Once you complete the training requirement, 25-30 hours, you will need to submit an application esc100.net for certification review..

After receiving required attestation signed you will be given a comprehensive certification test.

To meet mastery a 80% correct response is required. When the certification portion of the course is completed you will receive a certification.

ESC 100 Home Health Certification HHA Certification Curriculum, Final Certification Test and attestation form with signature.

For most care givers, it takes **about 25-30 hours** to become a HHA, home health aide. Esc100 is dedicated to providing curriculum that will allow employers and patience, including family members to feel comfortable in the skills and knowledge our certification provided. Esc100 is a cross curricular certification program and is registered as a Texas Education Agency Provider.

TEA Provider # 19-080-B

SYLLABUS

- Section 1 Roles and Responsibilities of the Nursing Assistant
- Section 2 Communication and Documentation
- Section 3 Safety, Standard Precautions, and Infection Control
- Section 4 Admission, Transfer and Discharge
- Section 5 Vital signs
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SECTION 1

Roles and Responsibilities of the Nursing Assistant

The Certified Home Health Assistant’s Role

A certified nursing assistant, or HHA, works under the supervision of nurses to deliver high quality care to patients. The job requires long hours and many responsibilities, but caring for patients on a daily basis provides some of the greatest rewards any profession could offer. Not to mention, the skills you learn as a Home Health Aidecan prepare you for a long-term career in the nursing field.

Take a closer look at the daily duties of a Home Health Aide(one who has completed HHA certification). Here are five important job objectives you can expect to perform as a HHA.

1. Feed, bathe, and dress patients

Certified nursing assistants help patients with their basic needs. Generally, this means helping them bathe, dress and feed themselves. These patients might include stroke victims, the elderly residents of nursing homes, or individuals recovering from an accident, injuries or surgeries in a hospital.

2. Take patient vital signs

From temperature to blood pressure, some HHAs are responsible for taking and recording patient vital signs. Routine tasks such as these are typically the initial steps of a patient’s visit to a physician’s office or hospital, which means the HHA has the responsibility of making a positive first impression for the medical team.

3. Serve meals, make beds, and keep rooms clean

In line with meeting patients' basic needs, duties of a Home Health Aideoften include serving meals to patients, making beds and helping clean rooms. This can mean cleaning out bedpans and changing soiled sheets. It also means getting the chance to have regular, one-on-one contact with patients—the compassionate relationships that can help people make it through times of illness with dignity.

4. Set up medical equipment and assist with some medical procedures

Storing and setting up medical equipment might involve laying out tools for the next patient exam or perhaps moving heavy medical equipment from one room to another. Some states allow HHA's who have had the appropriate training to assist with or perform some medical procedures, such as drawing blood.

5. Answer calls for help and observe changes in a patient's condition or behavior

Working so closely with patients on a daily basis, HHAs observe not only the obvious changes in a patient's physical condition but the subtleties of their emotional state. That intuition can have immeasurable impact on helping patients make it through a trying recovery or come to terms with a long-term condition.

Whether they take a patient's blood pressure before the doctor comes in, bring them breakfast in the morning or simply listen, HHAs make a significant difference to the quality of care patients receive.

Getting certified as a nursing assistant is a great way to begin your move up the nursing career ladder. Once you become certified, your next step is earning your associate's degree in nursing and becoming a registered nurse. From there you'll have nearly limitless options to consider in advanced practice nursing and administrative careers.

Section 2

Communication and Documentation

What do HHAs document? Plenty!

- Level of consciousness or alertness
- Measurements of vital signs
- Height and weight
- Intake and output
- Bowel elimination
- Appetite and food intake
- Skin: color, condition, integrity
- Activities and care: ambulation, turning and positioning, range of motion, catheter care, unsterile bandage changes, hot or cold compresses, bathing, etc.
- Patient's response to activities and care
- Significant statements from the patient
- Conversations you have with other members of the health care team

There are Eleven Golden Rules of Documentation. They apply to every professional who makes entries in a patient's medical record. Let's review them:

Eleven Golden Rules of Documentation

1

If you didn't write it down, it didn't happen.

You've probably already heard this: "If you didn't write it down, it didn't happen." This statement is one of the most important in health care. Failing to chart care properly may have two dangerous consequences. First, there will be no proof that a treatment or medication was given. Second, as a result, the

treatment or medication may be given twice. Either consequence may be considered malpractice. Therefore, if you do it, chart it!

> If you do it, chart it.

2

Date, time, and sign every entry.

If your facility uses electronic health records, this information will be automatically entered and unalterable. If your facility uses paper charts, you will write this information for each entry.

3

Chart care as soon as possible after you give it.

(**Ideally, you should chart it immediately, but in practice, that is usually difficult.**) Why must you be so prompt? Because once it's entered in the chart, no one will doubt that the care has been given and give it again. Patients don't always tell someone that their dressing was just changed or that they just got back from a walk. *Never* chart care before you give it. Not only is this illegal, but if you forget to give the care or something else happens, it will count as a false entry.

4

Write legibly every time.

As electronic health records become more common, written documentation will decrease. But it's likely that the patient's chart will always include paper forms or other written items. If your note can't be read, it won't do any good.

If your note can’t be read, it won’t do any good.

5

Be systematic

Always chart the same way. For example, you might choose to always use a head-to-toe method. You’ll begin with the patient’s level of consciousness and vital signs. Then you’ll chart your observations, care given, and activities. You’ll be less likely to skip something if you always do your charting the same way.

6

Be accurate.

Always review your entry before you sign it. Did you include everything? Is the spelling correct? Is the entry in the correct patient’s chart? To include a statement from a patient, use quotation marks and record it verbatim. Two examples:
Patient stated, “This is the worst pain I’ve ever had.”
Patient stated, “I’m so depressed. I want to go home.”

7

You absolutely must be objective.

Do not record your opinions. Use precise terminology and accurately describe what you have observed. For example, you can document that the patient’s wound is red and warm with white secretions. You cannot document that the wound is infected, because that conclusion would be beyond the scope of HHA practice. As another example, it’s fine to chart that a patient is

complaining of severe pain or saying that his or her level of pain is 9 out of 10, but not that the patient has a low tolerance for pain or that he or she is childish.

Do not record your opinions.

8

If you notify the nurse of something important, include it in your entry.

For example, suppose you observe that the skin over a patient's sacrum is red and warm to the touch. Of course, you will tell the nurse immediately. **Write it in the chart also.** If you report something about the patient to other team members, note that as well. You might be at the patient's bedside when the physician comes in. You can let the physician know that the patient complained of pain all night.

9

Use only abbreviations approved by your facility.

Every facility has a list of approved abbreviations, which can usually be found in the policy manual. There may also be a list of "Do Not Use" abbreviations. You must follow the policy even if you used different abbreviations at another job. If necessary, copy the list and keep it with you.

10

Never change what you have charted.

Never. Once an entry is made, it must be permanent. Electronic health records do not permit changes, but paper charts must not be altered either. If you make a mistake, follow your facility's policy for correction. Many facilities will accept a single line through the mistake with the date, the time, and your initials. Never erase, black out, or use correction fluid.

11

Don't chart for someone else or let anyone else chart for you.

When things are busy or others are way behind, you may be tempted to help, especially if nothing new has happened to the patients. But it must not be done. **It's illegal and unethical. Period.**
The patient's medical record is the only place that legally holds the patient's information. Documentation is not difficult, but it must be done properly. Your charting is just as important as that of every other member of the health care team. In every shift, your observations provide a baseline of each patient's status and can be the key to noticing a change in the patient's condition. Remember that your patients are counting on you, so take pride in your charting.

Section 3

Safety, Standard Precautions, and Infection Control

Bloodborne Pathogens, Infection Control

INTRODUCTION:

Protecting the patients and clients you care for and protecting yourself are two of your primary responsibilities when you are working as a Home Health Aide(HHA). In order to keep yourself and the people you are helping safe, you must understand the basic principles of infection control. Learning Break: The basic definition of infection control is: a system of techniques used to prevent infections and reduce the spread of infections. There will be many times during your career as a HHA when you will be caring for people with infectious diseases. Unlike some pathologies such as cancer or diabetes, infectious diseases can be transmitted from person to person. They can be spread through the air, by contact with blood or other body fluids, by touching contaminated surfaces, or by contact with infected wounds. Also, microscopic organism that can cause infection are everywhere in the environment, and they are especially plentiful in the setting of health care. In order to prevent these infections from moving to other patients, to yourself, or to the community at large, it is necessary to understand how the bacteria, viruses, and other microorganisms that cause these infections can be transmitted. It is also necessary to know how to work with people who have - or may have - a transmittable disease so that you do not become infected or infect others.

OBJECTIVES:

When the student has finished this module, he/she will be able to: 1. Identify a basic definition of infection control. 2. Identify the two basic goals of infection control. 3. Identify the most common way microorganism are spread from person to person. 4. Identify the most important method of infection control. 5. Identify the most important rule of hand washing. 6. Identify a definition of standard precautions. 7. Identify three body fluids/secretions that can be infectious. 8. Identify an important rule of the use of disposable gloves. 9. Identify an important rule of the use of disposable medical equipment. 10. Identify a definition of universal precautions.

