medications, etc.

It is important to know the areas of your facility that may generally be unsafe for residents, especially those with dementia. By knowing these areas, you are better able to keep residents from potentially wandering into rooms where they may harm themselves others unintentionally.

Quality of Care: Safety in the Kitchen



Kitchen safety sample checklist:

- Cover for garbage disposal
- Refrigerator/cabinet locks
- Hot water heater control
- Controls/knobs for stove burners/covers
- Cover for garbage container
- Storage of utensils (knives, gadgets, toaster, etc.)

Quality of Care: Safety in the Bathroom

Bathroom safety sample checklist:

- Water temperature monitoring
- Safety rails
- Privacy shower curtain
- Shower chair
- Electrical devices (e.g., blow dryers)
- Medications and personal products
- Razors and other dangerous items

Quality of Care: Safety for Fall Prevention

Fall prevention safety sample checklist:

- Adequate (non-glare) lightning
- Safety rails (e.g., hallways)
- Locked gates at stairways or steep inclines
- Furniture that is moveable
- Area rugs
- Pathways clear of clutter

Quality of Care: Safe Vision

Safety checklist sample for safe vision:

- Adequate (non-glare) night lights
- Doors and walls with contrasting color

It is important to understand that dementia is not a mental illness. Individuals with dementia, no matter the severity, have little control over the changes occurring in their brain. Compassion and understanding are necessary to provide care to these residents.

There are many types of dementia, though we will focus on the three most common.

Dementia with Lewey Bodies

This is the 3rd most common type of dementia, accounting for 5-10% of all dementia cases.

Dementia with Lewy Bodies is caused by abnormal protein deposits in the brain. These protein deposits are the same protein that are found in Parkinson's patients. While some of the effects are the same between the two disorders, the diagnoses remain separate.

It is a progressive type dementia, meaning the symptoms start off mild and progress to death. The average lifespan of an individual after diagnoses is 5-7 years.

Symptoms specific to Lewy Body Dementia include:

- Confusion and alertness that varies significantly from one time of day to another or from one day to the next.
- Memory loss that may be significant but less prominent than in Alzheimer's
- Slowness, gait imbalance and other parkinsonian movement features.
    - Movement symptoms are more likely to be an important cause of disability early in Lewy body dementia than in Alzheimer's. Alzheimer's patients have issues with mobility in the later stages of disease progression.
- Well-formed visual hallucinations and delusions.
    - Hallucination, delusions, and trouble identifying familiar people are more significant in early stages of Lewy body dementia than in early-stage Alzheimer's.
- REM sleep disorder is more common in early Lewy body dementia than in Alzheimer's.
- Disruption of the autonomic nervous system, causing a blood pressure drop on standing, dizziness, falls and urinary incontinence, is much more common in early Lewy body dementia than in Alzheimer's.

Vascular Dementia

The 2nd most common type of dementia is Vascular Dementia. This involves brain damage and a change to the amount of blood flow of the brain.

Strokes are a common cause, as blood vessels are blocked, or blood clots break off and reduce blood flow to the brain.

A stroke is not always considered a cause of Vascular Dementia. A stroke blocks blood flow to the brain, but strokes do not always cause Vascular Dementia. Severity and location of the stroke will determine the impact on thinking and cognition.

Vascular Dementia can also occur from conditions related to blood vessel health, such as: high blood pressure, high cholesterol and smoking.

On average, a person will live for about 5 years after a diagnosis. It should be noted that the individual with vascular dementia may die from a stroke or heart attach before the death of the dementia itself.

Vascular dementia signs and symptoms include:

- Confusion or problems concentrating
- Inability to organize thoughts
- Decline in the ability to analyze a situation
- Trouble executing a plan or explaining a plan to others
- Problems with step-by-step plans. There is confusion on what to do next.
- Restlessness and agitation
- Unsteady gait
- Sudden or frequent urge to urinate or inability to control passing urine
- Depression or apathy

Many times, vascular dementia onset is sudden, and can be traced back to a stroke or series of mini-strokes. There are occasions, though, when the onset is gradual. This may be due to a lifetime of coronary artery disease or smoking.

Often, patients who develop vascular dementia are also diagnosed with Alzheimer's.

Alzheimer's Disease

The most common type of dementia is Alzheimer's. This is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks.

Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks. The cause is unknown and there is no cure. Life expectancy from diagnosis to death can vary from 3-20 years. The degree of life expectancy is dependent on the stage of disease at diagnosis.

