



CE IN-SERVICES PART 3

OUTLINE

SEMINAR PART THREE - 8 HOURS

BASIC NURSING SKILLS

Promoting a Restraint-Proper Environment

Vital Signs, Height and Weight

Observing, Reporting and Charting

Admission, Transfer and Discharge

Coping with Death

Introduction to Restoration Services

Role of the Nurse Aide in Restoration Care

Psychosocial Needs of Residents

Culture Change

Specific Behavior Problems

Cognitive Impairment

Conflict Resolution

Technologies

KEY TERMS

ADLs – activities of daily living

Blood Pressure (BP) – the force of the blood against the artery walls as the heart beats

Document – to record information in a file or chart

Environment – the conditions and elements that make up the surroundings

Fahrenheit (F) – relating to a temperature scale

MINIMUM DATA SET (MDS) – a 52-page resident assessment document used to record a complete assessment of a nursing facility resident’s health status and functional capabilities

Omnibus Budget Reconciliation Act (OBRA) of 1987 – a federal law that established regulations for nursing facilities and nurse aide training in facilities

Observing – to take notice

Pulse (P) – the rate of the heartbeat

Reporting – to give an account of

Resident – a person accepted for care or residing in a nursing facility

Respiration (R) – breathing

Restraint – a means of restraining; a device or method that restricts movement

Temperature (T) – the amount of heat in the body

Vital Signs – signs of life; pulse rate, respiratory rate, body temperature, and blood pressure of a person

RESTRAINTS

There is a common misconception that restraints help improve the safety of the elderly. However restraints can be more dangerous and often cause more risks than benefits. Many studies document the dangers and recommend more dignified methods to improve residents’ safety.

OBRA defines “physical restraints” as any method or equipment used on or near the resident’s body that the resident cannot remove easily and which restricts freedom of movement or normal access to one’s body.

so in other words restraints are defined as any manual method, physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the resident cannot remove easily and that restricts freedom of movement or normal access to one's body.

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

Physical restraints include leg and arm restraints, hand mitts, vests, soft ties, or anything else that prevents residents from moving around. Also the way an item is used determines if it is considered a physical restraint such as trays, tables, bars and belts found on some chairs (geri chairs) are considered restraints if they are used to restrict your movement and you cannot easily remove them. Other methods of restraint are moving your wheelchair against a wall so that you cannot move, using a bedrail to prevent you from getting out of bed, or tucking in a bed sheet so tightly that you cannot move.

Chemical restraints are drugs used to control a person's behaviors when other forms of care are more appropriate. Psychoactive drugs, which affect emotions or behavior, are often used for this purpose. These drugs are not considered chemical restraints when used for the proper treatment of mental illness such as depression or schizophrenia. Psychoactive drugs are chemical restraints when they are prescribed to control an individual's behavior without adequate medical justification.

Risks Caused by Restraints

Physical restraints are most often used to prevent someone from falling out of a bed or a chair. Although restraints may prevent some falls and accidents, they cause significant risks. Many residents have been seriously injured while trying to escape restraints or by improperly applied restraints. For example, many people have died from strangulation or been seriously injured when they became trapped or entangled in bedrails.

Other common side effects of physical restraints are incontinence, increased agitation, poor circulation, weak muscles, chronic constipation, pressure sores, depressed appetite, loss of mobility and increased illness. Restraints also diminish independence and social contact, often leading to withdrawal, depression, anxiety and agitation.

Even when used properly, most psychoactive drugs have numerous potential side effects. The dangers multiply quickly when these drugs are used as chemical restraints. Although the risks vary by the drug, some common side effects are agitation, sedation, disordered thinking, decreased appetite, constipation, low blood pressure and muscle disorders. One problem tends to lead to another. For example, residents who are over-sedated face most of the side effects caused by physical restraints.

Alternatives to Restraints

A nursing home has many options to help improve safety, including the following examples:

Methods to Improve Your Safety

1. Using pads and pillows to support you in a comfortable and safe position;
2. Adapting and tailoring chairs you use to ensure comfort and safety;
3. If you use a wheelchair, ensuring that it is the correct size, comfortable and in good condition;
4. Responding quickly to your physical needs such as hunger, thirst, sleeping, toileting and exercise;
5. Tailoring care and caregiver assignments to your preferences;
6. Providing therapy and restorative care to improve your abilities to stand, transfer and walk safely;
7. Using devices that monitor your efforts to rise from your bed or chair;
8. Helping you to get in and out of bed as often as needed and desired.
- 9. Methods to Improve Safety of All Residents**
10. Increasing staffing levels to improve supervision;
11. Adapting the environment through good lighting, safe beds, alarms, and other features;
12. Removing accident hazards, such as over-bed tables with wheels and cluttered dining rooms;
13. Providing safe areas for residents to walk;
14. Training staff on methods to calm residents who are anxious or agitated;
15. Arranging mental health treatment for residents who need it.

A variety of strategies may be needed to improve your care and avoid use of restraints. The nursing home must carefully assess the symptoms that cause concern for your health and safety and consult with you and your representative about treatment options. Every appropriate option should be tried before restraints are considered.

Suggested restraint alternatives & least restrictive forms of restraint

- Beds that lower to the floor or a mattress in place next to the bed
- Encourage family members or organise volunteers to visit at 'high risk' times
- Consistency in staff and routines
- Limit the number of staff attending to the person
- Reduce noise levels
- Review lighting to ensure it's not too bright or too dim as this may lead to misinterpretation of objects
- Ongoing explanation of procedures
- Use of distraction/diversional activities
- Calm voice & soothing music
- Assessing and treating problems causing agitation - e.g.; UTI, dehydration
- Concave mattress
- Water noodles as an inexpensive alternative to concave mattress and can be one side or both
- Foam wedges to improve position & comfort
- Bed poles/ monkey bars for bed mobility

- Cot sides that can be released by the individual (after explanation of cot side risks)
- Half length cot sides
- If a seat belt is necessary, a velcro belt would be first choice rather than a clip belt
- Non-slip mats, e.g.; by the bed
- 'Stop' signs, 'No Exit' signs, strips across in front of the exit door - to prevent absconding
- Snoozelin therapy
- Individual behaviour management strategies
- Aromatherapy - must be prescribed by a qualified clinical aromatherapist
- Validation therapy
- Reminiscence therapy.