THE BASICS OF DISEASE TRANSMISSION:

Infectious diseases are diseases that can be spread from person to person. Infectious diseases are caused by different types of microorganisms. Microorganisms are microscopic life forms that cannot be seen and they are, literally, everywhere. (Note: bacteria and viruses are examples of common microorganisms) They live in the air, in the water, in the soil, and they live in and on our bodies.

Microorganisms are found on our skin, in our lungs, in our stomachs, etc. This sounds unpleasant, but many of these microorganisms are actually very helpful. In the stomach and the gastrointestinal tract they help us digest food. In other parts of the body they help fight infection and help maintain the proper internal environment that the body needs to function. However, there are microorganisms that are not a normal part of our internal environment that can cause illness, and there are microorganisms that do normally live in/on us, but can cause illness if they are particularly strong or we are particularly vulnerable. These microorganisms that cause, or can cause illness or disease are called pathogens. Some pathogens such as the virus that causes the flu produce an illness that is relatively mild and rarely causes serious harm. Some pathogens can cause a more serious illness such as pneumonia, but pneumonia can usually be successfully treated with antibiotics. And there are pathogens such as HIV, the virus that causes AIDS. There is no cure for AIDS and no vaccine to prevent infection with HIV. But regardless of how dangerous the pathogen might be, these microorganisms are potentially dangerous because they can move from one person to another. They pathogens are communicable and contagious. They can be spread from the healthcare professional (you) to a patient, they can move from a patient to you, or they can be carried by a healthcare professional from an infected patient to other people. And even the ones that are relatively harmless such as the flu virus can be dangerous if they infect someone who is weak or vulnerable. Someone who has AIDs, someone who has cancer, or a person with diabetes may not be able to contain an infection in the way that normally healthy person would. These patients may suffer serious consequences from a simple infection. There are five basic ways an infection can spread. Some pathogens can only be spread by one of the transmission routes but some can be spread by several.

Airborne transmission:

Microorganisms are always living in the mouth, the nose, the lungs, and the other parts of the respiratory tract. When someone exhales, talks, sneezes, or coughs, these bacteria and viruses are attached to droplets of moisture and move from the infected person to the air. The infected droplets can move long or short distances, and they can remain suspended in the environment for quite a while or for only a short period of time: how far they move, and how long they stay suspended in the air differs with each microorganism. The risk, of course, is that a dangerous pathogen will move far enough and stay in the air long enough for it to enter the respiratory tract of someone in the area and cause harm. Chicken pox, measles, and tuberculosis are common diseases that have airborne transmission. Influenza can also be spread by airborne transmission, but this method of transmission is limited to short distances: approximately three feet or so.

Blood transmission:

Pathogens such as hepatitis B, hepatitis C, and HIV are spread by contact with infected blood. This can happen if a healthcare worker is stuck by a needle or splashed with blood in the eyes, mouth, or nose. It can also happen if blood-contaminated medical equipment that is used for more than one patient is not properly cleaned and sterilized, or if the equipment is used improperly, e.g., if a single-use, disposable medical item is used twice. People who use IV drugs and share needles are at high risk for blood transmission of pathogens. Blood transmission can occur through the skin, but only if there is an abrasion or a cut - an entry port for the microorganism. The eyes, mouth, and nose have mucous

membranes. These are much more “porous” than the surface of the skin and bacteria and viruses can easily pass through them and reach the circulation.

Contact transmission:

Contact transmission of a microorganism occurs when someone has direct contact with the infectious agent. This contact may be simple skin-to-skin contact such as touching a contaminated wound or a contaminated object. Contact transmission is one of the ways that the cold and the influenza viruses are transmitted. These viruses are expelled when an infected person breathes, coughs, or sneezes and the virus settles on objects in the environment, objects such as a computer keyboard, a doorknob, or a telephone receiver. An uninfected person will touch that object, touch her/his nose or mouth and the virus enters the respiratory tract. Other relatively common diseases that are spread through contact transmission are hepatitis A (contact with infected stool), methicillin-resistant staphylococcus aureus (commonly known as MRSA), and many microorganisms that contaminate wounds. Contact transmission of a pathogen is possible by contact with almost any infected body fluid, e.g., blood, mucous, semen: Sweat and tears are not generally considered to be a high-risk body fluids and contact transmission of a pathogen from these fluids would be very unlikely.

Droplet transmission:

Droplet transmission could be considered to be a mix of airborne transmission and contact transmission. Droplet transmission occurs when an infected person breathes, coughs, sneezes, or talks and small droplets that are contaminated enter the air and are breathed in by other people. Droplet transmission can also happen during medical procedures such as suctioning. Most experts feel that droplet transmission only occurs within an area of three feet from an infected person (Note: Some people feel the distance may be up to 10 feet). Diseases that can be spread by droplet transmission include influenza, mumps, and pertussis, a.k.a. whooping cough.

Sexual transmission:

HIV, herpes, gonorrhea, hepatitis C (possibly), syphilis, Chlamydia, and other diseases can be spread during sexual contact. These contacts can be male-to-female, female-to-male, male-to-male, and female-to female. The sexual contact can be anal, oral, or vaginal. Learning Break: Contact transmission is easily overlooked. Viruses and bacteria live everywhere and even brief and casual contact with something that is contaminated is enough for a microorganism to move from that object or body fluid to you. And even brief and casual contact between you and someone else may be enough to spread that bacteria or virus to the patient. So, infectious pathogens are everywhere in the environment and there are many ways they can be spread. It might seem surprising then that most of us are healthy most of the time. However, for disease transmission to occur the proper conditions must be in place. Movement of a microorganism from one person is just the first step in the development of in infection For the infection to progress to the development of an infectious illness that produce signs and symptoms, the following factors have to be in place. The microorganism must be capable of causing an illness; it must be a pathogen. The pathogen must be strong enough to cause an illness: it must be virulent. The pathogen must be strong enough to resist the immune system. There must be a sufficient number of the

pathogens. The pathogen must move from person-to-person: transmission mechanism. There must be an entry point: airborne, blood, sexual contact, etc. The victim - commonly called the host - must be susceptible. The last part of this process, the susceptibility of the host, can be complicated. The susceptibility could be inherited, or the host may have a weak immune system; for example, infants and the elderly people do not have strong immune systems, and people who have certain cancers or who have HIV/AIDS have compromised immune systems. There also some drugs that can weaken the immune system and make people who are taking these drugs susceptible to infections. This is a complicated process and certain parts of the process of how someone develops an infection can't easily be influenced. For example, host susceptibility is hard to change, limiting the strength of the pathogen can't be practically done, nor can controlling host entry points Host susceptibility Pathogen defense mechanisms Sufficient number of pathogens Virulence Entry point Transmission mechanism However, years of experience and research have proved that the best way to prevent pathogen transmission it to practice good infection control procedures and techniques; doing so can dramatically reduce the risk of a pathogen moving from person to person. Infection control is designed to prevent infectious illnesses by disrupting/preventing airborne, blood, contact, droplet, and sexual transmission of pathogens from infected people to uninfected people or from the environment to a host.

INFECTION CONTROL:

Infection control starts with standard precautions. Standard precautions are the methods recommended by the Centers for Disease Control and Prevention (CDC) for preventing the transmission of infections. Standard precautions includes: 1) handwashing; 2) respiratory hygiene/cough etiquette; 3) safe injection practices, and; 4) the use of personal protective equipment (PPE). Each of these has specific techniques, rules, and procedures that will be discussed. But the principle that underlies all of the aspects of standard precautions, and the principle that you must remember is this: Blood and all body fluids and secretions (with the exception of sweat and tears) should always be considered potentially infectious. Of course, patient care inevitably involves the possibility of exposure to blood and body fluids and secretions. Many times you will know you are caring for a patient with an infectious disease. But it is possible that you could be in close contact with someone who has a communicable illness or a high level of a pathogen and neither you nor the patient knows. So, standard precautions are always used when delivering patient care. Infection control is extremely important. It has been estimated that each year millions of patients develop illnesses because microorganisms are spread to them from health care personnel or from the surrounding environment. Many of these healthcare-acquired infections are very serious, and the patients can suffer serious harm from them. However, it has also been recognized that these illnesses can prevented if health care personnel carefully and conscientiously follow standard methods of infection control. Infection control is simple, but it can be time consuming. Knowing and using good infection control procedures will not only protect your patients and clients and the community you live in, it will also protect you. Healthcare workers are at risk for developing infections transmitted for the patients. Learning Break: You may hear or read about the term universal precautions. Universal precautions were the infection control protocols and techniques that were used before standard precautions. They are essentially the same as standard precautions, but the standard precautions are a bit more complex and it is now the preferred term.