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Alzheimer's Disease: Early Signs and Symptoms

The complexities in diagnosing Dementia-related conditions are challenging. "Early" is referring to the state of the disease and not a person's life. The top ten early Alzheimer's disease signs are:

- Memory loss that disrupts life activities
- Challenges with planning and problem solving
- Difficulty completing familiar tasks
- Confusion over time and place
- Difficulty understanding visual images and spatial relationships
- Challenges speaking or writing words
- Losing or misplacing objects
- A decrease in good judgment and decision-making
- Diminishing in work and social activities
- Mood and personality shifts that are noticeable to others

Each of these changes occurs at different stages of disease progression. Alzheimer disease is broken into 7 stages, with 3 main categories (mild, moderate and severe.)

Mild Alzheimer's Disease

Moderate Alzheimer's Disease

This is the middle stage of progression is typically the longest stage.

Severe Alzheimer's Disease

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There are times when a resident may show signs of confusion, but not necessarily show signs of dementia. It is important to recognize the differences, as this determines the treatment.

Drug Therapy

Drugs may be prescribed to manage Dementia related symptoms.

Many of these drugs act upon the brain and inhibit the release or breakdown of a specific neurotransmitter.

It's important to remember that none of the drug therapies can stop or reverse a dementia condition.

Their sole function is to potentially slow the progression and manage the symptoms

Cholinesterase inhibitors

Acetylcholine is a neurotransmitter that moves through the nervous system telling post-synaptic nerves to signal. Acetylcholine (ACh) activates muscles and helps with short-term memory. In a healthy person, Cholinesterase is an enzyme that breaks down excess Acetylcholine so that the nerves are not over stimulated.

In someone with Alzheimer's, the body does not produce sufficient amounts of ACh. What little ACh is present is broken down rapidly. Eventually Alzheimer's will cause the body to stop production of acetylcholine, causing the loss of memory and thinking skills.

Cholinesterase inhibitors block the normal breakdown of acetylcholine, ***slowing*** the progression of disease.

Cholinesterase inhibitors cannot ***prevent*** the total progression of Alzheimer's disease. As Alzheimer's progresses, the amount of ACh being produced starts to decrease. Eventually ACh production stops, so the medication becomes less effective in managing the disease.

NMDA blockers

Glutamate (a key compound in cellular metabolism) functions as an excitatory neurotransmitter in the brain. It is one of the more important neurotransmitters for normal brain function.

Discussion topics may include:

- Behavioral changes;
- Use of prescribed drugs;
- Evaluation plans; and
- Alternative treatments for the resident.

All discussions will be documented in the resident's medical record.

Basics of a Dementia Care Plan

As a comprehensive dementia care plan is developed, the facility should consider all areas of care development. These areas include:

- The baseline for the resident;
- How to monitor changes for the resident;
- Goals for the resident's care; and
- Other related details documented in the medical record.

Quality of Care: Your Focus

Experience often shapes our perspective.

A person-centered view of care for residents living with dementia can help facility staff focus on a higher quality of care for each individual.

Remember the goal for quality care:

- The focus of care is placed on the person, not the care system.
- An effective system will serve the needs of the people living within it.

Quality of Care: Drug-Free Therapies

In module 5, we discussed two drug-based therapies that may be used to slow the progression of disease for dementia and dementia-related conditions.

To address dementia-related behaviors, drug-free interventions may be effective.

Music

Studies show that music can relieve anxiety, decrease aggression and may promote relaxation, increase attention span and socialization.

Remember to consider each resident's musical preference for the best outcome.

Simulated Presence Therapy

This type of therapy uses headphones or a video set-up for the resident with audiotaped family conversations or events. Allowing agitated residents access to familiar faces and voices may help calm the challenging behavior.

In addition, allowing virtual visits through Face Time, Zoom or Skype may be effective in helping residents maintain a relationship with family and friends who are unable to be physically present.

Touch Therapy

Touch therapy includes using hand massages.

This may relax the resident and decrease the chance for aggressive behavior.

It may also lower anxiety overall.

Simple Cognitive Activities

Regular use of games like BINGO may assist in managing resident's behavior patterns.

Other effective cognitive activities include story reading or sorting (using safe objects by type, size, color, etc.).

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Rocking Chairs

Having a rocking chair available may help, as rocking has been found to decrease depression and anxiety.

Approved Pet Therapy - Connecting with an approved animal visitor (serviced pet companion) has been found to reduce anxiety and depression.

General Guidelines for Emergency Measures: Seizures

Follow these emergency measures for seizures:

1. Stay with the resident and notify nurse immediately.
2. Do not move the resident (unless there is immediate danger).
3. Move any objects out of the way that could cause further injury.
4. Loosen the resident's belt and collar (if buttoned all the way up).
5. Provide privacy for the resident (ask onlookers to leave the area if not assisting).
6. Do not attempt to restrain the resident.
7. Do not attempt to place anything in the resident's mouth.
8. Observe/report to nurse (time of seizure, duration of seizure, description of body parts involved, severity of convulsive movements, other descriptive information, condition of the resident before and after and any other significant findings).

