

Orientation Packet
Section IX
Home Health Aide Training

Abundant Life Home Health Agency Orientation Packet Section IX

Advance Directives and End of Life Training

Questions and Answers about Advance Directives

More than ever before, people are being asked to take part in decisions about end-of-life care. Yet, most people still do not discuss end-of-life care at all, even if they are seriously thinking about these issues and some guidelines for discussions with their physicians, families, and loved ones. This fact sheet is also designed to help patients understand the medical, legal, and personal choice they may face in the future.

1. What rights do patients have regarding their medical treatment?

Patients are entitled to have complete information about their illness and how it may affect their lives, and they have the right to share or withhold that information from others. People with cancer should also be informed about any procedures and treatments that are planned, the benefits and risks, and any alternative that may be available. Patients may be asked to sign an “informed consent” form, which includes this information. Before signing such a form, patients should read it carefully and ask the physician any questions they might have.

Patients have the right to make decisions about their own treatment. These decisions may change over time. In the face of worsening disease, some patients may want to try every available drug or treatment in the hope that something will be effective. Other patients may choose to forgo aggressive medical treatment. Many patients turn to family members, friends, or caregivers for advice. But, it is the patient’s decision how much for how little treatment to have. Sometimes a patient is unable to make this decision, due to severe illness or change in mental condition. That is why it is important for people with cancer to make their wishes known in advance.

2. What is end-of-life care? What are advance directives?

End-of-life care is a general term that refers to the medical and psychosocial care given in the advanced or terminal stages of illness. Advance Directives are the legal documents such as the living will, durable power of attorney, and healthcare proxy that allow people to convey their decision about end-of-life care ahead of time. Advance directives provide a way for patients to

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Abundant Life Home Health Agency Orientation Packet Section IX

communicate their wishes to family, friends, and health care professionals and to avoid confusion later on, should they become unable to do so.

Ideally, the process of discussing and writing advance directive should be ongoing, rather than a single event. Advance directive can be modified as a patient's situation changes. Even after advance directives have been signed, patients can change their minds at any time.

3. Why are advance directives important?

Complex choices about end-of-life care are difficult even when people are well. If a person is seriously ill, these decisions can seem overwhelming. But, patients should keep in mind that avoiding these decisions when they are well will only place a heavier burden on them and their loved ones later on. Communicating wishes about end-of-life care will ensure that people with terminal illnesses face the end of their lives with dignity and with the same values by which they have lived.

4. Why is it important to write a will?

A will is important so that patients can give instructions about distribution of their money and property when they die. Patients can name a trusted family member, friend, or professional to handle their personal affairs (also known as an executor). It is advisable to seek the expert advice of a lawyer in drawing up a will so that the decision made about taxes, beneficiaries, and asset distribution will be legally binding. This process can relieve a patient's family and friends of an enormous burden in case of dispute or question about allocation of the patient's assets.

5. What is a living will?

A living will is a set of instruction documenting a person's wishes about medical care intended to sustain life. It is used if a patient becomes terminally ill, incapacitated, or unable to communicate or make decisions. Everyone has the right to accept or refuse medical care. A living will protects the patient's right and removes the burden for making decisions from family, friends, and physicians.

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Abundant Life Home Health Agency Orientation Packet Section IX

There are many types of life-sustaining care that should be taken into consideration when drafting a living will. These include:

- The use of life-sustaining equipment (dialysis machines, ventilators, and respirators)
- “do not resuscitate” orders; that is, instruction not to use CPR if breathing or heartbeat stops
- artificial hydration and nutrition (feeding tube)
- withholding of food and fluids
- palliative/comfort care
- organ and tissue donation

It is also important to understand that a decision not to receive “aggressive medical treatment” is not the same as withholding all medical care. A patient can still receive antibiotics, nutrition, pain medication, radiation therapy, and other intervention when the goal of treatment becomes comfort rather than cure.

This is called palliative care; its primary focus is helping the patient remain as comfortable as possible. Patients can change their mind and ask to resume more aggressive treatment. If the type of treatment a patient would like to receive changes, however, it is important to be aware that such a decision may raise insurance issues that will need to be explored with the patient’s health care plan. Any change in the type of treatment a patient wants to receive should be reflected in the patient’s living will.

After a living will has been drawn up, patients may want to talk about their decision with the people who matter most to them, explaining the values underlying their decisions. Most states require the document be witnessed. Then, it is advisable to make copies of the document, place the original in a safe, accessible place, and give copies to the patient’s physician, hospital, and next of kin. Patients may also want to consider keeping a card in their wallet declaring that they have a living will and where it can be found.

6. What is a health care proxy and durable power of attorney for health care?

A health care proxy is an agent (a person) appointed to make a patient’s medical decision if the patient is unable to do so. Generally, people assign someone they know well and trust to represent their preferences when they can

Abundant Life Home Health Agency Orientation Packet Section IX

no longer do so. Patients should be sure to ask this person for agreement to act as their agent. An agent may have to exercise judgment in the event of a medical decision for which

the patient's wishes are not known.

The durable power of attorney for health care is the legal document. After it is written, it should be signed, dated, witnessed, notarized, copied, distributed, and incorporated into the patient's medical record.

Patients may also want to appoint someone to manage their financial affairs if they cannot. This is called a durable power of attorney for finances, and is a separate legal document from the durable power of attorney for health care.

Patients may choose the same person or someone different from their health care proxy to act as their agent in financial matters.

7. Where can people get assistance with their advance directives?

If patients need help making the decisions discussed in this fact sheet, they should not hesitate to call on family, friends, and other loved ones.

Although a lawyer is not needed to complete advance directive, it is important to be aware that each state has its own laws for creating advance directive.

Because these laws can vary in important details, special care should be taken to adhere to the laws of the state a patient lives in or is treated in. It is possible that a living will or durable power of attorney signed in one state may not be recognized in another. Appropriate forms can be obtained from health care provider, legal offices, offices on aging, and state health departments

The patient with end-stage illness will most probably have various symptomatic problems that will affect ability to eat. A few of these are mentioned below with some suggestions to offer the patient.

Alzheimer and Dementia Training

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological

Abundant Life Home Health Agency Orientation Packet Section IX

illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's

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Abundant Life Home Health Agency Orientation Packet Section IX

disease. Forgetfulness due to aging or increased stress is not normal aging and is not dementia.

“Dementia” is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer’s disease, Multi-Infarct dementia or Parkinson’s disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitably need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer’s disease is the most common form of untreatable, irreversible dementia.

Alzheimer’s Disease - Stages of Progression

Alzheimer’s Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places
- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particularly significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

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- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings

People are “out to get them”

Fear that caregiver is going to abandon Current living space is not “home”

Abundant Life Home Health Agency Orientation Packet Section IX

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question Repetitive action such as wringing a towel

Wandering

Pacing

Sundowning: trying to get “home” Generally feeling uncomfortable or restless

Increased agitation at night

Losing thing/Hiding things

Simply do not remember where items are

Might hide things so that people don’t “steal” them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object.