Vital Signs, Height and Weight

In your role as a Nurse Aide, you may have take vital signs. Vital signs are important because they show how well the vital organs of the body, such as the heart and lungs are working. The five vital signs are the individual's temperature, pulse, respiration, blood pressure and pain level. Vitals should be taken on a regular basis: this helps you to know what is normal for the person so that you can monitor changes and recognize them as signs or symptoms of illness. All vital signs should be taken when the individual is "at rest." You should wait 20-30 minutes to take a temperature, pulse, respiration, or blood pressure if a person has just eaten, drank a hot or cold beverage, just smoked, or exercised.

Normal Ranges for Adult Vital Signs

Temperature: Oral 97.6 – 99.6

Rectal 98.6 – 100.6

Axillary 96.6 – 98.6

Pulse: 60 – 90 beats per minute

Respirations: 12 – 28 breaths per minute

Blood pressure: Systolic (top number) should be less than 130

Diastolic (bottom number) should be less than 85

TEMPERATURE

Temperature is the amount of heat in the body. Normal temperature is 98.6 degrees F. Anything within a degree either side (97.6 to 99.6) is considered normal. There are various methods of taking a person's temperature. The residential setting that you work in may have any or all of the following types of thermometers: A mercury free or glass thermometer, a digital thermometer, a tympanic (ear) thermometer, or a rectal thermometer. Rectal temperatures are the most accurate but are considered to be invasive and are not usually done unless recommended by a physician. The easiest and most commonly used is a digital thermometer. Digital thermometers are easy to read and hard to break.

Before beginning any procedure:

Have equipment clean and ready

Wash hands

Identify the person

Introduce yourself if necessary

Go to a private or quiet area

Explain the procedure

Document your results

How to take an individual's temperature using a digital thermometer:

Use a plastic slip to cover the thermometer.

Press the button to set the thermometer.

Place the thermometer under the tongue; have individual close mouth (breathing through the nose), for several minutes.

Take the thermometer out of the individual's mouth to read when the temperature indicator lights.

Note: If the individual is unable to keep the thermometer under his tongue, you may take an axillary temperature (under the armpit with tip of the thermometer against dry skin and held in place by the arm), waiting five minutes (not four). Do not use an oral thermometer for an individual, who has a history of seizures, breathes through his or her mouth, has just had oral surgery, or is unconscious.

How to take an individual's temperature using a mercury-free thermometer or a glass thermometer:

Hold the thermometer by the stem

Shake the thermometer down to below the lowest number (at least below 96 degrees) before placing it under the individual's tongue.

To shake thermometer down, hold it at the end opposite the bulb with the thumb and two fingers. With a snapping motion of the wrist shake the

thermometer.

Stand away from walls and furniture to prevent accidents!

Use a plastic slip to cover thermometer (if available)

Place the thermometer under the tongue and to one side; have individual close mouth (breathing through the nose), for at least three minutes

Remove the thermometer. Wipe with tissue from stem to bulb or remove

plastic cover

Hold thermometer at eye level by the stem (not the bulb). Rotate until the Line appears or the colored side is facing away from you. Roll the

thermometer between your thumb and forefinger, and read temperature.

Document temperature, date, time, and method used.

When doing an axillary (armpit) temperature you must leave the thermometer in place for 10 minutes

How to take an individual's temperature using a tympanic thermometer:

Follow manufacturer's directions for use

Tympanic thermometers are inserted in the ear canal

A disposable ear tip should be used

How to document a temperature:

Always document temperature, date, time taken, and the method used. Use "O" for oral, "R" for rectal, "A" for axillary, and "E" for ear. For example: 98.6A, or 98.6E or as such: T: 98.6 F (oral, axillary, or rectal)

How to clean and care for a thermometer:

Mercury-free or glass thermometers may be used to take oral, rectal, or axillary temperature. Thermometers must be labeled as “oral”, “rectal” or “axillary” and used only for that method. Glass thermometers must be cleaned before and after each use. Each individual should also have their own thermometer labeled with their name.

To clean the thermometer:

Wipe off anything visible with a tissue or gauze square.

Use a cotton ball or gauze square dipped in rubbing alcohol and wipe the thermometer from the cleanest to the dirtiest end

Rinse the thermometer in cool water

Air dry

Place in container and put it away!

Plastic slips or disposable sheaths may be used to cover the thermometer when taking temperatures. The thermometers must still be cleaned before and after each use

Refer to manufacturer’s instructions for cleaning digital and ear thermometers

All digital and electronic equipment should be checked prior to use

Pulse

Pulse is the rate of your heart beats (Bpm - Beats per minute). Your heartbeat is the sound of the valves in your heart closing as they push blood from one chamber to another. Heart rate is the number of times the heart beats per minute (BPM), and the pulse is the beat of the heart that can be felt in any artery that lies close to the skin.

Heart rate is measured by counting the number of times your heart beats in one minute. One way to determine your heart rate is to manually take your pulse. The two most common locations used to take a pulse are at the radial artery in the wrist and the carotid artery in the neck. It is best to practice locating and counting your pulse when you are at rest and again during physical activity.

Many factors go into your resting heart rate, including your weight, blood pressure, the medications you take and how much you exercise. Whether you are standing up or lying down when you take your reading can also affect pulse (that’s why your heart may race a bit when you first get up in the morning). Experts say healthy adults can have pulse rates ranging from 60 to 100 beats per minute. Elite athletes typically have lower heart rates, around 40 beats per minute because of their better heart fitness.

Disease Categories

Electrical: Abnormal heart rhythms (arrhythmias) are caused by problems with the electrical system that regulates the steady heartbeat. The heart rate may be too slow or too fast; it may stay steady or become chaotic (irregular and disorganized). Some arrhythmias are very dangerous and cause sudden cardiac death, while others may be bothersome but not life threatening.

Circulatory: High blood pressure and coronary artery disease (blockage in the pipes of the heart) are the main causes of blood vessel disorders. The results, such as stroke or heart attack, can be devastating. Fortunately, there are many treatment options.

Structural: Heart muscle disease (cardiomyopathy) and congenital abnormalities (problems present from birth) are two problems that can damage the heart muscle or valves.

Normal or an average pulse rate for a resting adult is 70-80 bpm (beats per minute).

Report if P < (less than) 60 & > (greater than) 100/minute

Know normal or regular rhythm vs irregular rhythm such as a "thready or weak pulse" one that is very fine and scarcely perceptible Bounding pulse is leaping and forceful pulse that quickly disappears.