Hand Washing:

Hand washing has been recognized by the Centers for Disease Control and Prevention (CDC) as the most important way to prevent the spread of infection. If it is done properly, hand washing has been proven to greatly reduce the number of healthcare-acquired infections. Hand washing is not complicated, but doing it right does take a bit of time. If you are working on a busy hospital floor or a clinic, it can be tempting to save time by cutting corners when you wash your hands. It can also be tempting to cut corners with hand washing because it may seem as if spreading bacteria or viruses is something that only happens if you are handling a contaminated bandage or working with a person who has a communicable disease. But microorganisms live everywhere, and it takes very little for them to move from a contaminated surface to you, and from you to a patient. Remember: even brief, causal contact with an infected object can be enough for the pathogen to move to you and then potentially to someone else. When should you wash your hands? Follow these rules: Table I: Situations That Require Hand Washing • At the beginning of the day before you start patient care. • When your hands are visibly soiled. • Before contact with a patient. • After contact with a patient. • Between contact with patients. • Before and after eating. • After you sneeze or cough. • After contact with any body secretions such as urine, stool, blood, saliva, or mucous. • After contact with surfaces that may be contaminated. • Before and after putting on gloves. • Before and after using the bathroom. • At the end of the day.

Hand washing: Soap and Water How should you wash your hands? It is not enough to simply rinse briefly and then dry off. To be effective, hand washing must be done properly. Follow these steps. The entire procedure should take 40-60 seconds if done correctly. Remove all jewelry: it has been proven that microorganisms can survive under rings, watches, etc., even if you have washed your hands. • Use lukewarm water and wet your hands up to the level of the wrists. • Use a reasonable amount of antimicrobial soap; these are soaps that have alcohol or some other disinfecting component. • Rub the soap gently for 15 seconds all over your hand. Pay particular attention to the areas between your fingers and the areas around your fingernails. Repeat for 15 seconds on the other hand. Do not rub your soapy hands under running water. If you suspect that you may have gotten blood, urine, or some other body secretion under your nails or near your nails, use a scrub brush to wash these areas. • Rinse under running water. • Dry your hands thoroughly with disposable paper towels. • Use the towel to turn the water off; do not touch the faucet with your clean hands. • Discard the towel. Infectious disease professionals recommend that health care personnel keep their fingernails short. Long fingernails can puncture rubber gloves, and it is difficult to clean away microorganisms from under long fingernails. Also, there is a much greater chance for bacteria and viruses to live and thrive on the hands when fingernails are long. One thing you will learn very quickly is that during the course of a normal work day you may find yourself washing your hands dozens of times. Even if your skin is not sensitive, frequent hand washing can cause your hands to become cracked, dry, and sore. This is not only very uncomfortable, it can be a health hazard for you and the patients if the irritation reaches a point to where you have open areas on your skin. If that occurs, one of the most important defenses you have against infection - an intact skin surface - has been compromised. Cracks that can allow entry to microorganisms can easily be too small to be seen. Dry and cracked skin can be prevented. It can help to use warm - not hot - water when hand washing. Limit hand washing to 15 seconds for each hand. Gently

pat your hands dry if they are chapped and sore and after you have finished, use a lubricating/moistening lotion. If you have open areas on your hands from hand washing and you are concerned that this puts you at risk, notify your immediate supervisor. You could be at risk for transmission of an infectious disease by the entry of a pathogen through the breaks in your skin. Hand washing: Alcohol-Based Hand Sanitizers Alcohol-based hand sanitizers are considered to be safe and effective for hand washing in healthcare settings. These products typically contain 62% ethyl alcohol, a substance that has been proven to be very effective in eliminating pathogens from skin. The only limitation to their use is if your hands are visibly contaminated or dirty. If that happens, you must use the soap and water technique. Follow these guidelines for using alcohol-based hand sanitizers. • Put a palmful of the alcohol-based sanitizer in one hand. • Rub the palms your hands together. • Right palm on the back of your left hand, intertwine your fingers and rub. • Left palm on the back of your right hands, intertwine your fingers and rub. • Palm to palm, intertwine fingers and rub. • Rub the backs of the fingers of each hand in the opposite palm. • Hold the left thumb in the right hand, close your hand and rub. • Hold the right thumb in the left hand, close your hand and rub. The procedure should take no more than 20-30 seconds. You should use alcohol-based hand sanitizers in the same situations that were listed in Table I. Learning Break: When you are washing your hands you are making them clean and removing pathogens, but hand washing does not sterilize your skin. Sterilization is a term that means complete removal of all pathogens, and this can only be done using extremely high temperature or with sterilization chemicals that would damage the skin. Medical devices that are used for surgery or that will be re-used can be sterilized: skin cannot. Respiratory Hygiene/Cough Etiquette Respiratory hygiene/cough etiquette is one of the simpler parts of standard precautions. It issued to prevent the transmission of respiratory illnesses such as influenza. Much of this information could be considered common sense • Cover your nose and mouth with a tissue when coughing or sneezing. • Wash your hands after coughing or sneezing. • If you have used a tissue, throw it away and then wash your hands. • Consider offering a simple face mask to patients who are coughing or sneezing. • Someone who is coughing should sit at least three feet away from other people. Safe Injection Practices Safe injections practices are an important part of standard precautions. It is unlikely that as a HHA you would be involved in any care or procedures that involve needles or sharps. However, you should know the basics of safe injection practices because you may be asked to dispose of needles or sharps. The basics of safe injection practices are: • Needles should never be recapped. • Needles are single-use only; never re-use a needle, even if it is to be used with the same patient. • Needles should never be bent or broken before discarding them. • All needles and sharps should be properly disposed of in the appropriate containers. These containers are usually red, they are made of a hard plastic, they have a biohazard symbol on the side, and they are usually marked SHARPS. • Never dispose of a needle or a sharp in the trash. Blood-borne infectious diseases such as hepatitis B, hepatitis C, and HIV can live in/on needles and sharps for several days after they have first been contaminated with blood. A contaminated needle or sharp in the trash can puncture anyone who handles the trash. If you stick yourself with a used needle or are splashed on the skin or in the eyes, mouth or nose with blood or any body fluid, notify your supervisor immediately. This cannot be emphasized strongly enough! If you suffer a needle stick or a splash contact with blood you may be at risk for becoming infected with hepatitis B, hepatitis C, or HIV. Do not try and decide by yourself if the exposure is serious or not serious. If the risk of infection is high, treatment

needs to be started very soon after the exposure. You must be evaluated as soon as possible by a physician. Learning Break: What is the risk of becoming infected from a needle stick or a splash with blood? The risk differs, and it depends on the pathogen, how contaminated the needle or sharp is, how deep the wound is, and several other factors. The risk of developing an infection with HIV after a needle stick is approximately 1 in 300, and the risk of developing an HIV infection after being splashed in the mouth or on an open cut is approximately 1 in 3000. Of course, as mentioned previously the risk of infection depends on many factors, and you should never try and decide for yourself if a needle stick or other exposure is/is not high-risk. Personal Protective Equipment Personal protective equipment includes disposable gloves, gowns, shoe covers, hair covers, and masks and face shields. Personal protective equipment is single-use and disposable. The rules for using PPE are as follows. • Gloves do not replace the need for hand washing. • Gloves should be worn if you will handle any body fluids or secretions (except sweat and tears) or any object that may be contaminated with them, or if you may be likely to handle any body fluids or secretions (except for sweat and tears) or any object that may be contaminated with them. • Gloves should be worn if you will be touching mucous membranes or non-intact skin. • Wearing two pairs of gloves is not necessary. • If you are wearing other PPE, gloves should be put on last. Gloves are removed first if they are worn with other PPE. • Wash your hand before putting on gloves. Put the gloves on by pulling them on by the bottom edge. • Remove gloves by grabbing the end of one glove and peeling it off. Then with your ungloved hand, slide a finger or two between your skin and the remaining glove and peel it off without touching the outside. • Wash your hands after removing gloves. • Do not use the same pair of gloves to perform two different tasks. • Never wear the same pair of gloves to care for two different patients. • Wear a disposable gown, shoes covers, and a hair cover if there is a chance that you may be splashed with blood, urine, or other body fluids. • Wear a face mask and/or eye protection if there is a chance that you may be splashed with blood or body fluids. • Discard all PPE in the proper receptacles.