Apraxia: loss of ability to perform purposeful motor movements Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked too many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

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Abundant Life Home Health Agency Orientation Packet Section IX

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification.

Abundant Life Home Health Agency Orientation Packet Section IX

Activities of Daily Living

Activities of daily living (ADLs) are those things we all need to do on a regular basis to ensure our health and well-being. ADLs are those need-to-do things that take up so much of our day and that we all take for granted – until we can't do them anymore. Activities involving health and hygiene are called basic activities of daily living. By contrast instrumental activities of daily living are those abilities that allow a person to live independently.

Basic Activities of Daily Living

- Eating
- Bathing
- Dressing
- Toileting
- Continence
- Ability to get out of bed or a chair
- Walking (can be with the aid of a cane or walker)

Instrumental Activities of Daily Living

- Food Preparation
- Housekeeping and Laundry
- Managing Financial Matters
- Shopping
- Use Telephone
- Take Medication
- Responsible for Transportation (public transit, auto, etc.)

Nutrition Components

3 major groups :

- Proteins

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Abundant Life Home Health Agency Orientation Packet Section IX

- Carbohydrates
- Fats

Other important components:

- Vitamins
- Minerals
- Water

Principles of Good Nutrition

1. Balance
2. Variety, Variety, Variety
3. Moderation

Balance

We need a good balance of the 3 main groups of nutrition, i.e. carbohydrates, proteins and fats to stay healthy. Vitamins, minerals and water should also be taken in the right amounts.

The general guideline for our caloric intakes is:

- 15% to 20% from proteins
- 15% to 30% from fats
- 50% to 85% from carbohydrates

Variety

- Every food or food group has its own unique nutritional values
- Only a good mix of the various food groups will give you the complete essential nutritional needs
- A wide variety of food groups helps to complement each other in nutrition's

Moderation

- Too much of any particular food can result in unbalanced nutritional intakes, causing excess weight and too much of certain nutrients
- On the other hand, too little of any particular food can lead to certain nutritional deficiencies
- Taking food in moderate amounts helps to prevent any imbalance

Abundant Life Home Health Agency Orientation Packet Section IX

Complications of Poor Nutrition

- Heart disease
- Cancer
- Stroke
- Diabetes
- Osteoporosis
- Many others...

Dehydration

How do you know if you're properly hydrated? Generally speaking, the clearer the urine, the better hydrated you are. If it is a clear-pale lemonade color, you are hydrated. If it is a darker lemonade to apple juice color, you are dehydrated. And if it is dark and cloudy, you are severely dehydrated.

Why is it so important to stay hydrated?

The body depends on water for survival. Did you know that water makes up more than half of your body weight? Every cell, tissue and organ in your body needs water to function correctly. For example, the body uses water to maintain its temperature, remove waste and lubricate joints. Water is essential for good health.

How does a body lose water?

When you go to the bathroom, sweat, and even when you breathe. Water is lost even faster when the weather is really hot, during exercise, or with a fever. Vomiting and diarrhea can also lead to rapid fluid loss. If you don't replace the water you lose, you can become dehydrated.

Symptoms of dehydration include:

- Little or no urine, or urine that is darker than usual
- Dry mouth
- Sleepiness or fatigue

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Abundant Life Home Health Agency Orientation Packet Section IX

- Extreme thirst
- Headache
- Confusion
- Feeling dizzy or lightheaded
- No tears when crying

Special Diets

There are many types of diets for all different reasons, such as weight loss, religious beliefs, vegetarianism, but the diets most associated with our patients are medical based. Here are a few of those types of diets.

People's dietary choices are sometimes affected by intolerance or allergy to certain types of food. There are also dietary patterns that might be recommended, prescribed or administered by medical professionals for people with specific medical needs.

- **Best Bet Diet:** A diet designed to help prevent or mitigate multiple sclerosis, by avoiding foods with certain types of protein.
- **Colon Cancer Diet:** Calcium, milk and garlic are thought to help prevent colon cancer. Red meat and processed meat may increase risk.
- **Diabetic diet:** An umbrella term for diets recommended to people with diabetes. There is considerable disagreement in the scientific community as to what sort of diet is best for sufferers.
- **DASH Diet (Dietary Approaches to Stop Hypertension):** A recommendation that those with high blood pressure consume large quantities of fruits, vegetables, whole-grains and low fat dairy foods as part of their diet, and avoid sugar sweetened foods, red meat and fats. Promoted by the US Department of Health and Human Services, a United States government organization.
- **Elemental diet:** A medical, liquid-only diet, in which liquid nutrients are consumed for ease of ingestion.
- **Elimination diet:** A method of identifying foods which cause a person adverse effects, by process of elimination.

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Abundant Life Home Health Agency Orientation Packet Section IX

- **Gluten-free diet:** A diet which avoids the protein gluten, which is found in barley, rye and wheat. It is a medical treatment for coeliac disease.
- **Gluten-free, casein-free diet:** A gluten-free diet which also avoids casein, a protein commonly found in milk and cheese.
- **Ketogenic diet:** A high-fat, low-carb diet, in which dietary and body fat is converted into energy. Used as a medical treatment for refractory epilepsy.
- **Liquid diet:** A diet in which only liquids are consumed. May be administered by clinicians for medical reasons, such as after a gastric bypass or to prevent death through starvation from a hunger strike.
- **Specific Carbohydrate Diet:** A diet that aims to restrict the intake of complex carbohydrates such as found in grains and complex sugars. It is promoted as a way of reducing the symptoms of irritable bowel syndrome (IBS), Crohn's disease, ulcerative colitis, coeliac disease and autism.

Meal Preparation

1. Get the patients input on what meal items they want prepared. Consider if the requested item fits in the patients diet. (Regardless it is the patient's choice but encourage the patient to consider their diet, if the patient is not willing to change their request, prepare the requested meal.
2. Clean.
This allows for clear counters for food prep and it's easier to find your equipment. An empty dishwasher and sink gives you somewhere to put your dirty stuff and a head start on cleaning. Remember to clean as you go. This is a key tip for meal preparation.
3. Check the refrigerator for items that may go with the meal.
A little left over roasted sweet potatoes will add a nice richness and color to the mashed potatoes.
4. Put all the food on the counter that you need and determine the order to start each item.
5. Prepare the items per recipe or carton instructions.
6. Serve and remind patients if items are hot!
7. Clean up any mess!

Erikson's Stages of Development

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Abundant Life Home Health Agency Orientation Packet Section IX

These eight stages, spanning from birth to death, are split in general age ranges.