Rate may be also noted as normal, fast (tachycardia), or slow (bradycardia).

Rates faster than 100 bpm are considered to be tachycardia.

Rates slower than 60 bpm are considered to be bradycardia.

7 Pulse points

There are many factors that affect the pulse rate. Some are listed below.

- (1) Sex. Women have a slightly faster pulse rate than men.
- (2) Age. The pulse rate gradually decreases from birth to adulthood then increases with advancing old age.
- (3) Body temperature. The pulse rate generally increases 7-10 beats for

each degree of temperature elevation.

(4) Digestion. The increased metabolic rate during digestion will increase the pulse rate slightly.

(5) Pain. Pain increases pulse rate.

(6) Emotion. Fear, anger, anxiety, and excitement increase the pulse rate.

(7) Exercise. The heart must beat faster during exercise to meet the increased demand for oxygen.

(8) Blood pressure. In general, heart rate and blood pressure have an inverse relationship. When the blood pressure is low, there is an increase in pulse rate as the heart attempts to increase the output of blood from the heart (cardiac output)

Please note: An irregular pulse can be life threatening; The normal rhythm of a healthy heart empties the heart's chambers of incoming blood and transports it around the body. If the heart is beating irregularly and rapidly, it doesn't move the blood quickly through the heart, and the blood flow can become sluggish. This can result in blood clots which break loose and travel to the brain or other parts of the body. If a clot travels to the brain it can block an artery and cause a stroke. Brain cells deprived of blood by a blocked artery can die, causing permanent disability or death.

HOW TO CHECK THE RESIDENTS RADIAL PULSE

You will need a clock, watch, or stopwatch with a second hand.

- Use your index and middle fingers. Do not use your thumb, **YOUR THUMB has a pulse of its own.**
- Place them on your wrist, just above the base of the thumb.
- Count the number of beats for 60 seconds (1 MINUTE)
- Write your findings down as such: P: 76 bpm
- **Respiration (R)**
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-
- **ONE INHALATION (taking a breath)**

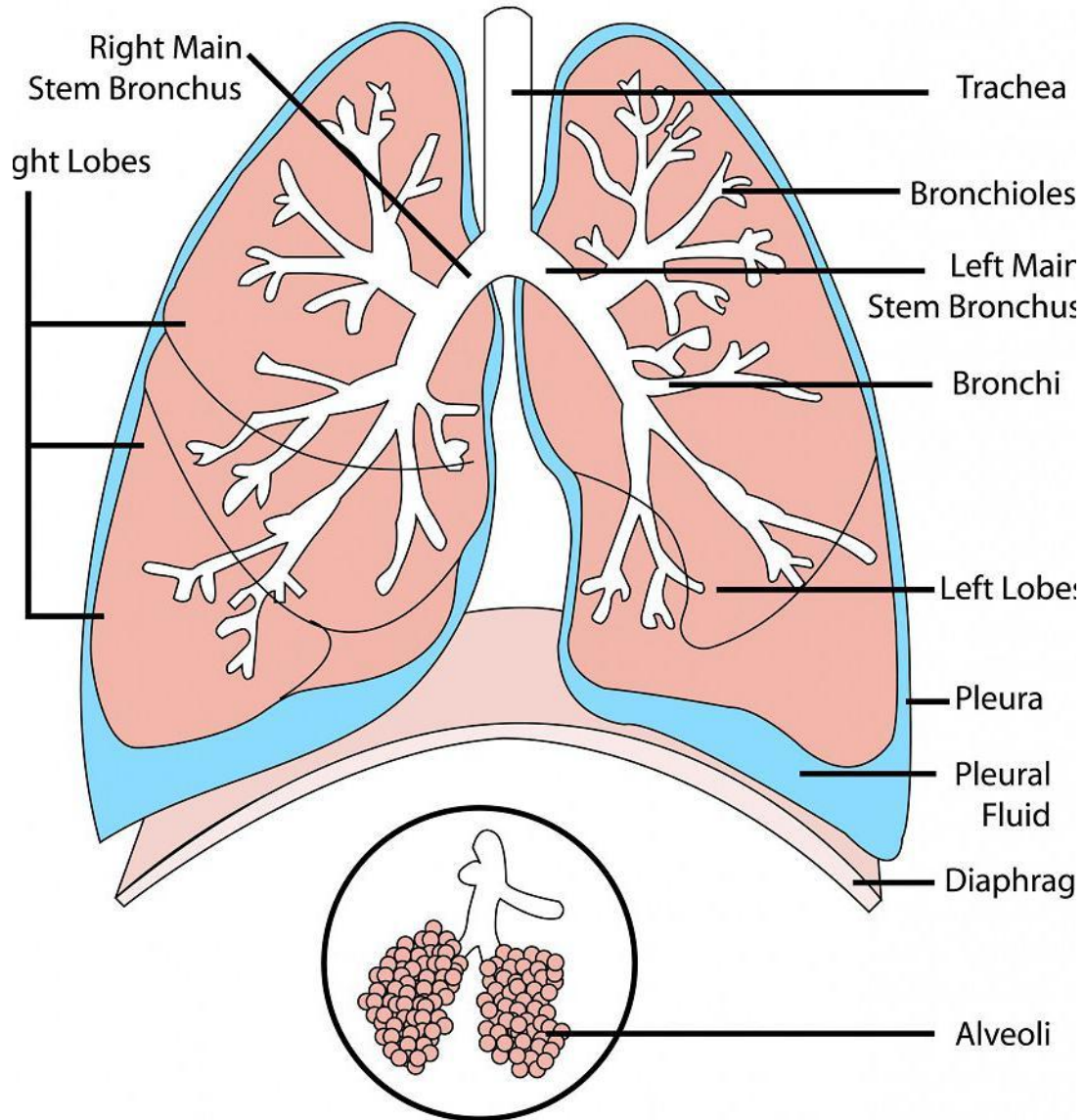
• AND ONE EXPIRATION (breathing out) = 1 RESPIRATION