General Guidelines for Emergency Measures: Choking

Follow these emergency measures for choking (or blocking of airway):

1. Remain calm and reassuring to the resident while calling for help.
2. Determine if the resident can cough, breathe or speak.
3. Clear the obstructed airway immediately, if possible.
4. Perform the Heimlich maneuver or abdominal thrusting technique (**only if** trained to do this procedure).
5. Observe/report to the nurse (time of the incident, if the resident was unconscious, what procedures were done and when they started/stopped, the resident's response to the procedures, the factors that relate to the choking and any other important information).

Fire Safety and Prevention

In addition to following the procedures during an emergency related to a resident, it is vital to know how to handle emergencies like fire and emergency evacuations.

In the case of a fire, always follow the facility's policies and procedures.

A helpful acronym to remember some of the basics for fire emergency rules (not necessarily in sequential order) is: **R.A.C.E.**

R. Remove residents from vicinity of fire.

A. Activate the alarm system.

C. Contain the fire and smoke by closing doors and windows.

E. Extinguish the fire if small enough to contain, if you are trained to do so.

<u>Best practices for fire safety and prevention</u>

- Supervise smoking in designated areas.

- Allow no open flames or burning materials, such as cigarettes, near oxygen.
- Report any wiring that appears frayed.
- Report faulty electrical equipment.
- Report concerns if outlets appear to be overloaded.
- Know facility policies and procedures for fire emergency.
- Remove other dangerously combustible items (such as cleaning products, paper, etc.) from hallways.
- Smoke rises, so stay close to the floor

Emergency Evacuation

Be sure to know your facility's emergency evacuation procedures for:

1. Tornados
2. Hurricanes
3. Other natural disasters
4. Other emergency situations

These protocols and procedures will vary by facility and by emergency. It is vital that you know and understand each evacuation protocol **BEFORE** disaster strikes.

Supportive Devices

Because of illness or injury, the resident may need the aid of a supportive device such a helmet (for protection during a seizure), a wheelchair, crutches or a walker.

Supportive devices may be considered restraints if intentionally and unnecessarily used to restrict a resident's movement, such as placing the device close to a wall, so the resident cannot rise.

Definition of Restraint

Restraints and Facility Practices

Examples of facility practices that meet the definition of a restraint are:

- Using side rails to keep an ambulatory resident from getting out of bed;
- Tucking the sheets in tight or using another fabric to restrict a resident's movement;
- Placing a resident in a chair that prevents them from rising (such as with a seat belt that fastens behind the wheelchair);
- Using devices in combination with a chair (such as a belt, tray or bar) to prevent the resident sitting in the chair from rising; and/or
- Placing a chair or bed very close to a wall to prevent the resident from moving in the tight space created.

Requirements for Use of Restraints

- Restraints require a written doctor's order and a resident's consent specifying the reason for use.
  - The exception to this is for emergency restraints for behaviors that are an immediate threat.

- Restraints may only be used to treat or protect the resident, not for staff's convenience or for a method of discipline.
- Restraints must use the *least restrictive* technique for the *least amount* of time.
- Restraints are used only as a **last** resort, when all other options are unsuccessful.

The CNA Role: Using Restraints

How to problem solve through observation

CNAs can use observation skills to reduce the need for restraints in most settings by:

- Observing a resident to identify what may be causing the undesirable change in behavior;
- Calming or distracting the resident;
- Reporting objective findings to the nurse to assist with the resident's care plan; and
- Providing additional care to the resident (within the scope of training) to eliminate or stop the change in behavior.

Resident care when restraints are needed

The use of restraints is only encouraged in an emergency or if use of the restraint can prevent harm or death.

Follow facility policies and procedures for restraint use.

In general, policies specify that a medical restraint include:

- Must be medically necessary;
- Must be ordered by a physician;
- Is needed to ensure the individual's safety;
- Is used only after less restrictive interventions have been considered and determined to be ineffective, or are judged unlikely to protect the individual or others from harm; and
- Is used in accordance with a written modification to the patient's treatment plan.

The CNA role: How to Avoid Using Restraints

CNAs can take these general measures to avoid the need for restraints, in most cases.

- Keep all communication calm.
- Provide gentle, kind and respectful care.
- Treat the resident as an individual at all times.
- Strive to meet the resident's needs for comfort.
- Observe the resident frequently.