INFECTION CONTROL: TRANSMISSION PRECAUTIONS Standard precautions are the cornerstone of infection control. But certain patients need protection that goes a bit beyond standard precautions; these patients have infectious diseases that can be easily transmitted to healthcare personnel or to other patients. These special transmission precautions are airborne transmission precautions, droplet transmission precautions, and neutropenic transmission precautions. Of course, standard precautions should always be used in conjunction with these other transmission precautions. Learning Break: It is not your responsibility to determine which special transmission precautions are needed for any particular patient. A physician or an infectious disease specialist will make that determination, and the rules and procedures for the specific transmission precaution are usually prominently posted. Also, some patients may only need to be placed on airborne transmission precautions for a certain period of time. Airborne Transmission Precautions Airborne transmission precautions are used to prevent the transmission of infectious diseases that are easily spread through the air. These diseases are: 1) chicken pox (varicella); 2) herpes zoster; 3) measles (rubella); 4) smallpox, and; 5) tuberculosis. Airborne transmission precautions are needed because these diseases are spread by infected droplets that are coughed or exhaled from the lungs and respiratory tract of an infected patient. The droplets stay in the air for a relatively long time and they can travel a relatively long distance - unlike droplets that are infected with common cold or influenza viruses. Learning Break: The use of airborne transmission

precautions was once called placing a patient in isolation. Airborne transmission precautions require a patient to be placed in a single room that has a special ventilation system. The door should be closed at all times. Anyone entering the room must wear special PPE that prevents inhalation of airborne droplets. This should be: 1) an N-95 mask, or; 2) a powered air-purifying respirator. It is not necessary to remember these terms, but it is important to remember that simple paper face mask is not sufficient protection. If a patient must be transported or moved, the patient should wear the required respiratory protection, as well. Droplet Transmission Precautions Droplet precautions are used if a patient is known to have or is suspected to have an infectious disease that is transmitted by coughing, sneezing, or talking. Some of these diseases are: 1) influenza; 2) mumps, and; 3) pertussis (whooping cough). These activities spread infected droplets into the air and onto surfaces in the environment. However, unlike the infected droplets from a patient who has chicken pox or tuberculosis, these droplets do not travel very far and do not remain in the air for a long time. Patients who require droplet precautions should be in a private room. Respiratory/cough etiquette must be strictly observed. Anyone who is within three feet of the patient should wear a mask; a simple paper face mask is sufficient. Neutropenic Precautions Neutropenic precautions are also called reverse isolation. Patients who need neutropenic precautions are not infected and you are not at risk when you are caring for them. The people who are providing the care are the potential source of contamination. A patient who needs neutropenic precautions has a seriously compromised immune system and cannot protect herself/himself from infections. Examples of patient who need to be protected with reverse isolation would include: • People who have AIDS: AIDS attacks the immune system. • People who have certain types of cancers: Certain cancers such as Hodgkin's disease affect the immune system, and patients who have these cancers would need neutropenic precautions. • Patients with severe burns: One of the most important protective mechanisms we have against infection is the intact skin. It acts as a physical that prevents the access of pathogens to the blood stream and organ systems. Small breaks in the skin are quickly and are not large enough to be a risk. But if large areas have been damaged, as with a patient who has many severe burns, the risk for infection is greatly increased. • Patients who have had an organ transplant: Regardless of how well the organ is matched to the organ recipient, there is always a risk that the body's immune system will recognize the transplanted organ as a foreign object and try and reject it. To prevent that from happening, organ transplant patients are given strong immune suppressing drugs, so these patients are highly susceptible to developing infections and need neutropenic precautions. A patient who needs neutropenic precautions should be placed in a private room with special ventilation. Standard precautions and respiratory hygiene/cough etiquette should be used. In addition, other precautions and PPE may be needed; each case is handled differently. SUMMARY Infection control is one of the most important aspects of your job as a HHA. Pathogens and the risk of infection are a constant presence, and to keep yourself, the patients you care for, and other staff members safe you must understand infection control techniques and practice them conscientiously. The infection control techniques discussed in this module are not complicated to learn and they are not difficult to practice. However, many studies have clearly shown that even experienced health care personnel who know how the proper way to practice infection control do not consistently do so.

The reasons?

First, they feel that using gloves, constant hand washing, and some of the other infection control techniques simply take too much time and are inconvenient. And second, they do not accurately assess the risks of transmitting pathogens. It's true that constantly putting on and taking off gloves and washing your hands 20, 30 or more times a day takes time. But your primary responsibility as a HHA is the safety of the people you are caring for. By skipping hand washing you may be saving time that is used to provide patient care, that's true. But the time you save is not a considerable amount and although you are using that time to help someone, in effect you are putting that person, yourself and other patients at risk. Is that a reasonable trade off? As far as risk assessment, the first thing to remember is that infection control is intended to prevent the transmission of microscopic pathogens that are literally everywhere, especially in a health care setting. And these pathogens are very easily spread. It may seem that simply touching a computer keyboard or a telephone receiver for a few seconds could not be enough exposure to pick up a bacteria or a virus and move it from you to someone else, but that's not so. It is very easy to become careless and complacent about pathogen transmission - "spreading germs." But once again, studies have clearly shown that it much, much easier for this happen than you would imagine. If in doubt, consider the situation to be a risk, and practice good infection control.

Section 4

Admission, Transfer and Discharge

Admission:

Entering a health care agency for nursing care and medical or surgical treatment

To meet patients' healthcare needs during the admission process, nurses provide holistic care and establish the basis for how patients will respond to and evaluate the remainder of their stay.

The following guidelines for establishing an effective nurse– patient relationship to ensure that each patient is considered as an individual in any setting.

1. Recognize and take steps to reduce the patient's anxiety. Anxiety is a natural reaction to the unknown, but it can be reduced by therapeutic communication, teaching, and acceptance.

2. Remember that the medical or surgical condition for which the patient is being treated is only one part of the patient's life. Other concerns include family needs, financial status, and the future.

3. Communicate with the patient as an individual so that he or she can maintain his or her own identity.

4. Take time to learn who the patient being admitted is, including his or her cultural and religious background. Respect the patient's values and beliefs even though they may differ from yours.

5. Encourage the patient's family to participate in and make decisions about all aspects of care. During admission, the nurse acts not only as a practitioner but also as an advocate concerned about the welfare of the patient and the family. Each patient's need for nursing care related to admission should be assessed by a registered nurse; this assessment includes consideration of biophysical, psychosocial, environmental, self-care, educational, and discharge planning factors. Admission, Transfer, Discharge, and Referrals

Admission Process Admission involves:

1. Authorization from a physician that the person requires specialized care and treatment.

2. Collection of billing information by the admitting department of the health care agency.

3. Completion of the agency's admission data base by nursing personnel.

4. Documentation of the client's medical history and findings from physical examination.

5. Development of an initial nursing care plan.

6. Initial medical orders for treatment.

7. Medical authorization.

8. The admitting department. a. Preliminary data collected. b. Addressograph plate.

9. Initial nursing plan for care.

10. Medical admission responsibilities.

Nursing Admission Activities

1. Preparing the client's room.

2. Welcoming the client.

3. Orienting the client.

4. Safeguarding valuables and clothing.

5. Helping the client undress.

6. Compiling the nursing data base.

Psychosocial Responses on Admission

1. Anxiety and fear.

2. Decisional conflict.

3. Situational low self-esteem.

Admission, Transfer, Discharge, and Referrals 4

4. Powerlessness.

5. Social isolation.

6. Risk for ineffective therapeutic regimen management.

The Transfer Process Transfer: Discharging a client from one unit or agency; admitting him or her to another without going home in the interim. Transfers are used when there is a need to: 1. Facilitate more specialized care in a life-threatening situation. 2. Reduce health care costs. 3. Provide less intensive nursing care.

Steps Involved in Transfer

1. Informing client and family about the transfer.

2. Completing a transfer summary.

3. Speaking with a nurse on the transfer unit to coordinate the transfer.

4. Transporting the client and his or her belongings, medications, nursing supplies, and chart to the other unit.

The Discharge Process

Discharge is the termination of care from a health care agency. Planning for discharge actually begins on admission, when information about the patient is collected and documented. The key to successful discharge planning is an exchange of information among the patient, the caregivers, and those

responsible for care while the patient is in the acute care setting and after the patient returns home. This coordination of care is usually the nurse's responsibility.

Steps in the Discharge

1. Discharge planning

a. Assessing and identifying health care needs.

b. Setting goals with the patient.

c. Important teaching topics about self-care at home must be covered before discharge. d. Meeting eligibility requirements for home health care.

2. Obtaining a written medical order.

3. Completing discharge instructions.

4. Notifying the business office.

5. Helping the client leave the agency.

6. Writing a summary of the client's condition at discharge.

7. Requesting that the room be cleaned.

Section 5

Vital Sighs

How to Measure and Record Vital Signs

Taking a set of **vital signs** will help you monitor the condition of your patient and identify if their condition is improving or deteriorating. First aiders and first responders may be trained to measure some, or all, of the five main vital signs. In this blog post we will look at how to measure and record vital signs in first aid.

The number of vital sign sets recorded will depend upon a number of factors:

- Time spent with the patient
- Seriousness of the patient condition (ie, how 'sick' they are)
- Any changes observed

It should be remembered that at all times when dealing with a patient you should explain what you want to do and obtain the patient's consent before carrying out any vital sign measurements.

Vital sign #1 Pulse rate

Taking a patient's pulse is an important part of your physical assessment and secondary survey.

Whist you can obtain this information electronically, you should always start by feeling the pulse yourself as this will give you more information.

What are you looking for when taking the pulse?
The obvious answer to this question is the number of **beats per minute** or **pulse rate** but in addition you should be feeling the pulse to see if it is r**egular** or **irregular**. An irregular pulse can be an indication of Atrial Fibrillation (A-Fib).
If you discover an irregular pulse, this should prompt you to ask your patient if they have any heart conditions, or if they have ever been told they have Atrial Fibrillation or A-Fib. A-Fib may cause no symptoms at all but does significantly increase the risk of a stroke.

Another important piece of information to note when taking a patients pulse is the quality or strength of the pulse. You should note if the patients pulse is any of the following:

Bounding
If the heart is pumping a large amount of blood with each heartbeat, the pulse will feel very strong. This strong pulse is called a "bounding" pulse

Weak or 'thready'
If the heart is pumping only a small amount of blood with each heartbeat, the pulse will be harder to detect. This type of pulse is called weak or thready. If the pulse is weak, you may have trouble feeling (palpating) the pulse at first.