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- Respiration is inspiration and expiration. Normal rate is about 16-18/minute . Nurse Aides must report R < (less than) 12 & > (grater than) 22/minute, or per facility/Physicians instructions. Respiration is the process in which outside air is taken in via the nasal passages into the lungs and air within the lungs are expelled via the same route.
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- There are several instances in which the air passages can become obstructed such as inhaling foreign bodies, water or other aspirates, through inflammatory manifestations in the air passages such as in the case of asthma, allergies, and occurrence of cancers in relation to respiratory passages.
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- There are a number of factors that affect it. For instance, there is the brain as it the primary controller of the respiratory rate.
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- The respiratory system is involved in the intake and exchange of oxygen (a colorless, odorless gas and life-supporting component of the air.) and carbon dioxide (waste) between an organism and the environment.
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- Respiration rhythm refers to the manner in which a person breathes. Respiration rhythm is classified as regular or irregular. and character
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- The nurse aid will need to report abnormal respirations they observe such deep (evidence of increased effort to breath- labored) or shallow (opposite of deep breathing - minimal breathing usaully rapid),or noisy such as gurgling (like breaths are passing through water), or wheezing/rhonchi (whistling or snoring sound), crackling sound (rales)
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- **When you need to take vital signs on a resident, make sure you tell them in advance what you are going to do, and to keep as quite as possible during procedrues. so when you start to count respirations you do not have to explain again. My suggestion is after you take the pulse for one minute, leave your hand on the radial pulse to make it seem like you are still taking thier pulse in order to distract them from realizing you are taking thier respirations, Why, because when people realize your are watching thier pattern of breathing they tend not to breath as they normally would.**
- You will need a second hand watch and Wait until the second hand on the clock is at the 6 or 12 marker (It will be easier to keep track)

Count how many times a person breathes in and out causing their chest to rise and fall.

- Write your findings and observations down. Also if they were in supine or fowlers position, etc.

Diagram of the Human Lungs



Findings:

Blood Pressure

Blood pressure is defined as the force of blood against the arterial walls as the heart beats hence arterial pressure. It is the Role of the Nurse Aide to perform blood pressure on a resident to determine the diastolic and systolic arterial pressure.

Normal BP is about 120/80 mmHg (millimeters of mercury)

The top number is the systolic pressure (heart at work or contraction) and the bottom number is the diastolic pressure (the heart at rest or relaxation)

Nurse Aide must report;

Report <100/60 & >140/90 mmHg

Break down as follows:

Systolic pressure (top number) < (less than) 100 or > (greater than)140

Diastolic pressure (bottom number) < (less than) 60 & > (greater than)90 mmHg

Factors Affecting Measurements:

When taking blood pressure, it is vital that all of the steps involved in the process are properly observed. Small variations in technique can cause large variances in measurements, even on the same patient. The chart below shows some common issues that could affect readings:

Using a blood pressure cuff that's too large or too small can give you inaccurate blood pressure readings. The inflatable part of the blood pressure cuff should cover about 80 percent of the circumference of your upper arm. The cuff should cover two-thirds of the distance from your elbow to your shoulder.

never use a limb that has an intravenous infusion or a dialysis fistula in it. Also never use the arm or leg on the same side where surgical removal of axillary or hip lymph nodes has occurred. This may be the case with some cancer patients.

A cuff that is too large or too small can give an erroneous blood pressure reading. This is also true if the cuff is either too loose or too tight around the limb. You should be able to insert 1 finger between the cuff and the limb for an accurate fit.

Don't drink coffee or smoke cigarettes 30 minutes before taking your BP. Go to the bathroom before taking your blood pressure—a full bladder can change your blood pressure reading.

The steps to taking blood pressure

You need the following items to take blood pressure:

1. A blood pressure cuff with a sphygmomanometer- A sphygmomanometer is connected by tube to the cuff and tells you how much air pressure is in the cuff.
2. A stethoscope-The stethoscope allows you to listen to and assess the blood pressure.
3. Alcohol pads
4. Pen and paper

Patient Positioning:

1. The patient should sitting (fowlers) or in supine position comfortably as allowed. The arm should be fully supported on a flat surface at heart level with palm up. (If the arm's position varies, or is not level with the heart, measurement values obtained will not be consistent with the patient's true blood pressure). When seated, the patient should have their back and arm supported, and their legs should not be crossed. The patient should relax prior to measurement comfortably for five (5) minutes, and should refrain from talking or moving during measurement.
2. Clean you earpieces and bell/diaphragm of stethoscope with an alcohol pad and lace ears pointing forward.
3. Ask the person to sit down with his or her arm slightly bent and resting on a table. The patient's feet should be on the floor and they should be resting quietly for at least 5 minutes.
4. Nurse Aide must remove residents clothing or adjust so arm is bare exposing arm from the Acromion (shoulder blade) to the Olecranon (elbow) and above the antecubital region.
5. Locate the brachial pulse which is on the inside of the elbow just above the elbow inner side of arm.
6. Wrap the cuff around the upper arm about one inch above the elbow with the artery mark positioned directly over the brachial artery. The bottom edge of the cuff should be positioned approximately one inch (2-3cm) above the antecubital fold. Wrap the end of the cuff not containing the bladder around the arm snugly, and smoothly and engage adhesive strips. To verify a correct fit, check that the Index Line falls between the two Range Lines. Make sure the cuff is touching the skin
7. Place the diaphragm of the stethoscope (the flat part) lightly but firmly in full contact of resident bare upper arm directly over the brachial artery, should be under where under the "artery mark" position located on the cuff, if cuff is placed correct.y. **DO NOT USE THUMB ON STETHOSCOPE/BELL.** your thumb has a pulse. Use your index and middle finger, make a peace sign as the picture shows.

8. DO NOT ALLOW THE STETHOSCOPE TO TOUCH THE CUFF, IT DOES NOT GO UNDER THE CUFF.
9. Follow the guidelines above for proper cuff fit.
10. Ask resident not to talk while you listen to BP!
11. Using the bulb attached to the cuff, inflate the cuff to about 30mmHg above where the person's normal systolic blood pressure is. The systolic is the top number of a blood pressure reading. So if the normal systolic blood pressure for this person is 130mmHg, inflate the cuff to around 160mmHg.
12. Slowly open the valve on the bulb to release the pressure in the cuff. The pressure should decrease at the rate of no more than 2-3mmHg per second while watching gauge and listening to pulse.
13. Using the stethoscope, record when you hear the first pulse (**thump sound**) **this is systolic pressure**. As the pressure decreases, you will continue to hear the pulse sounds until they disappear, however listen for 10 to 20 mmhg to confirm last sound. Record when you hear the last pulse (**thump sound**) **this is diastolic pressure**.
14. After measurement is completed, open valve fully to release any remaining air in the cuff until pressure is at zero and remove the cuff. Do not leave the cuff on the patient for an extended period of time.
15. Remove stethoscope from ears and clean the earpieces with a clean alcohol pad, the bell or diaphragm, and if contaminated, the tubing.