Effects of Restraints

When the need for restraints arise, it is important to understand the effects the restraints have on the resident.

Physical effects on residents

When restrained, a resident may experience:

2. Procedural Guidelines

Use the following Beginning, Closing and Observation steps for each Procedural Guideline unless specified.

Beginning Steps:

1. Gather needed supplies such as positioning devices, linen.
2. Knock on door and identify self by name and title.
3. Greet resident by preferred name and identify resident per facility policy.
4. Approach the resident in a calm and courteous manner.
5. Explain procedure and encourage resident's participation as appropriate.
6. Lock wheels of bed and lower head as tolerated.
7. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.
8. Provide privacy as appropriate such as closing door/curtains, and draping resident.
9. Provide safety as appropriate such as using good body mechanics, and adjusting the bed to proper working height.
10. If side rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from the bedside.

Closing Steps:

1. Clean and store reusable items and discard disposables per facility policy.
2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
3. Provide for resident's comfort and safety before leaving as appropriate such as clothing/bedding, adjusting bed/side-rails.
4. Always replace call signal and needed items within resident's reach and lower bed to a safe level.
5. Inform resident when finished and ask if anything is needed before you go.

Observe for, Report and Document to Nurse

1. Problems or complaints related to procedure.
2. Changes in the resident's ability to participate in moving or positioning.
3. Other significant observations.
4. Always be alert to changes in skin condition and report.

2.1 Safety and Emergency

2.1.1 Procedural Guideline #1 – Fainting and Falls

1. Purpose: To prevent further injury.
2. Emergency Guidelines
   A. Stay with resident and call for help. Be sure nurse is notified.
   B. Lower the resident's head to increase blood supply to brain:
      a. If resident is standing, assist to lie down or to sit in chair.
      b. If resident is sitting, assist to lie down or assist to bend forward and put head down between knees if able.
3. How to Assist a Resident After Fainting/Falling
   A. Stay with resident and call for help. Be sure nurse is notified.
   B. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.
   C. Keep the resident as quiet as possible. Do not attempt to move the resident or to straighten the injured area.
   D. Do not attempt to move the resident until the nurse examines the resident, assesses the risk of fracture, and gives instructions.
      a. Then, follow the directions of the nurse for moving the resident.
      b. Check vital signs and provide other care as requested by nurse.
   E. Do not leave the resident alone. Wait until the nurse arrives.
4. Observe for and Report to Nurse:

A. Time of the fall.

B. Cause of the fall such as wet floors, ill-fitting shoes or condition of resident. (Do not speculate on the cause of the fall. Report only what you know to be a fact).

C. Measures taken to break the fall and assist the resident.

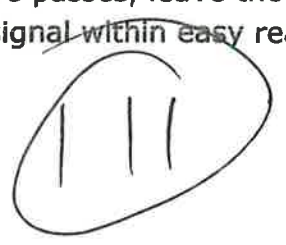
D. Any witnesses to the fall.

E. Additional information needed by the nurse to complete the incident report.

F. Other significant observations. Examples: side rails, alarms, signal/call light, bed low

2.1.2 Procedural Guideline #2 – Seizures

1. Purpose: To prevent injury due to seizures.
2. Emergency Guidelines
   A. Stay with the resident and call for help; note the time. Be sure the nurse is notified.
   B. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.
   C. If the resident is in bed, raise side rails if present, turn head to side or place in side-lying position and remove pillow.
   D. If the resident is out of bed, gently lower the resident to floor, turn head to side or place in side-lying position to open airway and promote drainage of secretions, and protect head with pillow, padding or hold head in your lap.
   E. Move hard objects out of the way as appropriate, or pad around the bed and/or objects that might cause injury during seizure.
   F. Provide privacy by asking onlookers to leave and closing doors and/or curtains.
   G. Do not attempt to restrain the resident.
   H. Do not attempt to place any object into the resident's mouth during seizure.
   I. When the seizure passes, leave the resident in a position of comfort and safety withcall signal within easy reach and lower bed.



J. If used, remove and discard gloves following facility policy. Wash hands.

3. Observe for and Report to Nurse:
   A. Changes in the resident before seizure such as visual or auditory aura, confusion, staggering or behavioral changes.
   B. Time the seizure started and stopped and duration of the seizure.
   C. Description of body parts involved and severity of convulsive movements.
   D. Presence of an aura, incontinence, unconsciousness, eyes rolled upward, frothing of the mouth, biting of the tongue or injuries due to seizures.
   E. Condition of the resident after seizure such as disorientation or sleepiness.
   F. Other significant observations.