1. Infancy: Birth-18 Months Old

Basic Trust vs. Mistrust – Hope

During the first or second year of life, the major emphasis is on the mother and father's nurturing ability and care for a child, especially in terms of visual contact and touch. The child will develop optimism, trust, confidence, and security if properly cared for and handled. If a child does not experience trust, he or she may develop insecurity, worthlessness, and general mistrust to the world.

2. Toddler / Early Childhood Years: 18 Months to 3 Years

Autonomy vs. Shame – Will

The second stage occurs between 18 months and 3 years. At this point, the child has an opportunity to build self-esteem and autonomy as he or she learns new skills and right from wrong. The well-cared for child is sure of himself, carrying himself or herself with pride rather than shame. During this time of the “terrible twos”, defiance, temper tantrums, and stubbornness can also appear. Children tend to be vulnerable during this stage, sometimes feeling shame and low self-esteem during an inability to learn certain skills.

3. Preschooler: 3 to 5 Years

Initiative vs. Guilt – Purpose

During this period we experience a desire to copy the adults around us and take initiative in creating play situations. We make up stories with Barbie and Ken, toy phones and miniature cars, playing out roles in a trial universe, experimenting with the blueprint for what we believe it means to be an adult. We also begin to use that wonderful word for exploring the world—”WHY?”

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Abundant Life Home Health Agency Orientation Packet Section IX

While Erikson was influenced by Freud, he downplays biological sexuality in favor of the psychosocial features of conflict between child and parents. Nevertheless, he said that at this stage we usually become involved in the classic “Oedipal struggle” and resolve this struggle through “social role identification.” If we’re frustrated over natural desires and goals, we may easily experience guilt.

The most significant relationship is with the basic family.

4. School Age Child: 6 to 12 Years

Industry vs. Inferiority – Competence

During this stage, often called the Latency, we are capable of learning, creating and accomplishing numerous new skills and knowledge, thus developing a sense of industry. This is also a very social stage of development and if we experience unresolved feelings of inadequacy and inferiority among our peers, we can have serious problems in terms of competence and self-esteem.

As the world expands a bit, our most significant relationship is with the school and neighborhood. Parents are no longer the complete authorities they once were, although they are still important.

5. Adolescent: 12 to 18 Years

Identity vs. Role Confusion – Fidelity

Up until this fifth stage, development depends on what is done to a person. At this point, development now depends primarily upon what a person does. An adolescent must struggle to discover and find his or her own identity, while negotiating and struggling with social interactions and “fitting in”, and developing a sense of morality and right from wrong.

Some attempt to delay entrance to adulthood and withdraw from responsibilities (moratorium). Those unsuccessful with this stage tend to

Abundant Life Home Health Agency Orientation Packet Section IX

experience role confusion and upheaval. Adolescents begin to develop a strong affiliation and devotion to ideals, causes, and friends.

6. Young adult: 18 to 35

Intimacy and Solidarity vs. Isolation – Love

At the young adult stage, people tend to seek companionship and love. Some also begin to “settle down” and start families, although it seems to have been pushed back further in recent years.

Young adults seek deep intimacy and satisfying relationships, but if unsuccessful, isolation may occur. Significant relationships at this stage are with marital partners and friends.

7. Middle-aged Adult: 35 to 55 or 65

Generativity vs. Self-absorption or Stagnation – Care

Career and work are the most important things at this stage, along with family. Middle adulthood is also the time when people can take on greater responsibilities and control.

For this stage, working to establish stability and Erikson’s idea of generativity – attempting to produce something that makes a difference to society. Inactivity and meaninglessness are common fears during this stage.

Major life shifts can occur during this stage. For example, children leave the household, careers can change, and so on. Some may struggle with finding purpose. Significant relationships are those within the family, workplace, local church and other communities.

8. Late Adult: 55 or 65 to Death

Integrity vs. Despair – Wisdom

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Abundant Life Home Health Agency Orientation Packet Section IX

Erikson believed that much of life is preparing for the middle adulthood stage and the last stage involves much reflection. As older adults, some can look back with a feeling of integrity — that is, contentment and fulfillment, having led a meaningful life and valuable contribution to society. Others may have a sense of despair during this stage, reflecting upon their experiences and failures. They may fear death as they struggle to find a purpose to their lives, wondering “What was the point of life? Was it worth it?”

COMMUNICATION AND INTERPERSONAL SKILLS

A. Guidelines for Starting a Conversation

1. Knock on the door before entering, identify yourself by name and title and greet patients by the preferred name.
2. Approach the patient in a calm and courteous manner.
3. Explain why you are there and what you are going to do.
4. If you are going to perform a procedure, explain the procedure to the patient and encourage the patient to participate as appropriate.

B. Guidelines for Talking and Listening

1. Get the patient's attention before speaking.
2. Use courtesy when communicating. Talk courteously with patients during care, listening and responding appropriately.
3. Speak in a language that is familiar and appropriate for the patient--avoid slang or words with more than one meaning.
4. Use a normal tone of voice and adjust your volume to the patient's needs.
5. Speak slowly and adjust your rate to the individual patient's needs.
6. Speak clearly--avoid mumbling.
7. Keep your message brief and concise--avoid rambling.
8. Face the patient. Sit at the patient's eye level and maintain frequent eye contact with the patient as appropriate.
9. Send positive messages by use of encouragement, praise, smiles, gentle touch and other methods acceptable to patients.
10. Be sure your verbal and nonverbal message match.
11. Use open posture, leaning slightly toward the patient while listening.
12. Pay attention and really listen to what the patient is saying.

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Abundant Life Home Health Agency Orientation Packet Section IX

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

C. Guidelines For Encouraging Patients To Express Feelings

1. Use silence to allow the patient to think and continue talking (this shows respect and acceptance).
2. Use broad opening statements like "You seem quiet today".
3. Use open-ended questions like "and then what happened?"
4. Use noncommittal responses like "Oh, I see", "Go on", "Hmm..."
5. Use responses that indicate you understand the patient's feelings such as "You really miss your son."

D. Guidelines for Avoiding Barriers to Conversation

1. Avoid interrupting or changing the subject.
2. Avoid expressing your opinion if it implies passing judgment.
3. Avoid talking about your own personal problems and the problems of other patients and co-workers.
4. Avoid pat answers such as "Don't worry" as this can make patients feel their concerns are not important.
5. Avoid questions that can be answered with "Yes" or "No" unless you want only direct answers.
6. Avoid questions that start with "Why" to avoid defensive responses.

E. Guidelines for Ending a Conversation

1. Tell the patient that you are finished, that you have to leave and, if appropriate, when you will be back. Be sure to come back at designated time.
2. Tell the patient that you enjoyed the conversation.
3. Leave the patient in a position of comfort and safety, with call signal and other needed items within easy reach.