What is the normal pulse rate?
A normal pulse rate is 60-100 beats per minute(btm)

Vital sign #2 Respiratory rate

Normal respiration is an automated process and does not require conscious effort. However, in the case of illness or trauma, a patient's respiratory rate may become unusually fast or slow indicating the need for immediate medical attention.

The respiratory rate is simply the number of breaths an individual takes per minute.

Observe and count the rise and fall of the patients chest over a period of time. Count the number of breaths in 15 seconds and multiply by 4, 20 seconds and multiply by 3, 30 seconds and multiply by 2 or observe for a full minute.

Try to count the respiratory rate discreetly to gain a more accurate reading. Also be aware of patient dignity when counting the respiratory rate of a female patient. An ideal way to obtain the respiratory rate of a female is to do so whilst taking the patients pulse as this will prevent any awkwardness.

What are Normal Respiratory Rates?
Respiratory rates, like pulse rates, will vary with the patient's age.

Adult: 12-20 breaths per minute

Child: 15-30 breaths per minute

Infant: 25-50 breaths per minute

Vital Sign #3 Oxygen Saturation (SpO2)

A pulse oximeter is a device intended for the non-invasive measurement of blood oxygen saturation (SpO2) and pulse rate.

Typically a pulse oximeter uses two LEDs (light-emitting diodes) generating red and infrared lights through a translucent part of the body. Bone, tissue, pigmentation, and venous vessels normally absorb a constant amount of light over time. Oxyhemoglobin and its deoxygenated form have significantly different absorption pattern.

The arteriolar bed normally pulsates and absorbs variable amounts of light during systole and diastole, as blood volume increases and decreases. The ratio of light absorbed at systole and diastole is translated into an oxygen saturation measurement.

The pulse oximeter should be placed on the patients finger. You should give the readings time to settle before taking note of the figures you are given. This can take anything from a few seconds to a minute or two depending upon a number of factors.

Normal oxygen saturation levels should be considered to be above **94%** or **88% – 92%** for a patient who has chronic lung disease.

Vital Sign #4 Blood Pressure (BP)

Every blood pressure reading consists of two numbers or levels. They are shown as one number on top of the other, for example 165/60. The first (or top) number is the **systolic** blood pressure. It is the highest level your blood pressure reaches when your heart contract.
The second (or bottom) number is the **diastolic** blood pressure. It is the lowest level your blood pressure reaches as your heart relaxes between beats.

How to record a manual blood pressure (BP)

To begin a manual blood pressure measurement, use a properly sized blood pressure cuff. Lightly press the stethoscope's bell over the brachial artery just below the cuff's edge.

Check for the patients pulse and inflate the cuff until the pulse stops. Add another 10-15 units on the pressure gauge. Checking the pulse during inflation prevents unnecessary discomfort caused by over-inflation of the cuff.

Listen with the stethoscope, slowly release the valve to maintain a slow deflation of the cuff and simultaneously observe the gauge. When the pulse is heard in the stethoscope you have identified the patients systolic pressure.

Continue to deflate the cuff – when the pulse sound disappears you have identified the diastolic pressure.

Vital Sign #5 Temperature

A temperature reading is often taken from the ear canal. This is known as a tympanic temperature reading as the thermometer uses the tympanic membrane (ear drum) in order to record the body temperature. Both low and high body temperatures can be life-threatening.

Section 6

Skills Test

HOW TO PERFORM THE TWENTY-THREE (23) SKILLS

ENTIRE LIST OF TWENTY-FIVE (25) SKILLS

You will randomly choose one (1) Skill Card when arriving at each of the three (3) Testing Stations remove.

1: Handwashing (at a real sink, using soap and water)

2: Position the Resident in a Fowler's Position

3: Position the Resident in a Side-Lying (Lateral) Position

4: Transfer the Resident from Bed to Chair Using a Gait Belt

5: Make an Occupied Bed

6: Brush the Resident's Dentures

7: Mouth Care for an Unconscious Resident

8: Give the Resident a Partial Bed Bath (Upper Body) – Face-Neck-Chest-Abdomen-Arms-Hands

9: Give the Resident a Partial Bed Bath (Lower Body) – Hips-Legs-Feet

10: Give the Resident Perineal Care (Female Resident)

11: Shave the Resident

12: Clean and Trim the Resident's Fingernails

13: Dress the Resident with a Paralyzed/Contracted Arm

14: Serve the Meal Tray and Feed the Paralyzed Resident

15: Measure and Record the Height of a Resident Using an Upright Scale

16: Measure and Record the Weight of a Resident Using an Upright Scale

17: Assist the Resident with the Bedpan

18: Count and Record the Resident's Radial Pulse

19: Count and Record the Resident's Respirations

20: Take and Record the Resident's Blood Pressure

21: Perform Passive Range of Motion (Upper Body) – Shoulders-Elbows-Wrists-Fingers

22: Perform Passive Range of Motion (Lower Body) – Hips-Knees-Ankles-Toes

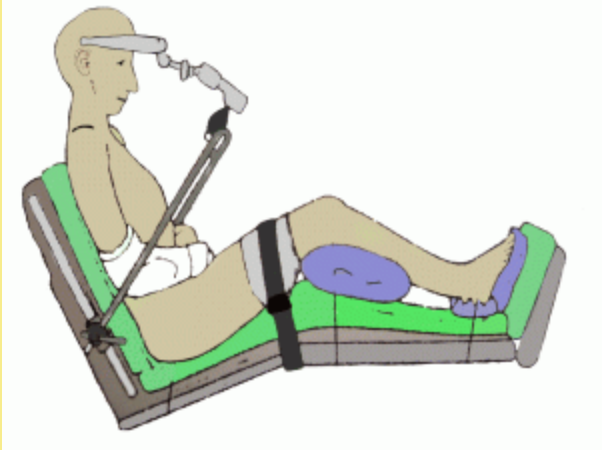
23: Assist the Resident in Walking Using a Gait Belt

CONTINUE TO NEXT PAGE

Skill #1: Handwashing (at a real sink, using soap and water)

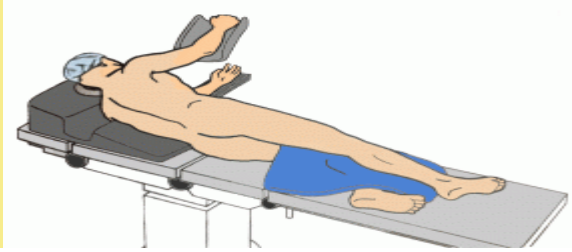
1. **Remove watch, or push it up on your forearm, roll up sleeves.**
2. **Turn on water adjust temperature.**
3. **Wet hands and wrists. Apply soap.**
4. **Keep hands lower than elbows. Rub hands together to make a bubbly lather.**
5. **Re-wet hands/wrists and re-apply soap as needed.**
6. **Wash hands, fingers, and wrists for about 15 seconds (not under the water).**
7. **Rinse hands and wrists (avoid splashing), keep hands lower than elbows.**
8. **Let hands drip; reach for paper towels.**
9. **Dry hands and wrists thoroughly (from fingertips to wrist). Discard towels.**
10. **Use a new clean paper towel to turn off the faucet.**
11. **Discard paper towel.**

Skill #3: Position the Resident in a Fowler's Position



1. **Perform “opening procedure”**
2. **Verbally acknowledge resident’s complaint of “having difficulty breathing”.**
3. **Adjust HOB to appropriate level as quickly as possible.**
4. **Re-check patient’s breathing.**
5. **Perform comfort measures (pillows, raising FOB to prevent sliding, etc).**
6. **Perform “closing procedure”**
7. **Report and record (resident’s complaint, what you did to help, and the results of your actions). HOB – head of bed FOB – foot of bed**