2.1.3 Procedural Guideline #3 – Clearing the Obstructed Airway

1. Purpose: To clear the obstructed airway of adults using the Heimlich Maneuver.
2. Guidelines and Precautions
   A. Choking is a true life-threatening emergency that requires immediate action.
   B. Choking is the sign of airway obstruction. The universal distress signal for choking is clutching the throat.
   C. Choking usually occurs when eating large and poorly chewed pieces of meat or other foods. Associated factors are wearing dentures, laughing and talking while eating. The airway can also be obstructed by blood, vomitus, foreign bodies, or the tongue.
   D. Measures to help prevent choking:
   E. Assure that meat and other foods are cut into small pieces.
   F. Encourage residents to chew foods slowly and adequately.
   G. Discourage laughing and talking while chewing and swallowing.
   H. Assure residents receive correct diets that contain only allowed foods. Peanut butter, nuts, popcorn and beans can cause choking in some residents.

I. This procedure is limited to use of the Heimlich Maneuver on adults. Specialized and advanced procedures and training are available from the American Red Cross and the American Heart Association.

J. Do not practice forceful abdominal thrusts on human subjects as part of training.

3. Determine if resident can cough, breathe or speak.

   A. Stay with the resident and call for help. Be sure the nurse is notified immediately.

   B. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluid is likely.

   C. Observe the resident for coughing, breathing and speech. Ask the resident "Are you choking?"

      a. If the resident is able to cough, breathe or speak (Partial Airway Obstruction), stand by and encourage coughing to clear the airway.

      b. If the resident is unable or becomes unable to cough, breathe or speak (Complete Airway Obstruction), perform the Heimlich Maneuver following step D below as appropriate.

4. Perform the Heimlich Maneuver (Abdominal Thrusts)

   A. With resident standing or sitting:

      a. Stand behind the resident.

      b. Wrap your arms around the resident's waist.

      c. Make a fist and place the thumb-side of the fist at the midline of the abdomen, just above the navel and well below the breastbone.

      d. Grasp fist with free hand and press inward with a quick upward thrust. Avoid pressure on the ribs and breastbone.

   B. With resident lying down:

      a. Place the resident in the supine position on the floor.

      b. Kneel down and straddle the residents' hips.

      c. Position the heel of one hand at the midline of abdomen, just above the navel and well below the breastbone.

      d. Place your free hand over the other hand and press inward with a quick upward thrust. Avoid pressure on the ribs and breastbone.

C. Repeat abdominal thrusts (as separate and distinct movements) until the airway is cleared (usually 5 to 10 thrusts).

D. Assist the nurse and/or EMS as appropriate.

E. If used, remove and discard gloves following facility policy. Wash hands.

5. Observe for and Report to Nurse:

   A. Exact time choking and unconsciousness started and stopped.

   B. Procedures done and time procedure started and stopped.

   C. Response to procedures.

   D. Factors related to cause of choking.

   E. Other significant observations.

6. Measures to be followed for any Resident who has vomiting, bleeding near the mouth, excess secretions or is unable to swallow:

   A. Notify the nurse immediately if:

      a. Resident is choking or is not able to swallow.

      b. Resident is not able to spit out vomitus, secretions or blood.

   B. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.

   C. Keep the resident's head elevated as allowed.

   D. Keep the resident turned on his/her side or with head turned well to one side, if possible, to allow fluids to drain out of mouth.

   E. Provide emesis basin for the resident who is vomiting.

   F. Nurse may provide suctioning and/or notify the physician.

   G. Leave the resident in a position of comfort and safety with the call signal within easy reach.

   H. Remove and discard gloves following facility policy. Wash hands.

7. Observe for and Report to Nurse:

   A. Immediately report difficulty swallowing, bleeding, vomiting, and choking or aspiration.

   B. Do not discard vomitus or blood until it is seen by the nurse and a specimen is obtained if needed.

C. Elevate the bed to comfortable working height when working at the bedside. Remember to return the bed to the lowest horizontal position when finished for resident safety.

D. Maintain good posture and good body alignment while lifting as indicated below: a. Keep your back straight.

   a. Keep your knees bent.

   b. Keep your weight evenly distributed on both feet.

   c. Keep your feet at shoulder width (about 12 inches apart) to provide a broad base of support.

E. Use the strongest and largest muscles to do the job. Leg and arm muscles are the strongest. Back and abdominal muscles are the weakest.