F. Communicating with Patients who have Vision Loss

1. Follow steps A thru E of this Procedural Guideline.
2. Identify yourself by name and title as you enter the room to avoid startling patients.
3. Encourage and assist patients to keep glasses clean and to wear them.

Abundant Life Home Health Agency Orientation Packet Section IX

4. Stand comfortably close to the patient in a good light and face the patient when you speak.
5. Speak in a normal tone of voice. Do not speak too loud.
6. Use talk and touch to communicate. Encourage patients to do the same.
7. Give ongoing, step by step explanations of what you are going to do and what is expected of the patient.

Clarify the patient's understanding as appropriate.

8. Do not rearrange the environment without the patient's knowledge and approval. Replace items to their original location in the patient's room.
9. Tell the patient when you are finished and when you are leaving.

G. Communicating with Patients who have Hearing Loss

1. Follow steps A thru E of this Procedural Guideline.
2. Alert the patient by approaching from the front or side and lightly touching the patient's arm. Avoid startling the patient.
3. Eliminate distracting background noise and activity if possible.
4. Speak at a slightly lower pitch and at a normal or only slightly increased volume--avoid shouting.
5. Encourage and assist the patient to use a hearing aid as appropriate.
6. If the patient hears better in one ear, stand on the preferred side.
7. Stand comfortably close to the patient in a good light and face the patient while you speak.
8. Speak slowly, clearly and distinctly using your lips to emphasize sounds--do not chew gum or cover your face with your hands while talking.
9. Use short words and sentences, clarify the patient's understanding then rephrase the message if needed.
10. Keep conversations short and limited to a single topic.
11. Do not convey negative messages by your tone of voice or body language.
12. Write out key words, if needed, or use other communication assistive devices such as communication boards if available.
13. If the patient uses sign language, try to find someone who "signs" to interpret.

H. Communicating with Patients who have Problems with Speaking

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

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Abundant Life Home Health Agency Orientation Packet Section IX

2. Keep conversation short, but frequent. Ask direct questions if the patient can answer "Yes" or "No."
3. Allow the patient adequate time to respond.
4. Listen carefully. Don't pretend to understand the patient if you don't.
5. Emphasize the positive aspects such as the words you understand.
6. If you can't understand the words, validate what you think the patient is saying or feeling.
7. Take time to complete each conversation to avoid conveying impatience.
8. Monitor your body language to assure you are not sending negative messages.
9. Encourage and assist the patient to point, nod, write, or to use assistive devices for communication such as picture boards and word boards as appropriate.

Guidelines for Effective Interpersonal Relations

1. Maintain open communication, be a good listener and encourage patients to express their feelings.
2. Be honest. Your best efforts will fail if you are not sincere.
3. Respect each patient as a unique individual with their own behavior patterns.
4. Be courteous, patient and hopeful.
5. Develop supportive and trusting relationships with patients by being supportive and trustworthy.
6. Show patients that you care "about" them as well as caring "for" them.
7. Understand and accept patients - without judging.
8. Don't take a patient's behavior personally.
9. Identify honest examples of patients' strengths and successes and provide positive feedback to patients.

Why is non-verbal communication important?

Basically, it is one of the key aspects of communication (and especially important in a high- context culture). It has multiple functions:

- o Used to repeat the verbal message (e.g. point in a direction while stating directions).

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- o Often used to accent a verbal message. (e.g. verbal tone indicates the actual meaning of the specific words).
- o Often complement the verbal message but also may contradict. E.g.: a nod reinforces a positive message (among Americans); a “wink” may contradict a stated positive message.
- o Regulate interactions (non-verbal cues convey when the other person should speak or not speak).
- o May substitute for the verbal message (especially if it is blocked by noise, interruption, etc.) — i.e. gestures (finger to lips to indicate need for quiet), facial expressions (i.e. a nod instead of a yes).

BODY MECHANICS

A. Purpose

1. To maximize strength
2. To avoid injury to the side and the patient

B. General Guidelines and Precautions for Lifting and Moving

1. Wear loose clothing and low heeled, comfortable, non-skid shoes to allow good body mechanics.
2. Always get help from coworkers when needed before lifting heavy objects or patients who are unable to stand.
 - a. Plan the lift ahead of time.
 - b. Lift on signals such as “on the count of three.”
3. Elevate the bed to a comfortable working height when working at the bedside. Remember to return the bed to the lowest horizontal position when finished for patient safety.
4. Maintain good posture and good body alignment while lifting.
 - a. Keep your back straight.
 - b. Keep your knees bent.
 - c. Keep your weight evenly distributed on both feet.
 - d. Keep your feet at shoulder width (about 12 inches apart) to provide a broad base of support.

Abundant Life Home Health Agency Orientation Packet Section IX

5. Use the strongest and largest muscles to do the job. Leg and arm muscles are the strongest. Back and abdominal muscles are the weakest.
6. Bend from the hip and knees--not waist--when lifting objects.
7. Always squat down to lift heavy objects from the floor.
8. Keep objects close to your body when lifting and carrying.
9. Use both hands when lifting or moving heavy objects.
10. Slide, push or pull heavy objects rather than lifting them, when possible.
11. Use the weight of your body to help push or pull objects.
12. Work with smooth, even movements--not quick, jerky motions.
13. Face your work and avoid twisting your body.
14. To change the direction of your work, take short steps and turn your whole body without twisting your back and neck.
15. Avoid unnecessary bending and reaching.
16. Do not lift objects higher than your shoulders.

Maslow's Hierarchy of Needs

This hierarchy suggests that people are motivated to fulfill basic needs before moving on to other needs. As people progress up the pyramid, needs become increasingly psychological and social.

(insert chart)

Assistive Technology

Assistive technology devices are mechanical aids which substitute for or enhance the function of some physical or mental ability that is impaired. Assistive technology can be anything homemade, purchased off the shelf, modified, or commercially available which is used to help an individual perform some task of daily living. The term assistive technology encompasses a broad range of devices from "low tech" (e.g., pencil grips, splints, paper stabilizers) to "high tech" (e.g., computers, voice synthesizers, braille readers). These devices include the entire range of supportive tools and equipment from adapted spoons to wheelchairs and computer systems for environmental control. The Individuals with Disabilities Education Act (IDEA), the federal special education law, provides the following

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Abundant Life Home Health Agency Orientation Packet Section IX

legal definition of an assistive technology device: “any item, piece of equipment, or product system... that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.” Under IDEA, assistive technology devices can be used in the educational setting to provide a variety of accommodations or adaptations for people with disabilities.

The emotional effects of having a serious physical illness

A serious physical illness can affect every area of your life:

- relationships
- work
- spiritual beliefs
- how we socialize with other people.