Again, The first sound heard is the systolic pressure, which is the maximum pressure exerted when the heart contracts. This is the top number. The last sound heard is the diastolic pressure, which is the minimum pressure in the arteries while the heart rests. This is the bottom number. So if you heard the first sound at 140mmHg and the last sound at 80mmHg, you would record the blood pressure as 140/80.

Blood pressure is recorded in even numbers.

Report significant observations to your charge nurse, such as blood pressure too high or too low per parameters set by physician or per facility policy, chest pain, headaches, dizziness, fainting, swelling.

HEIGHT & WEIGHT

You must balance the scale prior to assisting resident onto scale. If its a balance scale: Adjust the sliders along the beam until it is horizontal and balanced and fixed at zero. Many of these scales will have an arrow or pointer at the end of the beam which will point to a fixed mark to indicating the scale is balanced. Make sure resident is centered on the scale with arms ar side and not holding on to anything, not even you. If a resident can not stand on their own for this short amount of time, you should try a different method, such as a wheel chair, ask you charge nurse. To calculate weight; move larger slider (usually on bottom and in increments of 10 lbs) to estimated weight MAKE SURE SLIDER or INDICATOR is in groove, then move the smaller slider (on top ususally in 1 lb increments) add the values the sliders from upper and lower positions in order to get the total weight. If resident is not wearing shoes, place a paper towel on the scale for infection control. Record weight in lbs as such: W: 215 lbs.

Measuring Height of ambulatory resident

Assist resident to take off shoes, place clean paper towel on scale with a height bar. Have resident stand upright and look straight ahead. Raise height arm bar higher than residents head. Slowly lower height arm until level with top of residents head. Record height in feet and inches. to convert feet to inches: Divide number of inches by 12 and the result will be measurement in terms of feet. One foot is equivalent to 12 inches, For instance, 60 inches in terms of feet is: = 60 inches divided by 12 = 5 feet or 65 inches= 5.41 (5 feet & 41 inches)

Height of a non ambulatory

Assit resident into supine position in bed with legs as extended as possible, use a pencil to mark the top of the fitted sheet with no wrinkles right at the top of residents head and make andother mark at the bottom of the foot. Measure the distance between the tow marks to calculate height. If resident is contracted use a tape measure from top of heat to bas of heel following the curves fo the spine and legs, Again record height in inches.

Observing and Reporting and Documenting

MEDICAL RECORDS ARE LEGAL DOCUMENTS that must be documented very carefully, acurately and correct. Entries in chart/care plan/ kardex/ any type of nurse aide notes.

They must have date, time and signed by the Nurse Aide.

Make sure you chart is in the RIGHT Residents chart.

Write neatly and LEGIBLY with blue or black ink (per facility policy)

Provide ALL significant details.

Chart ALL changes of conditions and report to the charge nurse.

If there is a check box, make sure you check the right box and inside the box on the form

Sign and date EVERY entry NO EXCUSES!

Use only AUTHORIZED abbreviations, if your not sure ask your nurse. Unless your facility says otherwise its better to write out the word instead of abbreviating for less of a risk of mistakes.

Make certain patient's name is on EVERY page.

Correct an error by drawing a single line through the error and chart your initials (No erasing, blacking out or white out.)

Do NOT document "Incident Report Completed".

AVOID tattling and finger pointing. (this should be adressed with your supervisor or Director of Nursing for clarifcation and counsel.

NEVER chart ahead of time.

DO NOT record staffing problems or conflicts. (Again this is an administrative issue that need to be addressed with your superiors)

NEVER chart care that was not done.

DO NOT chart words associated with errors like "accidentally", unintentionally", "appears", "Maybe", "miscalculated,"not sure" "by mistake".

If you have a late entry follow facility policy. Do a proper "late entry." Do note date an entry so it appears it was written at an earlier time.

Do not add inaccurate information.

Do not re-write records or destroy records.

Remember Medical records tell the story of the residents care. Important parts of that story include:

- What care was given.
- Who was on the health care team.
- How the patient responded to the care.

Documentation must be done on time. You must document as soon as possible after you have provided care or observed something that needs to be in the patient's record.

To Observe – using your senses to collect information about a resident

To Report- A formal written or verbal account of an observation or subjective data.

Subjective Data: Something your resident (your **subject**) reported to you

Objective Data: Is what the Nurse Aide observes (the **object** of your eyes)

OBSERVING AND REPORTING CONTINUES

Truth is, there is a lot to observing and reporting.. YOU ARE THE EYES AND THE EARS OF THE NURSE AND RESIDENT

Documentation is not left up to your charge nurse. Nurse aides report ofn skin color, temperature, turgor, Mood and mental status Behavior, movement Unusual odors, vital signs, Appetite, ADL Performance, Elimination, imput and Pain or discomfort

REMEMBER A RESIDENTS CHART

Communicates and records health history,
status, and treatment. A legal record

MINIMUM DATA SET – The MDS is a 52 page resident assessment document that is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.

The Purpose of the MDS

- a) Drives care
- b) Sets reimbursement
- c) Regulatory document

d) Justifies staffing

Categories of MDS (Minimum Data Set)

- 1) Cognitive patterns
- 2) Communication and hearing patterns
- 3) Vision patterns
- 4) Physical functioning and structural problems
- 5) Continence
- 6) Psychosocial well-being
- 7) Mood and behavior patterns
- 8) Activity pursuit patterns
- 9) Disease diagnoses
- 10) Other health conditions
- 11) Oral/nutritional status
- 12) Oral/dental status
- 13) Skin condition
- 14) Medication use
- 15) Treatments and procedures

Participants in the assessment process are licensed health care professionals, usually Registered Nurses, employed by the nursing home.

Resource Utilization Groups (RUG) are part of this process, and provide the foundation upon which a resident's individual care plan is formulated.

ADMISSION, TRANSFER AND DISCHARGE

YOUR ROLE AS A NURSE AIDE IN ADMITTING, DISCHARGING AND TRANSFERRING RESIDENTS !!!!