F. Bend from the hip and knees-not waist-when lifting objects.

G. Always squat down to lift heavy objects from the floor.

H. Keep objects close to your body when lifting and carrying.

I. Use both hands when lifting or moving heavy objects.

J. Slide, push or pull heavy objects rather than lifting them, when possible.

K. Use the weight of your body to help push or pull objects.

L. Work with smooth, even movements--not quick, jerky motions.

M. Face your work and avoid twisting your body.

N. To change the direction of your work, take short steps and turn your whole body without twisting your back and neck.

O. Avoid unnecessary bending and reaching.

P. Do not lift objects higher than your shoulders.

[redacted]

Guidelines and Precaution[redacted]

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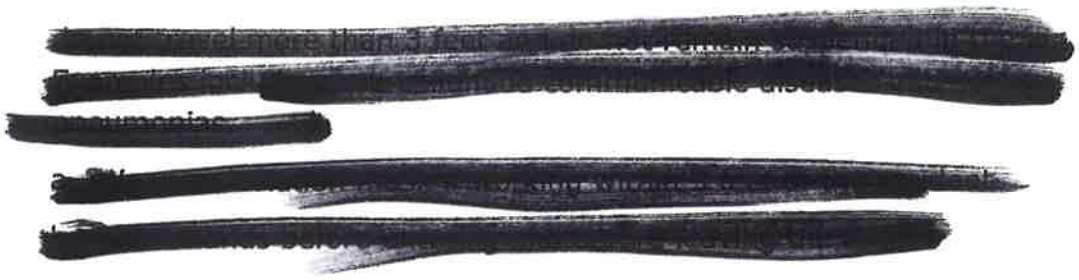

2.3 Communication

2.3.1 Procedural Guideline #8 – Communication and Interpersonal Skills

1. Guidelines for Starting a Conversation
   A. Knock on the door before entering, identify yourself by name and title and greet resident by the preferred name.
   B. Approach the resident in a calm and courteous manner.
   C. Explain why you are there and what you are going to do.
   D. If you are going to perform a procedure, explain the procedure to resident and encourage resident to participate as appropriate.
2. Guidelines for Talking and Listening
   A. Get resident's attention before speaking.
   B. Use courtesy when communicating. Talk courteously with the resident during care, listening and responding appropriately.
   C. Speak in a language that is familiar and appropriate for the resident--avoid slang or words with more than one meaning.
   D. Use a normal tone of voice and adjust your volume to the resident's needs.
   E. Speak slowly and adjust your rate to the individual resident's needs.
   F. Speak clearly--avoid mumbling.
   G. Keep your message brief and concise--avoid rambling.
   H. Face the resident. Sit at resident's eye level and maintain frequent eye contact with the resident as appropriate.

I. Send positive messages by use of encouragement, praise, smiles, gentle touch and other methods acceptable to the resident.

J. Be sure your verbal and nonverbal message match.

K. Use open posture, leaning slightly toward the resident while listening.

L. Pay attention and really listen to what the resident is saying.

M. Give, receive and/or request feedback as appropriate to assure that the communication is understood.

3. Guidelines for Encouraging Residents to Express Feelings

   A. Use silence to allow the resident to think and continue talking (this shows respect and acceptance).

   B. Use broad opening statements like "You seem quiet today."

   C. Use open-ended questions like "and then what happened?"

   D. Use noncommittal responses like "Oh, I see", "Go on", "Hmm..."

   E. Use responses that indicate you understand the resident's feelings, such as: "You really miss your son."

4. Guidelines for Avoiding Barriers to Conversation

   A. Avoid interrupting or changing the subject.

   B. Avoid expressing your opinion if it implies passing judgment.

   C. Avoid talking about your own personal problems and the problems of other residents and co- workers.

   D. Avoid pat answers such as "Don't worry" as this can make residents feel his/her concerns are not important.

   E. Avoid questions that can be answered with "Yes" or "No" unless you want only direct answers.

   F. Avoid questions that start with "Why" to avoid defensive responses.

5. Guidelines for Ending a Conversation

   A. Tell the resident that you are finished, that you have to leave and, if appropriate, when you will be back. Be sure to come back at the designated time.