Skill #4: Position the Resident in a Side-Lying (Lateral) Position

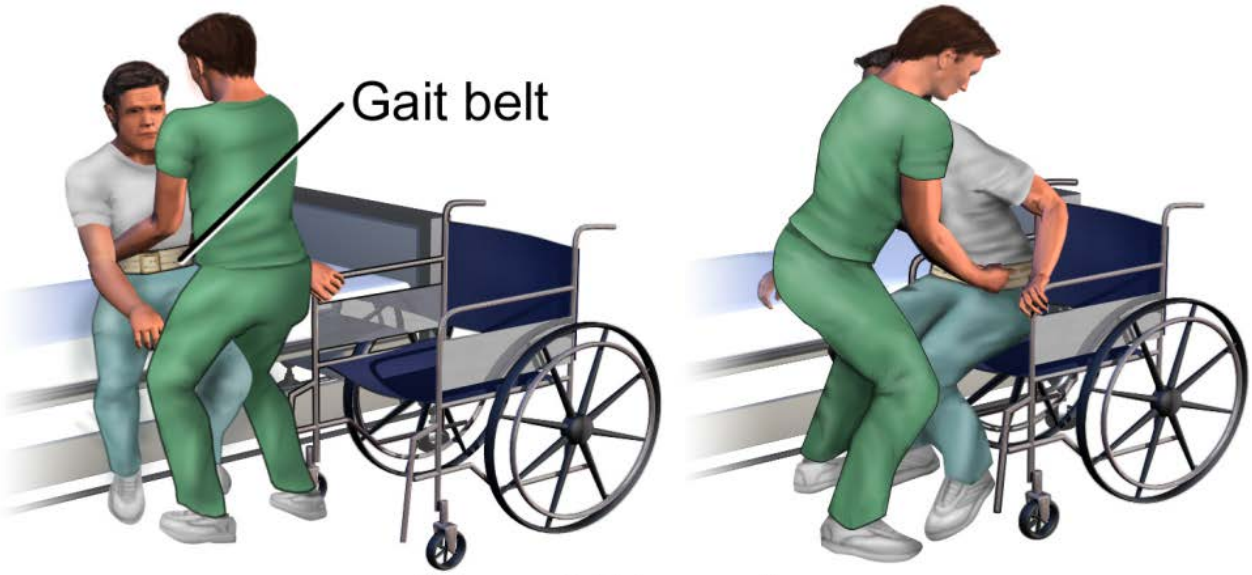


1. **Perform “opening procedure”**
2. **Use good body mechanics: raise level of bed, bend knees, spread feet apart.**
3. **Safely move the supine resident to the side (edge) of bed in 3-segments.**
4. **Cross resident’s arms over chest or prepare correct arm in “stop-sign” position.**
5. **Cross ankles or bend the knee of the upper (top) leg.**
6. **Be sure side rail is up on the side resident is turned toward.**
7. **Place one hand on shoulder, the other on hip, and “log-roll” the resident.**
8. **Support resident’s back by tucking a pillow, folded lengthwise, behind back.**
9. **Support resident’s top arm with a pillow in front of chest; use hand roll if needed.**
10. **Place resident’s top leg slightly forward, with knee bent; support top leg with a pillow.**
11. **Be sure that the top leg/foot does not rest on (or rub) the lower leg/foot.**
12. **Stand at FOB to see if resident’s body is properly aligned.**
13. **Resident should not be lying on his/her arm or shoulder.**
14. **Adjust pillow to cradle/support resident’s head/face comfortably.**
15. **Perform “closing procedure”.**

Skill #5: Transfer the Resident from Bed to Chair Using a Gait (Safety) Belt

Pivot Transfer

Slide Board Transfer



Scoot Transfer

1. **Perform “opening procedure”**
2. **Place chair or wheelchair near the bed.**
3. **Remove/fold back wheelchair footrest and lock bed/wheelchair brakes (if used).**
4. **Raise HOB fully to assist resident to a sitting position.**
5. **Lower side rail nearest to chair.**
6. **To Dangle: place one arm behind resident’s back and the other arm under the thighs.**

7. **Encourage resident to assist in turning to a sitting position, placing feet flat on the floor.**

8. **Assist resident with robe and non-skid shoes (may do prior to dangle).**

9. **Stand in front of resident to apply gait belt snugly around resident's waist, with room between resident's body and belt to grasp belt (with two hands) at each side of waist.**

10. **Place your knee, (furthest from wheelchair), between resident's knees.**

11. **Use a secure, underhand (palms-up) grasp to hold belt at each side of resident's waist.**

12. **May instruct resident to assist (to stand) by having resident pressing hands on mattress.**

13. **On the count of "three", assist resident to stand up, maintaining palms-up grasp on belt.**

14. **If belt loosens upon standing, assist resident to sit on the bed for all belt adjustments.**

15. **Turn, taking steps along with the resident, until resident is right in front of chair.**

16. **Lower resident into chair, then release your 2-handed grasp and remove gait belt. Remove belt carefully, lifting it away from resident's body (to avoid injury from friction).**

17. **Position wheelchair footrest and provide a lap blanket.**

18. **Perform "closing procedure"**

Skill #6: Make an Occupied Bed

1. **Perform “opening procedure”**
2. **Remove and fold any reusable linen (blanket/spread) and place over a clean chair.**
3. **Raise side rail, roll resident away from you, towards opposite side.**
4. **Only rail down is on the side where you’ll be working.**
5. **For resident’s comfort, leave pillow under head and top sheet in place.**
6. **Wear gloves while handling soiled linens, then discard gloves and wash hands.**
7. **Loosen and roll all dirty bottom linens toward resident and tuck against back.**
8. **Secure ½ of clean (fitted) bottom sheet on the bare mattress, with minimal wrinkles.**
9. **Roll other ½ of clean (fitted) bottom sheet towards resident, tucking it under old sheets.**
10. **Flatten the rolled sheets and help the resident roll over the linen, towards you.**
11. **Raise the side rail; go to the opposite side; lower the side rail.**
12. **Remove dirty linens; place in linen bag (on FOB or on chair with barrier).**
13. **Pull clean bottom linens towards you and secure onto mattress with minimal wrinkles.**
14. **Center resident on back and comfortably aligned; raise both side rails.**

15. **Cover resident with clean top sheet. Resident can hold it as you remove the old one.**

16. **Place blanket/spread over top sheet and miter together at FOB; make a toe pleat.**

17. **Neatly fold hem of top sheet down over the blanket/spread.**

18. **Wear gloves (as necessary) to dispose of linens. Remove gloves and wash hands.**

19. **Perform “closing procedure”.**

Skill #7: Brush the Resident's Dentures

1. **Perform "opening procedure"**
2. **Apply gloves. (Remove gloves, sanitize hands, and re-glove as needed)**
3. **Take dirty dentures (already in denture cup) and supplies to sink area.**
4. **Line bottom of sink with a washcloth or small towel. Turn on water without splash.**
5. **Place dirty dentures in emesis basin. Clean denture cup and fill will cool water.**
6. **Apply toothpaste (or denture cleanser) to toothbrush (or denture brush).**
7. **Brush all areas of dentures (on both sides of each plate) within sink area.**
8. **Handle dentures carefully by holding/brushing one plate at a time.**
9. **Rinse dentures under cool, running water.**
10. **Place dentures back in denture cup that is (filled with clean, cool water.)**
11. **Offer mouthwash solution/sponge-tipped swabs, emesis basin for oral hygiene.**
12. **Clean and store equipment. Dispose of linens and trash appropriately.**
13. **Remove gloves and wash hands.**
14. **Perform "closing procedure".**

Skill #8: Mouth Care for the Unconscious Resident

1. **Perform “opening procedure”**
2. **Apply gloves. (Remove gloves, sanitize hands, and re-glove as needed)**
3. **Gently position resident’s head towards you. (Entire body may be turned to side)**
4. **Place a towel or waterproof barrier under head and over chest.**
5. **Place emesis basin under the chin, at side of resident’s face, if resident is fully lateral.**
6. **Open packages of sponge-tipped swabs and/or lemon glycerin swabs.**
7. **Prepare a small cup of mouthwash/water solution to dip sponge-tipped swabs.**
8. **Gently open mouth and separate teeth with a padded tongue blade.**
9. **Clean entire mouth (roof, tongue, cheeks, teeth, gums, lips) –use sponge-tipped swabs for cleaning and glycerin swabs for stimulating moisture and refreshing.**
10. **Place used swabs directly into trash bag.**
11. **Dry resident’s face. Remove basin, towels, and waterproof barriers.**
12. **Apply lip lubricant.**
13. **Clean and store equipment. Dispose of linens and trash appropriately.**
14. **Remove gloves and wash hands.** 15. **Perform “closing procedure”.**

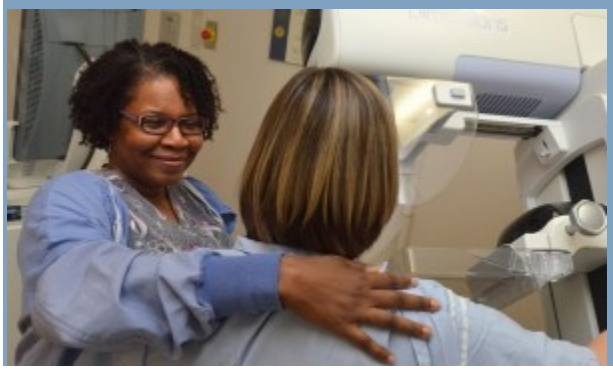
Skill #9: Give the Resident a Partial Bed-Bath (Upper Body): Face-Neck-Chest-Abdomen-Arms- Hands

1. **Perform “opening procedure”**
2. **Apply gloves. (Remove gloves, sanitize hands, and re-glove as needed)**
3. **Drape resident for warmth and privacy with a bath blanket.**
4. **Keep linens dry by placing a towel/waterproof barrier under limbs while washing.**
5. **Gently wash (with soap), rinse and pat-dry entire upper body, starting with face*.**
6. **Only uncover one area at a time to ensure warmth, dignity, and privacy.**
7. **Leave resident draped and comfortable when bath is completed.**
8. **Clean and store equipment. Dispose of linens and trash appropriately.**
9. **Remove gloves and wash hands.**
10. **Perform “closing procedure”. * may omit soap for face (as desired by resident)**