It's very important to understand the Psychological Impact & Well-being of a newly admitted resident. Please observe resident for signs of depression, frustration, abuse, lack of socializing. For a newly admitted resident, make the resident feel welcome and ask how the resident prefers to be addressed. Use effective communication and interpersonal skills by being a good listener, observing body language, providing feedback and developing supportive relationships with residents. Provide assistance and support to reduce the resident's stress and anxiety. Even under the best circumstances, these procedures represent changes that may result in increased stress and anxiety for the resident. If applicable, ask the resident or their family questions about a normal day for the resident, such as toileting, eating, socializing, ambulation and ambulation aides etc. You also need to know why they are there, what brought them to the nursing facility. Did the resident experience a loss besides losing their home?

Always follow the policies and procedures of your facility, as variations exist in methods, roles and responsibilities.

Request and follow instructions from charge nurse, the nurse aide is very valuable to the nurse in the head-to-toe assessment required upon admission. This may include; TPR, BP, Height and Weight, following facility policy, turning resident, checking for open sores - paying special attention to bony prominences; sacrum, iliac crest, coccyx.

Set aside adequate time for the admission procedure and have the clean room ready with needed supplies available, such as soap, tooth brush, tooth paste, bedpan, urinal, wash basin,

Transport the resident following facility policy.

Care for the resident's valuables and personal belongings following facility policy.

The buttocks are formed by the masses of the gluteal muscles or "glutes" (the gluteus maximus muscle and the gluteus medius muscle) superimposed by a layer of fat. The superior aspect of the buttock ends at the iliac crest, and the lower aspect is outlined by the horizontal gluteal crease.

Discharge

It is the Nurse Aide role to aid in the discharge of a resident. Much of the discharge process is like the admission process. The Nurse will make sure the patient has Physicians orders in place, medications (drug list and dosing) and resident discharge teaching e.g. postsurgery teaching or rehabilitation, Social services will also help plan ahead for home such Home Health Care. While nursing assistants help to make sure residents' belongings are neatly stored for the trip home. After discharge, nursing assistants may arrange housekeeping duties or perform duties themselves to prepare the environment for the next patient.

- Nursing assistants may also be more responsible for residents social and emotional care than the resident receives from nurses or doctors. Because nursing assistant duties take them in frequent and close proximity to patients, they might develop deeper social and emotional bonds with patients. In particular, patients who do not have families or friends to care for them socially might expect a nursing assistant to fill that role. Providing personal patient care can make the difference in a hospital experience.

Introduction to Restoration Services

Key Terms

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

Prosthetic Devices – an artificial device extension that replaces a missing body part

Resident – a person accepted for care or residing in a nursing facility

Restraint – a means of restraining; a device that restricts movement

Restorative Services – services given to maintain or give new strength or vigor

Restoration is the care given to attain and maintain the highest possible level of independence and functional ability (physical and psychosocial). It is the Nurse Aides responsibility to make sure residents received the best care possible while encouraging independence and giving praises .

I like to look at the work RESTORATION as RESTORE. To restore is to bring back into existence or use; to reestablish.

The Nurse Aides role is to prevent deterioration or declines in residents' conditions this can be obtained by promoting independence and giving praises.

For Example: Smith is back from the hospital from having hip surgery.

Physical & Occupational therapy will normally work with the resident upon admission immediately. Their treatment strategies for residents with hip fracture is focused on return to independent ambulation and transfers. They teach resident on how to sit up on side of bed, ambulate.

The nurses goal is to Prevent further bone/tissue injury. Alleviate pain. Prevent complications .Provide information about condition/prognosis and treatment needs. Maintain stabilization and alignment of fracture(s).

Nurse aides will help promote body mechanics that promote stability at fracture site. Maintain stabilization and alignment of fracture(s). Demonstrate body mechanics that promote stability at fracture site. Support fracture site with pillows/folded

blankets as ordered. Maintain neutral position of affected part with sandbags, splints, trochanter roll, footboard as ordered this provides stability, reducing possibility of disturbing alignment/muscle spasms, which enhances healing. Prevents unnecessary movement and disruption of alignment. Proper placement of pillows also can prevent pressure deformities in the drying cast. Use sufficient personnel for turning. Failure to properly support limbs in after a hip fracture may cause the injury or complications. Report to charge nurse immediately if wound is open or has an foul odor, pain, rashes, bleeding, discoloration, duskiness, blanching, drainage, increased temperature or any abnormal finding.

ROLE OF THE NURSE AIDE IN RESTORATIVE MEASURES

Nurse aide must emphasize the residents strengths and abilities—not weakness and disabilities. Emphasize independence—not helplessness. **Convey a positive attitude of hope.**

Encourage residents to function as independently as possible—but not beyond their capabilities. Independence can be physical such as walking or mental such as decision-making. Encourage resident to use strengths to overcome weaknesses. Look for things the resident can do and build on the abilities.

Restorative measures related to the activities of daily living (ADL's):

- a) Hygiene and grooming
- b) Activity
- c) Nutrition and hydration
- d) Elimination
- e) Communication
- f) Mobility and bed mobility

Specific restorative programs

- a) Hygiene and grooming program
- b) Exercise program
- c) Ambulation program
- d) PROM program
- e) Pressure sore prevention program
- f) Dining program

g) Bowel/bladder program

h) "Alternatives to Restraints" program

ROM

Range of motion exercises are also called "ROM" exercises

Types of PROM

a) Active

b) Passive

c) Assisted

ROM exercises help keep your muscles and joints as healthy and moveable as possible. ROM exercises may be active or passive.

Active ROM exercises are done by a person who can do the exercises all by himself, Many residents go to exercise in their nursing communities that offer it.

Active-assisted ROM exercises are done by the person and a Nurse Aide, mostly for guidance and encouragement.

Passive ROM exercises are done for a person by a Nurse Aide . The Nurse Aide does the ROM exercises because a person cannot do them by himself.

First make sure ROM and type used is in the residents care plan before you perform ROM to make sure it is not contraindicated: (of a condition or circumstance) suggest or indicate that (a particular technique or drug) should not be used in the case in question.

After greeting the resident and washing hands.

Let resident know you are going to perform ROM exercise on their lower or/and upper extremities. Here is an example of how to explain what you need to do.

" Hi, Mrs Smith, my name is Jane your Certified Nurse Aide and I am going to be performing a series of exercise on your lower extremities, however if you feel any pain or discomfort please let me know and I will stop".

Raise the person's bed to a height that is comfortable for you. This will help keep you from hurting your back or other muscles. Make sure the wheels of the bed or wheelchair are locked before you start the exercises.

Do all ROM exercises smoothly and gently. Never force, jerk, or over-stretch a muscle. This can hurt the muscle or joint instead of helping.