A serious illness can make us feel sad, frightened, worried or angry. It may be because:

- You feel out of control of your body and your situation generally. You may feel that there is nothing that you can do.
- You feel lonely and isolated from family and friends. Sometimes it can be difficult to talk about the illness with those close to you. You don't want to worry or upset them.

For some of us, the emotional impact of a serious physical illness can be overwhelming. Cancer or heart disease, for example, can make us very anxious and depressed. It can stop us from doing the things we need to do in our daily lives.

Why are depression and anxiety more likely to happen if you have a serious physical illness?

- People become depressed and anxious when they are stressed for any reason. Being ill and having treatment are stressful. This is probably the most common reason.

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- Some drug treatments, such as steroids, affect the way the brain works and so cause anxiety and depression directly.
- Some physical illnesses, such as an under-active thyroid, affect the way the brain works. They cause anxiety and depression directly.
- Anxiety and depression are common. You may just happen by chance to become anxious or depressed at the same time as you become physically ill.

How can depression and anxiety be helped?

There are several different types of professionals who may be able to help you. These include your GP, trained counselors, psychotherapists, clinical psychologists and psychiatrists. Any treatment suggested will depend on your symptoms, the severity of your anxiety and depression, and your circumstances. It may involve talking, antidepressant tablets or both.

SKILLS:

Perineal Care

Perineal care is performed after a patient uses the bedpan, becomes incontinent, and as a part of daily bathing. As the nurse's aide performs perineal care, she is able to observe the skin on the perineal area for signs of infection such as lesions or swelling, which can be early signs of more serious conditions. Care performed regularly and properly will reduce the risk of urinary tract infection which can lead to bladder and kidney infection. Before you begin, wash your hands thoroughly and put on a pair of gloves. Then, follow these steps:

1. Ask the patient to open his or her legs if they are able. If not, you will need to gently separate the legs.
2. Using a washcloth and warm water, gently clean the skin of the perineal area moving from front to back. Do not move from back to front due to the risk of introducing germs from the anal area into the urethra, a primary source of urinary tract infection.
3. When you are finished washing, dry the area thoroughly to prevent skin from becoming chapped.

Abundant Life Home Health Agency Orientation Packet Section IX

4. Never reuse linens used to clean the perineal area to clean any other part of the body. Use a clean washcloth for this area only to minimize the spread of germs.
5. If bed linens are soiled or become wet during the cleaning process, you will need to replace them as quickly as possible.
6. Place used linens in the appropriate receptacle. Help the patient move to a comfortable position. Dispose of gloves and wash hands.

As you work, remember it is important to look for signs that may indicate infection. This can include pain or tenderness in an area, rashes, sores, or boils. If you notice any of these signs, report them to your supervisor immediately. Proper care can help your patient remain comfortable as they recover.

Bedpan

Find out how to assist with use of a bed pan in this important PCA skill. For patients who are unable to walk or stand, the use of a bedpan may be necessary. Assisting your patient in the use of the bedpan can minimize embarrassment and prevent unpleasant messes. Before you begin, wash your hands to prevent the spread of germs. Greet your patient, and explain that you will be helping him/her to use the bedpan. Ensure the patient has adequate privacy, and put on a pair of gloves. Assist the patient into a supine position (laying on the back, face up), and then help him/her turn onto their side. Follow these steps to make the process safe and efficient:

- Place the bedpan against the patient buttocks, and then roll the patient back onto his/her back. Ask the patient to spread their legs to ensure the bedpan has been properly placed. Raise the head of the bed to make the patient comfortable, and then step away to allow the patient privacy. Remove gloves and dispose of them properly. Wash your hands thoroughly.
- When the patient is finished, again ensure that the patient has adequate privacy. Wash your hands and put on gloves.
- Return the head of the bed to a flat position, and assist the patient in turning onto his/her side. As you turn the patient, support the bedpan in order

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Abundant Life Home Health Agency Orientation Packet Section IX

to prevent contents from spilling onto the bed. If a spill does occur, you will need to immediately change bed linens.

- Remove the bedpan and set it aside. Ensure that the patient's buttocks and genitals are clean to prevent infection. Return the patient to a comfortable position of his/her choice. Provide a damp cloth to allow the patient to wash his/her hands, if the patient wishes.
- Measure the output and record appropriately, then dispose of the secretions as directed. Ensure that the bedpan is either replaced or cleaned.
- Remove your gloves and immediately wash hands for at least one minute.

Careful use of the bedpan will prevent infection and allow the patient to complete necessary bodily or bowel functions with a minimum of discomfort. Try to remain professional as you assist the patient with this process, and ensure proper hand washing procedures are followed.

Catheter Cleaning

A Foley catheter is a sterile (germ-free) tube that is inserted through your urethra and into your bladder to drain urine. The catheter has a small balloon filled with solution that holds the catheter inside your bladder. A Foley catheter is also called an indwelling urinary catheter.

Gather all of the supplies needed for your catheter care. This would include:

- A basin of clean warm water or use of a clean sink with running warm water.
 - Two clean washcloths and a clean towel
 - Soap
1. Wash your hands thoroughly with soap and water before and after cleaning and touching the catheter, drainage bag, or urine.
 2. Apply soap and water to one washcloth and thoroughly clean the area around the meatus then rinse well to remove all soap.
 3. Rinse the washcloth, apply more soap, and clean the rest of the area between your legs and buttocks. For female patients, it is important to wipe from front to back to prevent an infection. For male patients, it is important to begin at the tip of the penis and wash downward toward the body.

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Abundant Life Home Health Agency Orientation Packet Section IX

4. Rinse and pat dry the area well with the towel.
5. Change the water in the basin and clean the catheter next.
6. Apply soap to the second washcloth.
7. Firmly grasp the catheter to prevent tugging on it and gently wash the tubing. Begin at the meatus and wash the first 2 to 3 inches of the tube, moving away from the body toward the drainage bag. DO NOT wash from the tubing toward the body because this may push bacteria into the meatus.
8. Gently remove any drainage or crusting that may be present on the tube.
9. Gently dry the tubing.
10. Do not use any powders in this area.
11. After cleansing, the catheter should be secured to the inner thigh to prevent irritation around the meatus and to prevent pulling the catheter out.

Drainage Bag

The drainage bag should be emptied, at a minimum, two to three times a day. The bag should not be allowed to become full. This will put pressure on the catheter and cause tugging and irritation at the meatus. It also will be too heavy and bulky to carry around.

1. Wash your hands before and after emptying the bag.
2. The bag should be kept below the level of the hip (bladder) at all times to prevent urine from flowing back into the tubing and into the bladder.
3. Use a clean container to empty urine into if your doctor wants you to measure the amounts in the drainage bag. Otherwise, you can also empty the bag directly into the toilet.
4. Carefully open the spigot (pour spout) at the bottom of the bag to empty. Do not allow the spigot to touch the container or toilet. This causes contamination of the bag with bacteria.
5. Clean the end of the spigot with rubbing alcohol on a gauze pad or cotton ball.
6. Close the spigot securely to prevent leaking.
7. Do not allow the drainage bag to rest on the floor.
8. When completed, position the drainage bag so that the tubing is not kinked and the bag does not tug on the patient.