   B. Tell the resident that you enjoyed the conversation. Such as: "Thanks for your time," "Thanks for sharing."

C. Leave the resident in a position of comfort and safety, with call signal and other needed items within easy reach.

6. Communicating with Residents Who Have Vision Loss
   A. Follow steps 1 thru 5 of this Procedural Guideline.
   B. Identify self by name and title as you enter room to avoid startling the resident.
   C. Encourage and assist the resident to keep glasses clean and to wear them.
   D. Stand comfortably close to the resident in a good light and face the resident when you speak.
   E. Speak in a normal tone of voice. Do not speak too loudly.
   F. Use talk and touch to communicate. Encourage the resident to do the same.
   G. Give ongoing, step-by-step explanations of what you are going to do and what is expected of the resident. Clarify the resident's understanding as appropriate.
   H. Do not rearrange the environment without the resident's knowledge and approval. Replace items to their original location in the resident's room.
   I. Tell the resident when you are finished and when you are leaving.
7. Communicating with Residents Who Have Hearing Loss
   A. Follow steps 1 thru 5 of this Procedural Guideline.
   B. Alert the resident by approaching from the front or side and lightly touching resident's arm. Avoid startling the resident.
   C. Eliminate distracting background noise and activity if possible.
   D. Speak at a slightly lower pitch and at a normal or only slightly increased volume-- avoid shouting.
   E. Encourage and assist the resident to use a hearing aid as appropriate.
   F. If the resident hears better in one ear, stand on the preferred side.
   G. Stand comfortably close to resident in a good light and face the resident while you speak.
   H. Speak slowly, clearly and distinctly using your lips to emphasize sounds-- do not chew gum or cover your face with your hands while talking.

I. Use short words and sentences, clarify the resident's understanding then rephrase message if needed.

J. Keep conversations short and limited to a single topic.

K. Do not convey negative messages by your tone of voice or body language.

L. Write out key words, if needed, or use other communication assistive devices such as communication boards if available.

8. Communicating with Residents Who Have Problems with Speaking

A. Follow steps 1 thru 5 of this Procedural Guideline.

B. Keep conversation short, but frequent. Ask direct questions if the resident can answer "Yes" or "No."

C. Allow the resident adequate time to respond.

D. Listen carefully. Don't pretend to understand the resident if you don't.

E. Emphasize the positive aspects such as the words you understand.

F. If you can't understand the words, validate what you think the resident is saying or feeling.

G. Take time to complete each conversation to avoid conveying impatience.

H. Monitor your body language to assure you are not sending negative messages.

I. Encourage and assist the resident to point, nod, write, or to use assistive devices for communication such as picture boards and word boards as appropriate.

J. Request assistance when needed.

9. Communicating with Residents Who Have Problems with Confusion, Memory Loss and Other Language.

A. Follow steps 1 thru 5 of this Procedural Guideline.

B. Use simple sentences and words and pronounce words clearly and slowly.

C. Keep conversation short, but frequent and focused on a single topic.

D. Give simple one-step instructions as appropriate.

E. Allow the resident adequate time to respond.

F. Monitor your body language to assure you are not sending negative messages.

G. Use gestures and expressions to enhance the message.

H. Use clues to go with your verbal message, i.e., as you ask the resident to brush his/her teeth, put the toothbrush into the resident's hand.

I. Take time to complete each conversation to avoid conveying impatience.

10. Guidelines for Effective Interpersonal Relations

A. Maintain open communication, be a good listener and encourage residents to express his/her feelings.

B. Be honest. Your best efforts will fail if you are not sincere.

C. Respect each resident as a unique individual with his/her own behavior patterns.

D. Be courteous, patient and hopeful.

E. Develop supportive and trusting relationships with residents by being supportive and trustworthy.

F. Show residents that you care "about" them as well as caring "for" them.

G. Understand and accept residents – without judging.

11. Recap of communicating with residents:

A. Knock on resident's door; wait to be invited into the resident's room.

B. Identify yourself and your title, nurse aide.

C. Do not walk up behind the resident, approach resident from the side or front.

D. If possible, get on the resident's level to talk; try not to "look down" on the resident while talking.

E. Stay in the resident's line of vision when talking; this helps the resident understand.

F. Address the resident by proper name, such as Ms. Smith or Mr. Smith, unless the resident asks you to use his/her first name. Do not use pet names to address the resident such as "honey" etc.

G. Ask the resident if you can turn the volume down on the television if it is loud and interfering with conversation or taking vital signs.

H. Talk while giving the resident care. Explain step-by-step to the resident the care you are providing.

I. Listen to the resident! Respond to resident questions or statements.

J. Remain calm at all times.

K. Do not give the resident your personal information or problems.

L. Use courtesy at all times.

M. Maintain professional boundaries.

2.4 Nutrition and Hydration

2.4.1 Procedural Guideline #9 – Assisting with Meals

1. Purpose:
   A. To provide nutrition to residents.
   B. To serve meals to residents in a pleasant environment.
2. Precautions
   A. Do not offer foods hot enough to burn to residents who drink from a straw or have visual problems, weakness, shakiness, inability to grasp objects or other problems that might lead to burns.
   B. Do not attempt to feed a resident who is asleep, unresponsive, choking, unable to swallow, unable to tolerate at least a 75º elevation, whose head is tilted backward (airway is open), or whose head and chin are tilted downward and inward toward chest (airway is closed). Report promptly to nurse for directions.
   C. Follow Procedural Guideline #3 if choking occurs.
3. Procedural Guidelines
   A. Preparing residents prior to mealtime:
      a. Assist with toileting, handwashing, oral hygiene and other care as indicated.
      b. Be sure resident has dentures and/or eyeglasses if needed.

c. Assist resident to safe and comfortable seating in the eating area as able.

d. Assure that resident is correctly positioned, sitting with head and body as straight upright as possible. Check with nurse for directions if resident cannot tolerate at least a 75° elevation.

e. Provide clothing protectors as indicated.