Skill #10: Give the Resident a Partial Bed-Bath (Lower Body): Hips-Legs-Feet

1. **Perform “opening procedure”**
2. **Apply gloves. (Remove gloves, sanitize hands, and re-glove as needed)**
3. **Drape resident for warmth and privacy with a bath blanket.**
4. **Keep linens dry by placing a towel/waterproof barrier under limbs while washing.**
5. **Gently wash (with soap), rinse and pat-dry entire lower body, starting with hips.**
6. **Only uncover one area at a time to ensure warmth, dignity, and privacy.**
7. **Leave resident draped and comfortable when bath is completed.**
8. **Clean and store equipment. Dispose of linens and trash appropriately.**
9. **Remove gloves and wash hands.**
10. **Perform “closing procedure”.**

Skill #12: Give the Resident Perineal Care (Female Resident)



1. **Perform “opening procedure”**
2. **Apply gloves. (Remove gloves, sanitize hands, and re-glove as needed)**
3. **Gently assist resident into a supine position with knees bent and legs apart.**
4. **Place a linen protector under resident’s buttocks.**
5. **Keep resident warm and completely draped with a bath blanket.**
6. **Only uncover perineal area/buttocks area to ensure warmth, dignity, and privacy.**
7. **Wash (using soap/peri-wash), rinse, and pat dry genital area from front to back (while resident is in supine position).**
8. **Wash (using soap/peri-wash), rinse, and pat dry rectal area from front to back (resident is in a side-lying position with side-rail up).**
9. **Use a different part of the washcloth/mitt for each wipe/stroke.**
10. **Remove gloves, wash, re-glove to assist resident into position of choice.**
11. **Cover resident with sheet (bed linens) and remove bath blanket.**
12. **Wear gloves to clean and store equipment. Dispose of linens and trash appropriately.**
13. **Remove gloves and wash hands.**
14. **Perform “closing procedure”.**

Skill #13: Shave the Resident

1. **Perform “opening procedure”**
2. **Place barrier for supplies to maintain clean set-up.**
3. **Place clothing protector to resident’s chest area prior to shave.**
4. **Assess skin for abrasions, moles, and/or direction of hair growth.**
5. **Check razor for rust, chips, or breaks.**
6. **Soften beard with warm, moist cloth before applying shaving cream.**
7. **Apply shaving cream to resident’s face.**
8. **Apply gloves before shaving. (Remove gloves, sanitize hands, and re-glove as needed)**
9. **Hold skin taut to prevent nicks.**
10. **Shave face using downward strokes, in direction of hair growth.**
11. **Rinse razor often during procedure to remove hair/excess shaving cream.**
12. **Wipe/rinse resident’s face of remaining lather after the shave.**
13. **Dry resident’s face.**
14. **Offer resident a mirror.**
15. **Offer resident choice of aftershave or shaving lotion.**
16. **Remove towel from resident, clean equipment and return to proper area.**

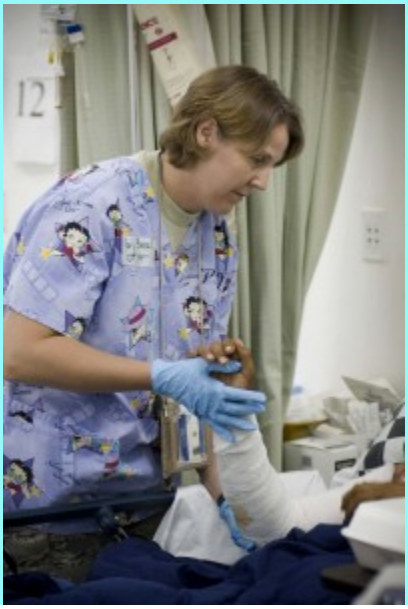
17. **Dispose of razor in sharps container.**
18. **Dispose of linens and trash appropriately.**
19. **Remove gloves and wash hands.**
20. **Perform “closing procedure”.**

Skill #14: Clean and Trim the Resident’s Fingernails

1. **Perform “opening procedure”**
2. **Apply gloves. (Remove gloves, sanitize hands, and re-glove as needed)**
3. **Soak resident’s hands/fingernails in a basin of warm water. Use soap to clean them.**
4. **Place towel under resident’s hands for comfort and hygiene.**
5. **Push back cuticles gently with a washcloth and/or orange stick padded with cotton.**
6. **Use orange stick to clean under dirty fingernails.**
7. **Change water and rinse resident’s hands.**
8. **Dry resident’s hands thoroughly.**

9. **Use clippers to trim fingernails straight across.**
10. **Use nail file/emery board to smooth rough and sharp edges.**
11. **Offer lotion and gently massage resident's hands.**
12. **Dispose of linens and trash appropriately.**
13. **Return clippers to facility designated dirty area (or to resident's personal grooming kit).**
14. **Remove gloves and wash hands.**
15. **Perform "closing procedure".**

Skill #15: Dress the Resident with a Paralyzed and Contracted Arm



1. **Perform "opening procedure"**
2. **Allow resident choice of clothing/gown.**
3. **Pull the curtain and/or shut the door to maintain resident's privacy.**

4. **Keep resident covered with a bath blanket until fully dressed.**
5. **Dress the resident's paralyzed (weak) arm first, with the entire arm completely through the sleeve before dressing the other arm.**
6. **Move resident's arms gently and naturally without force.**
7. **Encourage resident to assist with non-paralyzed arm as able.**
8. **Dispose of linens and trash appropriately.**
9. **Perform "closing procedure".**

Skill #16: Serve the Meal Tray and Feed the Paralyzed Resident

1. **Perform "opening procedure"**
2. **Validate/check for the correct resident by reading name printed on ID band.**
3. **Offer resident a washcloth for hands before meal.**
4. **Clean over bed table before serving the meal.**
5. **Select correct meal tray from meal cart by checking the diet card located on tray.**
6. **Compare dietary card with resident's name; check for correct diet; be alert for allergies.**

7. **Verify that the food items on tray match diet (lift the plate cover “lid” to see the food).**
8. **Drape resident with a towel/clothing protector prior to feeding.**
9. **Open containers, cut meat, offer condiments, remove items NOT allowed, etc.**
10. **Check temperature of hot liquids/food items.**
11. **Allow the resident time to chew food; feed resident slowly, without rushing.**
12. **Offer liquids between swallows as needed.**
13. **Offer the resident choices during meal; encourage use of unaffected hand.**
14. **Offer the resident a washcloth for hands after meal.**
15. **Clean over-bed table after meal.**
16. **Dispose of linens and trash appropriately.**
17. **Remove tray and note % of meal eaten and cc’s or ml’s of fluids taken.**
18. **Perform “closing procedure”.**

Skill #17: Measure and Record the Height of a Resident Using an Upright Scale

1. **Perform “opening procedure”**
2. **Place chair at side of scale.**
3. **Gather paper towel (to place on scale platform).**
4. **Assist resident to put on non-skid shoes.**
5. **Drape resident with a robe.**
6. **Keep one hand behind/near resident while walking to the scale.**
7. **Place paper towel on scale platform.**
8. **Assist the resident to sit in the chair to remove shoes.**
9. **Assist the resident to step on the scale from the side, facing away from scale.**
10. **Raise height bar safely.**
11. **Lower height bar until it touches top of resident’s head and is level with resident’s head.**
12. **Read resident’s height at correct location.**
13. **Record resident’s height, using words, abbreviations, or symbols: FEET (feet, ft, or ‘) INCHES (inches, in, or “) CENTIMETERS (centimeters or cm)**
14. **Assist resident to step safely off of the scale.**
15. **Assist resident to sit in the chair and to put non-skid shoes back on.**
16. **Remove paper towel from scale platform and discard (gloves may be worn).**
17. **Assist resident back to room, keeping one hand behind/near resident while walking.**
18. **Perform “closing procedure”.**

Note: Some testing sites have scales with multiple measurement functions. Be familiar with multiple ways to record height: feet/inches [ft/in] or inches [in] or centimeters [cm]

Skill #18: Measure and Record the Weight of a Resident Using an Upright Scale

1. **Perform "opening procedure"**
2. **Place chair at the side of the scale.**
3. **Gather paper towel (to place on scale platform).**
4. **Assist resident to put on non-skid shoes.**
5. **Drape resident with a robe.**
6. **Keep one hand behind/near resident while walking to the scale.**
7. **Place paper towel on the scale platform.**
8. **Assist the resident to sit in the chair to remove shoes/robe.**
9. **"Zero" (balance) scale prior to the resident standing on the scale platform.**
10. **Assist the resident to stand on the scale platform.**
11. **Measure the resident's weight correctly by sliding weights to appropriate areas until scale indicator balances. (Begin with "large weight" clicked in place)**
12. **Adjust smaller weight indicator to balance.**
13. **Read scale and record the resident's weight in pounds (lb.) or kilograms (kg).Assist the resident to step safely off the scale. Assist resident to sit in the chair and to put non-skid shoes/robe back. Remove paper towel from**

scale platform and discard (gloves may be worn)Assist resident back to room, keeping one hand behind/near resident while walking.