Abundant Life Home Health Agency Orientation Packet Section IX

Urinary Tract Infection (UTI)

Symptoms of lower urinary tract infections usually begin suddenly and may include one or more of the following signs:

- The urge to urinate frequently, which may recur immediately after the bladder is emptied.
- A painful burning sensation when urinating. (If this is the only symptom, then the infection is most likely urethritis, an infection limited to the urethra.)
- Discomfort or pressure in the lower abdomen. The abdomen can feel bloated.
- Pain in the pelvic area or back.
- The urine often has a strong smell, looks cloudy, or contains blood. This is a sign of pyuria, or a high white blood cell count in the urine, and is a very reliable indicator of urinary tract infections.
- Occasionally, fever develops.

Colostomy

A surgically-created opening in the abdomen and the colon (or large intestine). The surgeon brings the colon through the abdominal opening and sews it down to the skin.

- You will hear this new opening referred to as “stoma”, “ostomy”, or “colostomy”.

Types of Ostomies:

Colostomy: Typically installed as a result of the loss of all or a portion of the patient’s colon (large intestine).

Ileostomy: Similar to a colostomy, an ileostomy is connected to the small intestine and can also be temporary or permanent.

Urostomy: A common form of ostomy which is designed to divert urine from the genitals into a pouch for collection.

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Handling an ostomy means dealing with human waste and as a result, you must handle it carefully. Always wear latex gloves when handling the ostomy valve and be sure to clean the tube thoroughly after each evacuation. Pay close attention to the instructions included with the ostomy to ensure that you handle it correctly and that you replace the valve as needed. It's best to empty the bag before it gets too full to prevent leaks and spills.

Constipation and Diarrhea Symptoms

Constipation is a symptom, not a disease. Constipation is when a person passes small amounts of hard, dry stool, usually fewer than three times a week. People who are constipated may find it difficult and painful to have a bowel movement.

Other constipation symptoms include feeling:

- Bloating
- Uncomfortable
- Sluggish.

Diarrhea is not an illness; it is a symptom, similar to the way fever is a symptom. Depending on the cause of diarrhea, other symptoms may or may not accompany it. So when someone asks, "What are diarrhea symptoms?" he or she is most likely interested in the other symptoms that may come along with diarrhea.

While diarrhea is extremely common, many people are not familiar with its formal definition. Diarrhea is defined as loose, watery, unformed stools occurring more than three times in one day. People with diarrhea may pass more than a quart of stool a day. Diarrhea is not the occasional loose stool or the frequent passing of formed stools.

Diarrhea may be accompanied by a number of other symptoms. These symptoms can help your healthcare provider diagnose the cause of diarrhea. Symptoms that may be present with diarrhea include:

- Cramping abdominal pain (or stomach pain)

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Abundant Life Home Health Agency Orientation Packet Section IX

- Bloating
- Nausea
- An urgent need to use the bathroom
- An inability to control the bowels (fecal incontinence)
- Feeling sick to the stomach
- Fever
- Chills
- Muscle aches or pain
- Headache
- Low heart rate
- Joint pain
- Alternating constipation
- Blood in stool
- Mucus in stool

Skin Care

The skin consists of three layers: Epidermis, dermis, and subcutaneous tissue. The outermost layer, the epidermis, is composed mostly of dead skin cells that are constantly being shed and replaced. The dermis or second layer has sweat glands, oil glands, nerve endings, and small blood vessels called capillaries, which are all woven together by a protein called collagen. Collagen provides nourishment and support for skin cells. The nerves ending in this layer transmit sensations of pain, itch, touch and pleasure. The hair follicles also originate in this layer. Destruction of either the epidermis or dermis can leave the body open and susceptible to infection. The subcutaneous adipose tissue is the deepest layer of skin and is a layer of fat and collagen that houses larger blood vessels and nerves. This layer is important in controlling the temperature of the skin itself and the body and protects the body from injury by acting as a shock absorber. The thickness of this layer varies throughout the body and from person to person. Underneath the subcutaneous tissue lays muscle and bone.

For the most part, the skin is tough, pliable and resistant to injury. If the skin becomes injured or broken, it is generally very resilient and has an amazing ability to self-repair and heal. Despite this resiliency, the skin is susceptible to breakdown, if subjected to prolonged abuses, such as excessive pressure, shear

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Abundant Life Home Health Agency Orientation Packet Section IX

force, friction or moisture. This is a major concern for persons with transverse myelitis or other neuroimmunologic conditions that cause paralysis and/or decreased sensation.

For people with paralysis, the skin is at increased risk for breakdown for several reasons. Paralysis itself affects the skin and underlying tissue. There is loss of collagen which weakens the skin and makes it less elastic. The lack of muscle function around bony areas of the body leads to muscle atrophy, resulting in less padding, which in turn, adds to the risk of skin breakdown. People with paralysis often have difficulty shifting their weight, repositioning themselves, or transferring without assistance.

Impaired sensation is often present, limiting the ability to sense when to make a weight shift or position adjustment. People with impaired sensation are also vulnerable to injury from many other hazards, such as, heat, cold, sun and trauma. Loss of sensation put an individual at risk for burns from very ordinary activities, such as using a laptop computer sitting directly on your lap or sitting too close to a fireplace. Injury can be caused from things that are too cold such as ice packs or cold exposure causing frostbite. Ingrown toenails can become infected and sunburn can become severe without feeling it.

When limited mobility is coupled with decreased sensation, a person is more likely to develop a specific type of skin breakdown called a pressure ulcer. According to the National Pressure Ulcer Advisory Panel, a pressure ulcer is defined as a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are one of the leading causes of complications across the life span of persons with paralysis. Up to 95 % of adults with spinal cord injury will develop at least one serious pressure ulcer at some time during their life.

Skin breakdown can range from minor scrapes, cuts, tears, blisters or burns to the most serious pressure ulcers with the destruction of tissue down to and even including the bone. A pressure ulcer, especially one that requires surgery, such as a muscle flap or skin graft, can cost thousands of dollars to treat, require lengthy hospitalization, and weeks to months away from family, work, school or community activities. It has been estimated that for persons with spinal cord

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Abundant Life Home Health Agency Orientation Packet Section IX

injury the cost of care for pressure ulcers is about \$1.2 to 1.3 billion dollars annually.

With a concerted effort, skin breakdown is, for the most part, preventable. It can occur, however, even in people who maintain the most diligent care and use the proper equipment. If skin breakdown is identified early, when still in the minor stages, and if the cause of the breakdown can be identified and eliminated, healing should occur fairly quickly. If it is not identified in its early stages, skin breakdown can rapidly progress from minor to serious.

Skin breakdown is caused in several different ways, including friction, shear, moisture and pressure. These causes can occur individually or in combination. Friction, moisture and sheer are identified as contributing factors to pressure ulcers. A friction injury occurs when the skin rubs on surfaces, such as a bed sheet, arm rest or brace and has the appearance of a scrape, abrasion or blister. This type of injury is typically seen on the heels and elbows and may result from repositioning, propping or rubbing due to increased spasticity.

A shearing injury occurs with dragging or sliding of a body part across a surface and has the appearance of a cut or tear. This type of injury can occur from dragging your bottom during a transfer or sliding down in bed when the head of the bed is elevated. With the sliding force, bone is moved against the subcutaneous tissue while the epidermis and dermis remains essentially in the same position; against the supporting surface such as a wheelchair or bed. This action causes occlusion of the blood vessels, decreasing blood flow, oxygen and nourishment to the skin, which eventually leads to breakdown. Sometimes a shear injury will actually tear the tissue over the tailbone and with unrelieved pressure will become a pressure ulcer.

Too much moisture over-hydrates the skin, making it weak and more sensitive to friction, shear and breakdown (think about being in the tub or pool for a long time). Primary sources of excess skin moisture include sweating, bowel and bladder accidents, and drainage from wounds.

Abundant Life Home Health Agency Orientation Packet Section IX

Pressure ulcers occur when skin, soft tissue and blood vessels are compressed or squeezed between a bony prominence (such as your tailbone) and an external surface (such as your wheelchair cushion). With compression of these vessels, the blood that nourishes the cells and takes away waste is cut off, starving the tissue of oxygen and vital nutrients. Without food and oxygen, tissue dies and skin breakdown begins. The body tries to compensate by sending more blood to the area. This process results in redness and swelling, places even more pressure on the blood vessels, and further endangers the health of the skin and underlying tissue. Ultimately, a pressure ulcer forms. Increased pressure over short periods of time and slight pressure over long periods of time have been shown to cause equal amounts of damage.

Many factors have been identified as responsible for the development of skin breakdown and pressure ulcer formation. In addition to immobility, impaired sensation and the external factors described above,

many internal contributing factors have been identified. These internal factors include poor nutrition and hydration, weight, impaired circulation and oxygenation, impaired cognition or thinking, substance abuse, depression and age. Nutritional factors important to prevent or heal wounds include a balanced diet with an adequate intake of protein, vitamin C, vitamin A, and zinc, as well as an adequate intake of fluids (8). When a person is overweight, extra pounds place extra pressure on vulnerable skin areas increasing the risk of compression of blood vessels. Individuals that are underweight often have decreased muscle mass with less fat padding over bony areas leaving them vulnerable to skin breakdown. Smoking, diabetes, anemia and other vascular conditions all lead to decreased circulation, increasing risk for skin breakdown. Individuals who are depressed or have impaired thinking and judgment due to substance abuse are less likely to be vigilant with regard to important self-care issues, such as skin health. Young children generally have more resilient and elastic skin and more baby fat and padding so they often have very little difficulty with skin breakdown. As children move into adolescence, their skin loses some of its elasticity. They generally have more body weight, putting more stress on pressure areas, such as the ischial tuberosities and tailbone with sitting. Teens often begin to have more difficulty with skin breakdown. As we continue to age,

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Abundant Life Home Health Agency Orientation Packet Section IX

our skin becomes increasingly less pliable and resilient. We experience the loss of collagen and muscle mass, as well as decreased circulation, making the skin more vulnerable. The elderly are most prone to skin tears and stripping due to fragile, thin, and vulnerable skin. In addition, incontinence may become a more frequent issue for bedridden or ill persons, increasing problems with moisture as described above.

Avoid prolonged pressure on any one spot

Encourage patients to reposition frequently. If the patient is unable the aide must assist with relieving pressure. When seated in a wheelchair, do weight shifts every 15 minutes. When lying in bed, reposition every 2 - 4 hours. Use pillows or wedges behind your back and between bony areas, such as knees and ankles. "Float" your heels and ankles off of the bed by supporting your lower leg with a pillow. Keep the head of the bed up less than 30 degrees to prevent shearing of skin from sliding down or the need to be pulled back up. If you use a wheelchair most of the day, avoid lying on your back at night. Instead, turn side to side to give your backside a break. Better yet, sleep on your stomach, if this position is comfortable and you are able to breathe safely. When positioned on your stomach, you have fewer pressure points, and can generally turn less frequently. Being on your stomach gives your backside a break, and allows you to stretch your hip flexor muscles and hamstring muscles, all for the price of one!

Maintenance of a clean and safe environment

Ensuring that the homes of our home health patients are clean and safe is an essential component in the provision of effective healthcare. It is also of paramount importance for our patients and their families to ensure a germ free environment to maintain optimal health and ward off respiratory problems, insect and rodent infestation and other health and environmental problems. A clean and tidy premise is also fundamental to assist our patients to remain healthy. And finally, a clean, safe and healthy home environment is critical to prevent and/or control the spread of healthcare associated infections.

Abundant Life Home Health Agency Orientation Packet Section IX

The goal of healthy housekeeping is to reduce the number of microorganisms in the home to minimize the risk of infection and accidents to both the patient and other family members.

Keep the patient area free of clutter and filth.

Mobility and Transfers

Assisting your patient to ambulate regularly provides exercise and helps prevent mobility and circulation problems for the patient. Many patients who need your assistance may have difficulty getting to a standing position and then walking without help. Falls can be very dangerous for patients, particularly the elderly, and may result in severe injuries. For this reason, the use of a transfer belt can make the process safer and more comfortable for the patient. Before you begin, assist the patient into suitably warm and comfortable clothing that will not hamper movement, such as a robe. Then, ensure the patient is wearing rubber-soled shoes or slippers that will provide traction. If your patient requires oxygen or an IV, ensure that the proper equipment is available such as a portable oxygen tank or IV pole with wheels. If necessary, provide the patient with a walker or cane to assist with movement. Once you are ready, follow these steps to ensure safety:

1. Lower the patient's bed to the lowest level, and lock the wheels. Assist the patient in sitting, and then moving legs so that they hang over the edge of the bed. Allow the person to remain in this position for a period of time to ensure the patient is not becoming dizzy.
2. Apply the transfer belt around the patient's waist. Help the person to stand by first standing in front of the patient. Have the patient place his/her hands on the bed alongside the legs, and feet on the floor. Tell the patient to lean forward, while you grasp the transfer belt with an underhand grip. Place your feet alongside the patient's feet, and flex your knees slightly. Assist the patient to a standing position by gently lifting and steadying the person. Remain in this position for a brief period to ensure the patient does not feel dizzy and his/her respiration remains constant.
3. Once you are certain the patient is steady, provide a cane or walker. The patient should hold a cane using their strong side. Assist the person to walk by

Abundant Life Home Health Agency Orientation Packet Section IX

standing slightly behind the patient on their weaker side and holding the transfer belt using an underhanded grip.

4. As you walk, monitor the patient carefully. If you notice changes in the person's respiration, or if the patient reports feeling dizzy or tired, you will need to discontinue the walk. Be sure you do not rush the patient, and allow them to move at whatever pace is comfortable. If the patient needs a rest, allow him or her to sit until they feel ready to walk again. Use the same procedure for standing from a chair as you did when helping them get up from bed.

5. After the patient is returned to his/her bed, be sure to again wash your hands. Do not leave the transfer belt on the patient after they return to bed.

Passive ROM

Performing passive range of motion checks on a patient can indicate the progress of the patient's recovery and prevent complications from stiff joints. If practical, a range of motion exercises should be performed as you give a patient his or her bath. Before you begin, wash your hands. Greet your patient, and explain that you will be checking his or her range of motion by performing several exercises. Then, follow these steps:

1. Raise the height of the bed until you can comfortably reach the patient to assist if necessary.
2. Start with a range of motion tests on the head. Ask the patient to turn the head from one side to the other. This check should not be performed on a patient who has a neck or spinal cord injury as it could aggravate the problem.
3. Next, move to the arms. Have the patient flex and extend both arms at the elbow. Then, have the patient move the arms in a crossing motion toward the body and then away. Ask the patient to move all fingers and flex their wrists. Perform each test ten times per arm.
4. Move to the legs, and ask the patient to flex and extend each knee, then move the leg toward the centerline of the body and back. Perform ten times on each leg. Ask the patient to flex and extend feet at the ankles, and then move or wiggle the toes.

For a bed-bound patient, checks should be performed once or twice per day to ensure that joints do not become contracted. If the patient experiences stiffness or an inability to move a joint, it may be an indication of contractures and

Abundant Life Home Health Agency Orientation Packet Section IX

should be reported immediately. As you perform each test, observe the patient for signs of swelling or inflammation in any of the joints. If your patient reports severe pain or shows signs of respiratory distress while performing tests, notify nursing staff right away. There are six different positions that you can use to perform checks:

Supine Position – the patient lies on the back with arms extended to each side.

Sims Position – the patient is positioned on either side with both legs straightened.

Lateral Position – the patient is lying on one side with the top leg flexed, and the flexed leg and top arm are elevated on a pillow for support.

Semi-Fowler Position – the patient lies on the back with the head of the bed elevated to a 45 degree angle.

High-Fowler Position – the patient lies with the head of the bed raised to a 90 degree angle.

As you perform these checks, monitor the patient for any difficulty completing exercises. Notify nursing staff of any issues right away. Range of motion checks will help your patient to remain more comfortable and prevent complications arising from contractures of joints.

Contractures

Prevention of contractures is very important in maintaining the ability to walk and to do daily living activities. Contractures are prevented by actively exercising the muscles and joints through their range daily. If the individual cannot do so due to muscle weakness, the family, caregivers, aides, or friends can do gentle passive range of motion under the guidance of programs developed by the physician, the physical therapist, or the occupational therapist. Splints are also important in preventing contractures, especially at night when sleeping postures frequently encourage the development of contractures.

Abundant Life Home Health Agency Orientation Packet Section IX

Special Needs of the Elderly

There are a number of aspects that are involved in taking care of elderly or aged people. Having a good amount of awareness about the various possible needs and requirements of the elders is extremely important for those people who have the responsibility of taking care of their aged family members, parents or relatives.

Financial Needs

If elderly individuals happen to be living on their own, i.e. without anyone else's support, it is but natural that they will have a certain amount of financial needs. They will need to fend for themselves for everything such as food, groceries, medicines, etc. Pensioners would have the benefit of a steady source of monthly income (whatever be the amount trickling in). However, those senior citizens who do not have any pension facilities or any other sources of income would have to live entirely on the basis of their savings or through special senior citizen government finance schemes.

Health Care Requirements

Senior health is the most important requirement when it comes to elderly needs. With advancing age, the body tends to slow down and becomes less efficient. Elderly people are prone to a few age-related health issues. This is a normal aspect of life and one cannot help it. However, through proper care and nursing facilities, one can definitely help in keeping most of these health issues in check and preventing them from causing any serious harm. Regular medical checkups are necessary. They can help in anticipating potential future health-related issues. At the same time, they may help in identifying serious health problems at an early enough stage during which treatment is possible.

Dietary Requirements

As people age, their digestive system gradually starts weakening. Aged and elderly people especially, face this problem wherein they start finding certain foods indigestible or difficult to digest. What one must realize is that their diet can no longer be the same as it was, say, twenty years ago. Their diet should now be modified accordingly such that it remains a nutritious, balanced diet and yet, contains foodstuffs that their system is able to accept, without causing

Abundant Life Home Health Agency Orientation Packet Section IX

them any discomfort or problems. Often, the diets of elderly people need to be altered depending on their medicinal prescriptions.

Activities of Daily Living (ADLS)

Elderly people whose mobility has become limited due to aging, he or she would require a certain amount of assistance in his or her daily routine. They may require assistance in basic activities like walking, eating, bathing, dressing, etc.

Social and Other Needs

Just because they have become older and slower, does not mean that you should ignore them or let them be confined to themselves. Remember, a few years down the line, you yourself will be in their position.

Spend time with them, chat with them and make them feel wanted, cared for and loved. Pay special attention to their room. You could consider installing a few senior citizen friendly appliances which they would be comfortable using. Also, you should consider installing certain medical alarms that are specially made keeping in mind elderly citizens.

Prepared by the Florida Health Care Association with the assistance of the Alzheimer Resource Center of Tallahassee, Florida to meet the statutory requirement of 400.4785(1) (a) F.S.

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

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Abundant Life Home Health Agency Orientation Packet Section IX

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is not normal aging and is not dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitably need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and

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reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places
- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particularly significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions

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- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings People are “out to get them”

Fear that caregiver is going to abandon (results in AD person never leaving caregiver’s side) Current living space is not “home”

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

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They forget they asked the question Repetitive action such as wringing a towel

Wandering

Pacing

Sundowning: trying to get “home” Generally feeling uncomfortable or restless

Increased agitation at night

Losing thing/Hiding things

Simply do not remember where items are

Might hide things so that people don’t “steal” them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods.

The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked too many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

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One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification

Alzheimer Resource Center of Tallahassee: (850) 561-6869 Website:
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