B. Serving diet trays:

a. Sanitize hands before handling food and serving trays.

b. Identify diet tray by card.

c. Identify the resident and place tray within easy reach of resident.

d. Remove food covers and assist with napkins as indicated.

e. Replace missing items following facility policy.

C. Assisting residents with eating:

a. Encourage resident to help self as much as possible.

b. Assist resident as needed to ensure adequate dietary intake.

c. Prepare food as needed such as open packets, cut meat, butter bread, offer condiments as preferred.

d. For residents with impaired vision, describe food and location of food as placed on plate in relation to the face of the clock if appropriate.

e. Observe for and/or inquire about problems with eating, and try to correct problem if possible:

(1) Offer encouragement and/or assistance as indicated.

(2) Offer appropriate food substitutes if needed.

(3) Offer to replace or rewarm food that has become cold.

f. Provide encouragement and help with assistive eating devices as indicated.

D. Monitoring mealtime:

a. Allow resident ample time to eat.

b. Encourage socialization.

c. Remain pleasant and unhurried.

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d. Try to avoid or control unpleasant situations.

e. Monitor and record dietary intake of all residents during mealtime and identify problems with eating.

f. Notify nurse of residents who are absent or who have eating problems.

g. For residents feeding self in own room, check frequently, offer assistance and visit briefly with resident as possible.

E. Removing trays if used

a. Remove tray after resident has finished eating.

b. Determine and record fluid and food intake as required following facility policy.

c. Place used trays on cart after all clean trays have been served.

d. Wash hands.

F. Assisting resident after meals:

a. Assist residents with ambulation, oral hygiene, toileting, hand-washing and other needs after eating as appropriate.

b. Assist resident to return to a position of comfort and safety.

2.4.2 Procedural Guideline #10 – Feeding the Dependent Resident

1. Purpose: To feed the resident who needs assistance with eating.
2. General Guidelines and Precautions

A. Take care when serving hot foods to avoid burns. Check temperature of food by dropping a small amount on your wrist or forearm.

B. Try to reduce the stress and frustration the resident may feel about being fed. Converse pleasantly with the resident during meal.

C. Do not attempt to feed a resident who is asleep, unresponsive, choking, unable to swallow, unable to tolerate at least a 75° elevation; or whose head is tilted backward (airway is open), or whose head and chin are tilted downward and inward toward chest (airway is closed). Report promptly to nurse for directions.

D. Follow Procedural Guidelines #3 if choking occurs.

- Communicate verbally with the resident, even if he/she gives no response.

Non-verbal tips for the Caregiver

When interacting silently with a resident who has Dementia, these general guidelines may be helpful for the caregiver:

- Make eye contact with the resident.
- Smile and use positive facial expressions with the resident.
- Touch the resident as appropriate.
- Be aware of your own body language around the resident.
- Observe the resident's actions.
- Listen carefully to any words spoken by the resident.
- Observe the resident's body language for any change in emotion.

Quality of Care: Eating

Loss of memory/knowledge can also affect essential human needs, like eating.

Dementia-related areas impact nutrition and well-being for a resident including:

- Inability to evaluate hunger (forgetting to eat);
- Inability to identify what food is (by type, temperature, etc.);
- Inability to comprehend meal schedules; and
- Inability to understand/work with physical changes (e.g., mouth sores, dry mouth, denture issues, etc.).

A resident's Care Plan may follow these guidelines to help a person with dementia maintain a healthy eating routine, such as:

- Serving the resident's food at mid-range temperatures (not too hot/cold);
- Limiting high salt/sugar foods for the resident;
- Monitoring weight for the resident; and
- Serving smaller portions of food to the resident more often.

Quality of Care: Eating

A caregiver's meal time practices with a resident may help a resident with dementia have a more positive eating experience. Activities that can create a positive experience include:

- Preparing the food to eat immediately (e.g. cut food into bite-size portions, butter the bread, etc.);
- Putting only one food item at a time on the plate;
- Providing finger foods (if the resident is unable to use utensils);
- Offering fluids frequently;
- Keeping the environment calm/quiet; and
- Cueing the resident to eat, as needed.