Move the joint slowly. This is especially important if the person has muscle spasms (tightening). Move the joint only to the point of resistance. This is the point where you cannot bend the joint any further. Put slow, steady pressure on the joint until the muscle relaxes.

Stop ROM exercises if the person feels pain. Ask the person to tell you right away if he feels any pain. Watch for signs of pain if the person is unable to talk. The exercises should never cause pain or go beyond the normal movement of that joint.

Make ROM exercises a part of the person's daily routine. Do ROM exercises at the same time every day. Do them while bathing the person or while the person watches TV. This will make the time go faster and help the person relax more.

Follow the physicians orders. The residents care plan will tell you how many times per day you should do ROM exercises. The careplan will also tell you how many repetitions (number of times) you should do exercises on each joint/limb.

Leave the person in a comfortable position after you finish each exercise. Always wash your hands before and after doing ROM exercises for a person.

COPING WITH DEATH

WAYS RESIDENTS COPE WITH IMPENDING DEATH

1. Denial
2. Anger
3. Bargaining
4. Depression
5. Acceptance

People of all ages go through the natural dying process unless they have had a sudden illness or accident. The years, months or days before death are often filled with more and more physical and mental problems for most people as they go through the end of their life. The end of life requires special nursing care. Nurses that care for themselves will grieve better. People deal with grief differently. Some common ways to cope with death is:

Communicating- talking with your co-workers, friends, or patients family is a good way to start a grieving process

Exercise and relaxation therapies- a hot bath, to help ease stress caused by patient death

Rituals to help the patient and family feel better- bringing the family food; attending funerals or posting obituaries; and praying or drawing strength from spiritual beliefs.

Nurse aides must stay strong in these circumstances. They must also be able to care for family members while they hold up the patient's or resident's rights to decision making, privacy, confidentiality and dignity. Care at the end of life is a very rewarding part of nursing care.

Death is a personal journey that each individual approaches in their own way. A resident has to also deal with the forthcoming of death. Giving up their independence isn't easy but understanding what happens when they are approaching death will help them to anticipate the care they need. There are known to be stages of grieving our own impending death, which are: denial, anger, bargaining, depression, and acceptance. Although all steps may not occur with certain people, mostly everyone experience at least one of these stages.

When death is approaching common bodily functions change. Some may experience a change in their eating, drinking, sleeping, and breathing. Some people may become restless, agitated or confused. While realizing death is approaching, a resident may begin to withdraw from there surroundings. There body begins to slow down, they become disoriented and delusional. It is also not unusual for a resident to get a surge of energy the closer they get to death. Hands and feet begins to get blotchy and purplish. The person become unresponsive, hard of hearing and breathing. Eventually the heart will stop. Death has then occurred.

A nurse aide will need to play a part of the residents physical needs. With knowing that there body is getting weaker and weaker by the day, a nurse aide will need to do there best to make the resident as comfortable as they can. It is your job to observe and report signs of pain. Provide a quiet room, give them back rubs, bathe and provide well skin care and mouth care, keep bed and room neat, and make sure the tempature of the room is adjusted to the residents needs. Comfort care is an essential part of medical care at the end of life. It is care that helps or soothes a person who is dying. The goal is to prevent or relieve suffering as much as possible while respecting the dying person's wishes.

Not only does a resident have physical needs they also require emotional needs such as:

Preserving their dignity- allow the resident to perform their end of life task. Encourage them to continue to make their own choices whether is picking out a dress or when they want a bath. Call them by their name and let them be independent with only enough assistance not to make them feel uncomfortable.

Provide privacy- provide privacy when bathing or caring for your resident. Keep resident information confidential. Do Not discuss any information about your resident with other residents or unknown people.

Spiritual and cultural needs- Respect the need for spiritual support. People nearing the end of life may have spiritual needs as compelling as their physical concerns. Do NOT force your own religious or spiritual beliefs on the patient. People have the right to choose their own beliefs. These beliefs must be respected. People also have the right to have no religious or spiritual beliefs at all.

As a Nurse aide providing comfort not only deals with the resident, but also with the residents family, friends, and other concerned residents. Welcome visitors. People at the end of life have a desire for closeness. Make visitors comfortable and welcome. We must allow families to spend a lot of times with the loved that is dying. Most important thing to remember is that you want the residents last days to be easy, comfortable, and smooth.

Hospice allows for compassion and dignity in the process of dying. Hospice is a form of palliative care for patients who are terminally ill. Palliative care is the active total care of patients whose disease is not responsive to curative treatment.

Palliative care is a special care, which affirms life and regards dying as a normal process, neither hastens nor postpones death, provides relief from pain and other distressing symptoms, integrates the psychological and spiritual aspects of patient care and offers a support system to help patients live as actively as possible until death and helps the family cope during the patient's illness and in their own bereavement.

Once your resident has met their final day, a nurse aide must perform postmortem care.

Typically, when a resident dies, the Charge Nurse calls the family and Resident's physician to pronounce the death. The doctor is usually responsible for completing the death certificate, notifying the family, and obtaining consent for donor services or an autopsy. But that's not always the case. However, **THE NURSE AIDE DO NOT** call family or pronounce death. The role of the nurse aide in Postmortem care is very vital. In death it's the Nurse Aide's duty to provide and maintain respect and dignity of the Resident and their loved ones.

Postmortem Care

1. Give enough time for family to grieve and be with resident. Then ask the family to leave so you can prepare the resident for transport.
2. Place "No visitor" or "Check at Nurses' Station" or "See Nurse before entering" sign to door.
3. Wash hands and wear gloves
4. Place body in supine position with bed flat.
5. Place pillow under head.
6. Close patient's eyes by gently pulling eyelids down
5. Give the deceased patient's personal belongings to his family or bring them to the morgue/funeral home- ask charge nurse. If you give the family jewelry or money, make sure a coworker is present as a witness. Obtain the signature of an adult family member to verify receipt of valuables or to state their preference that jewelry remain on the resident. Remove watch, jewelry and all possessions, give it to the nearest relative.
6. Ask family what if there were any special requests such as what they want their loved one wear to funeral home
7. Place small towel under chin to keep mouth close
8. Ask nurse to Remove IV and other tubes (nurse aide cannot do this).

9. Remove soiled dressing ostomy bags and replace them.
10. Wash soiled areas of body.
11. Place ABD's (disposable pads) to the perineal area to absorb any stool or urine released as the sphincter muscle relaxes.
12. Remove and discard gloves. Put clean ones on
13. Put a clean gown on the patient.
14. Leave the wrist identifications band in place, if applicable
15. Offer emotional support to the deceased patient's family and friends and to the patient's facility roommate, if appropriate.
16. If the body is to be viewed, replace top linens and tidy the unit.
17. Care for dentures and eye glasses, after viewing leave dentures in patients mount or place them in a denture container. Dentures and eyeglasses are sent to the morticians with the body.
18. Wrap body, if facility policy indicates or religion such as shrods
19. wait for the arrival of the mortician
20. Put away or dispose equipment and supplies used.
21. Wash your hands.
22. Again offer emotional support

SPECIFIC BEHAVIOR PROBLEMS

We must remember and understand the ALL behavior has a meaning.

Experts believe that the purpose of behavior is to satisfy unmet needs. UNMET NEEDS such as hinder and in ADLs such as toileting (brief change, needing to go to bathroom, need for exercise or activities. Patterns of behavior are developed throughout a lifetime based on heredity, environment, and life experiences.

Most older adults continue to use the same behavioral responses that they learned throughout their life.

CAUSES OF BEHAVIORAL PROBLEMS

Remember that a resident's behavior may be a response to an unmet need.

In an alert, orientated resident the unmet need is usually psychosocial. (such as the resident may be crying because her/his son has not been to visit lately and is not like him- Though she may not say anything possibly due to embarrassment.

However the CNA should know when their patient has a change in behavior and should also realize that her/his son has not come to visit which is unusual. At this point it would be therapeutic to say "Are you missing your son? Lets ask the charge nurse to call him for us, ok" You may have found the root of her unmet need.

In other words we need basic essentials such as air food and water before we can go up the ladder and we go up and down the pyramid throughout life. After you achieve reading this material, you should experience self actualization, a feeling of achievement or best feeling you can have.

The possibility of joy for the elderly in long-term care is certainly attainable. Especially when care staff that is sensitive, and encouraging residents to engage in social activities, this can help minimize the impact of loss and loneliness that the elderly often suffer. Social programs such as exercise, music and entertainment events, church, or community groups that visit the care facility can also help keep an older person connected socially. Pets give elderly persons in long-term care companionship.

Loneliness

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The elderly are especially sensitive to loneliness, as their long-term care environments can often remind them of their own mortality. Elderly in long-term care have almost always suffered major losses. The loss of significant relationships through death of a spouse, relatives, friends or even pets can be difficult for anyone. Also, the sense of loss through physical relocation---where the places and people are unfamiliar---can be just as difficult for an older person. Unfamiliarity with a long-term care residence can heighten anxiety and the feeling of being uprooted from home and having to part with possessions. This can cause anxiety and grief in which can lead to physical ailments such as low immunity from stress, or pneumonia, bedsores etc.

Guilt

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For many elderly, the loss of being bread winner or head of household role to others may make them feel useless or worthless, especially in cases where the adult must rely on someone else to address their basic needs, a reality of daily life for many elderly in facilities. The role reversal is especially hard for those who have had lifelong caregiver roles, such as a full-time mother and homemaker, before having to enter long-term care.

Anger

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Feelings of abandonment and their own limited mobility may cause irritation and anger in some older persons. Elderly in long-term care may feel frustration at needing assistance at what once were simple tasks or when the elderly perceive that Nurse Aides are treating them as fragile or unstable individuals.

CAREGIVERS

One thing that you should keep in mind is, to shower all the love and care on your elderly relative or family member. Just because they have become old and slow, 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 your residents , chat with them and make them feel wanted, cared for and loved. Pay special attention to their room and whats in it such as ballons, birthday cards, pictures etc.

These were some basic elderly needs that you should bear in mind. Try your best to fulfill all of them so that they can spend the golden days of life happily and comfortably.

Appropriate sexual behavior of residents

Sexuality is stongly affected by the social enviroment. It plays a crucial role on how people assess themselves and relate to others. Elderly sexual needs are similar to those of younger people, but may vary in frequency, intensity and expression. it is not uncommon for a significant percent of elderly to remain sexually active. As for patients with dementia,there is either an increase or even a decline in sexual desire, which means less sexualactivity especially in cases of severe cognitive dysfunction. central role on how they view and project themselves to others, Sexuality is regarded as a sensitive and emotivetopic covered my misunderstandings and fear Even professional caregivers are influencedby these social conventions and as a result sexuality is regarded with stereotypical thinking.More specifically, it is generally suggested that there is a gradual decline with age . This may be partly explained by the general attitudes associating sexuality to physical attrac-tiveness and beauty regarding both as necessary components for relationships, while the media creates a comic picture on elderly sexuality. However, people, capable or not,continue to have sexual feelings and needs. Even when physical health changes occur,decrease in sexual activity is not always the case as desire is not necessarily absent. A high proportion of people are active in later life prevailing the myth that aging ands exual dysfunction are linked.

Inappropriate Sexual Behaviors

Hypersexuality, also referred in the literature as Inappropriate Sexual Behavior may manifest as a clinical symptom in either verbal or physical form. ISB must be examined as part of the overall behavioral and psychological symptoms of dementia. Inappropriate is defined any vigorous sexual drive after the onset of dementia that interferes with normal activities of living or is pursued at inconvenient times and with unwilling partners. The physical inappropriate behavior includes touching, fondling, disrobing and masturbation. Furthermore, these behaviors in the long term care setting include unwanted sexual advances such as 'climbing into bed with other residents in a nursing home' or 'actual intercourse attempts and aberrant sexual behavior such as aggression. often results in feelings of anxiety, embarrassment or unease in the caregivers and the result is often disruption in continuity of care for the patient at home. Moreover, patients who appear with such behaviors increase the care burden which increases the possibilities of entering residential care. According to a survey, caregivers think of inappropriate hypersexuality as the most difficult symptom of the cluster behavioral disturbances to manage.

The cognitive decline does not necessarily diminish sexuality. During the first stages, many patients may become hypersexual whereas others completely indifferent. Patients with dementia may become sexually disinhibited in relation to their cognitive deficits progress. While dementia progresses and cognitive impairment subsequently follows sexual interest and behavior does not disappear automatically, though sexual apathy and diminished need are often observed. It is important to point that often hypersexuality may be confused with the normal sexual needs for sex and intimacy, which causes a cluster of difficulties impeding to patient's daily care.