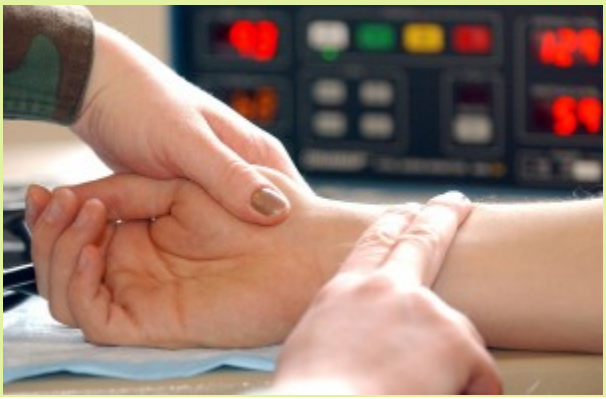
14. **Perform “closing procedure”.**

Skill #19: Assist the Resident with a Bedpan (Standard or Fracture)

1. **Perform “opening procedure”**
2. **Apply gloves. (Remove gloves, sanitize hands, and re-glove as needed)**
3. **Assist resident to lift hips, slide linen protector and bedpan under buttocks.**
4. **Place the resident on the bedpan correctly with resident’s buttocks well-centered over the opening of the bedpan. (Note the direction of the bedpan)**
5. **Drape the resident with a bath blanket/sheet while on the bedpan.**
6. **Remove gloves and sanitize hands.**
7. **Raise HOB for resident’s comfort during bowel movement.**
8. **Leave call light within resident’s reach, before leaving room–to allow privacy.**
9. **Return to room when resident signals or after no more than 5 minutes.**
10. **Lower HOB for resident’s comfort during bedpan removal.**
11. **Wash hands and reapply gloves.**

12. **Turn resident to the side and remove the bedpan. Cover it and properly place it out of the way (on FOB or on chair with barrier).**
13. **While resident is on the side, wipe the resident from front to back.**
14. **Place soiled toilet paper into a prepared (cuffed) plastic trash bag.**
15. **Assist resident to lift hips; remove linen protector and discard it in the trash bag.**
16. **Discard gloves, sanitize hands, then raise side rail.**
17. **Reapply gloves — take bedpan to the bathroom.**
18. **Observe any abnormalities in bowel movement (for reporting and recording)**
19. **Empty bedpan into toilet.**
20. **Clean and rinse bedpan and store in proper area.**
21. **Dispose of linens and trash appropriately.**
22. **Remove gloves and wash hands.**
23. **Perform “closing procedure”.**

Skill #20: Count and Record the Resident’s Radial Pulse



1. **Perform “opening procedure”**
2. **Place resident’s hand in comfortable resting position prior to counting pulse.**
3. **Place your fingertips correctly on the radial artery (thumb side of wrist).**
4. **Count the resident’s radial pulse using a second-hand watch for one (1) minute.**

5. **Record the resident's radial pulse within (plus or minus) 5 beats of Evaluator's result.**

6. **Perform "closing procedure".**

Skill #21: Count and Record the Resident's Respiration

1. **Perform "opening procedure"**

2. **Avoid telling resident that respirations are being counted; you can say you are "taking vital signs" while pretending to take resident's pulse).**

3. **Count resident's respirations using a second-hand watch for one (1) minute.**

4. **Record resident's respirations within (plus or minus) 2 breaths of the Evaluator's recording.**

5. **Perform "closing procedure".**

Skill #22: Take and Record the Resident's Blood Pressure

1. **Perform "opening procedure"**
2. **Place resident's arm, with the palm up, in a comfortable resting position.**
3. **Clean the stethoscope's diaphragm/bell and earpieces with alcohol before use.**
4. **Feel for the resident's brachial artery on the inner aspect of the resident's arm.**
5. **Wrap the blood pressure cuff snugly around the resident's arm, approximately 1-2 inches above the antecubital area.**
6. **Correctly place the stethoscope earpieces in your ears.**
7. **Safely and correctly place the diaphragm of the stethoscope over the brachial artery.**
8. **Inflate the cuff.**
9. **Let the air out smoothly, at a safe rate (2-4 mm Hg per second), and listen for the first sound (the systolic reading).**
10. **Continue steady deflation as you listen for the last sound– becomes quiet/almost silent (the diastolic reading).**
11. **Remember the readings to be able to record them.**
12. **Quickly let all air out of the cuff (completely deflate).**
13. **Record the blood pressure reading correctly within (plus or minus) 8mm Hg of the Evaluator's recording (systolic and/or diastolic).**

14. **Remove the blood pressure cuff from resident's arm.**

15. **Perform "closing procedure"**

Skill #23: Perform Passive Range of Motion (Upper Body): Shoulders-Elbows-Wrists-Fingers

1. **Perform "opening procedure"**
2. **Adjust bed to a safe and comfortable working height.**
3. **Lower side rail on the side you will be working on.**
4. **Ask resident to inform you if any pain or discomfort is experienced during the exercises.**
5. **Safely and gently exercise the resident's shoulder, elbow, wrist, and fingers, supporting and moving each joint gently and naturally (without force to limbs or joints).**
6. **Exercise each joint in as many patterns as are appropriate and safe for the joint. Examples of Patterns: Flexion, Extension, Abduction, Adduction, and Rotation**
7. **Each pattern must be demonstrated at least 3 times for each joint.**
8. **Ask frequently during the exercises if the resident is having any pain.**
9. **Repeat exercises on the other arm.**

10. **Perform “closing procedure”**

Skill #24: Perform Passive Range of Motion (Lower Body): Hips-Knees-Ankles-Toes

1. **Perform “opening procedure”**
2. **Adjust bed to a safe and comfortable working height.**
3. **Lower side rail on the side you will be working on.**
4. **Ask resident to inform you if any pain or discomfort is experienced during the exercises.**
5. **Safely and gently exercise the resident’s hip, knee, ankle, and toes, supporting and moving each joint gently and naturally (without force to limbs or joints).**
6. **Exercise each joint in as many patterns as are appropriate and safe for the joint. Examples of Patterns: Flexion, Extension, Abduction, Adduction, and Rotation**
7. **Each pattern must be demonstrated at least 3 times for each joint.**
8. **Ask frequently during the exercises if the resident is having any pain.**
9. **Repeat exercises on the other leg.**
10. **Perform “closing procedure”**

Skill #25: Assist the Resident in Walking Using a Gait (Safety) Belt

1. **Perform “opening procedure”**
2. **Apply resident’s non-skid shoes and robe.**

3. **Stand in front of resident to apply gait belt snugly around resident's waist, with room between resident's body and belt to grasp belt, with hands at each side of waist.**
4. **Ask resident if he/she is dizzy before assisting resident to stand.**
5. **Use a secure, underhand (palms-upward) grasp to hold belt at each side of resident's waist.**
6. **May instruct resident to assist (to stand) by pressing hands on mattress.**
7. **On the count of "three", assist resident to a standing position, maintaining palms-up grasp on each side of belt.**
8. **If belt loosens upon standing, assist resident to sit on the bed for all belt adjustments.**
9. **Maintain an upward grasp (one hand grasping belt is OK) while walking the resident.**
10. **Remain slightly behind and to the side of the resident while walking.**
11. **Ask resident if he/she is dizzy, tired, in pain, or short of breath while walking.**
12. **Return resident back to the room.**
13. **Hold belt (with two hands) at each side of the resident's waist, with an upward grasp, when seating the resident on the bed.**
14. **Remove belt carefully, lifting it away from resident's body (to avoid injury from friction)**
15. **Perform "closing procedure"**

REFERENCE/S:

https://www.redcross.org/take-a-class/HHA-testing/california-nurse-competency-test

Once you complete the training requirement, 25-30 hours, you will need to submit an application esc100.net for certification review..

After receiving required attestation signed you will be given a comprehensive certification test.

To meet mastery a 80% correct response is required. When the certification portion of the course is completed you will receive a certification.

ATTESTATION SHEET

ESC 100 Home Health Certification HHA Certification Curriculum, Final Certification Test and attestation form with signature.

For most care givers, it takes **about 25-30 hours** to become a HHA, home health aide. Esc100 is dedicated to providing curriculum that will allow employers and patience, including family members to feel comfortable in the skills and knowledge our certification provided. Esc100 is a cross curricular certification program and is a registered Texas Education Agency Provider, TEA Provider # 19-080-B.

Email completed, initialed with signature to **info@esc100.net**. You will receive a return email within 3 days.

I ATTEST THAT I HAVE COMPLETE ALL SECTIONS OF THE ESC 100 HHA CURRICULUM AND HAVE INITIALED EACH SECTION AND SIGNED BELOW.

- Section 1 Roles and Responsibilities of the Nursing Assistant _____INITIAL
- Section 2 Communication and Documentation _____INITIAL
- Section 3 Safety, Standard Precautions, and Infection Control_____ INITIAL
- Section 4 Admission, Transfer and Discharge_____ INITIAL
- Section 5 Vital signs_____ INITIAL
- Section 6 25 Skills Test_____ INITIAL
- Attestation form signed_____ INITIAL

NAME:

DATE:

SIGNATURE: