



CE IN-SERVICES PART 2

OUTLINE

SEMINAR PART TWO - 8 HOURS

Personal Care Skills

Body Mechanics, Positioning and Moving Residents

Care of The Residents Environment

Assisting Residents with Bathing

Toileting and Perineal Care

Skin Care

Hygiene and Grooming

Nutrition

Hydration

Elimination

BODY MECHANICS

Alignment (posture) – how the head, trunk, arms, and legs are aligned with one another, when the back is straight

Base of Support – foundation that supports an object

Body Mechanics – efficient and safe use of the body by the coordination of body alignment, balance, and movement

Center of Gravity – point where most weight is concentrated for an object or body. NOTE: YOUR WAIST IS THE CENTER OF GRAVITY.

- Maintain good posture and good body alignment while lifting as indicated below:
- a. Keep your back straight.
- b. Keep your knees bent.
- c. Keep your weight evenly distributed on both feet.
- d. Keep your feet at shoulder width (about 12 inches apart) to provide a broad base of support.

Body Mechanics is the efficient and safe use of the body by the coordination of body alignment, balance, and movement. Maintaining good body mechanics is super important due to the nature of Nurse Aide duties, NAs are subject to back and other injuries to the body so practicing correct body mechanics is critical. Nurse Aides duties usually includes lifting, moving and carrying objects. You would be surprised something as simple as picking up piece of paper from the floor can cause back injury with improper body mechanics.

Proper Body Mechanics:

* Maximizes strength, minimizes fatigue, avoids muscle strain and injury, and assures personal and resident safety.

* Reduces costs to resident and facility.

* Reduces employee absences due to back injuries.

*Reduces liability for the facility due to workman's compensation NURSE AIDES PLEASE follow correct body mechanics and alignment (posture and How the head, trunk, arms, and legs are aligned with one another, when the back is straight) and Base of Support (wide) and Coordination.

Things to Never forget

- Never lift more than you can comfortably handle. (get assistance)
- Create a base of support by standing with your feet 8–12" (shoulder width) apart with one foot a half-step ahead of the other.
- DO NOT let your back do the heavy work—USE YOUR LEGS. (The back muscles are not your strongest muscles.)
- If the bed is low, put one foot on a footstool. This relieves pressure on your lower back.
- Consider using a support belt for your back. (this helps you remember to keep back straight)

SHOW TIME Do this exercise!!!!!!!!!!!!!!*

1. Stand up first, stand on one foot. • How stable are you?

2. Second, have students stand with both feet together. • Dont you feel more How stable do you feel?

3. Third, stand with both feet shoulder length apart. • Now how stable do you feel now?

The fact that a person feet are their base of support and when your feet and legs are shoulder-length apart, base of support is ideal

you can keep your center of gravity- By bending knees to lift an objects, instead of at the waist. When your center of gravity lowered, Stability increases and your less likely to strain muscles

When moving or transferring resident, center of gravity includes the resident, **so resident needs to be close to your body as possible.**

Points to Remember When Lifting:

1. When given a choice, push or slide objects rather than lifting them
2. Use large muscles of upper arms and thighs to lift
3. Keep movements smooth when lifting and do not twist or make jerky movements
4. Face object or person when moving
5. Use both arms and hands when lifting, pushing or carrying object
6. Maintain correct body alignment

Positioning and protective devices

- a) Pillows - Pillows in medical facilities usually have a blue plastic covering, useful for cleaning.
- b) Foam wedges
- c) Handrolls/trochanter rolls
- d) Foot cradles/footboards
- e) Trapeze
- f) Specialized beds and mattresses
- g) Specialized equipment for heels and feet

- h) bolster

Before lifting, transferring or moving a resident. You should always tell the person what you are going to do before you do it and as you perform it, then make sure leave them in a safe comfortable position with call light within EASY reach. Before starting a move, have a prearrange signal such as counting with the resident and assistant. It is also important to look at your assistant in the face know exactly what to do. It should sound like this: "Mrs. Smith, Sue and I are going to [move you up in bed] [or roll you on your left side] [or transfer you to your wheel chair], [or lift you using mechanical lift"] [or move you in bed towards the window or door"] on "3" ok, (residents acknowledges) Now "1-2-3." Lift!

POSITIONING PATIENTS

(This page is dedicated to Matt, a good friend who is paralyzed from the neck down from a sports injury)

"A page from a my Nurse Aide Diaries" (True Stories)

I came into work many days displaying my usual sign of regret, another day at work urrrg!. My heart is in it but my mind is saying "Rats I have do the same ol thing, take care of the same ol person, without deviation from the *Norm*". Also knowing that a particular family member will be there that I didn't see eye to eye with. Now nevermind it was one of the easiest jobs I had in my nurse aide career, I was clueless to the fact how good this job really was. Not because of the great pay or awesome meals offered within my 12 hour shifts, but because my patient help me put my life in perspective.

So one day I came in on my off day to help this young quadriplegic. When I walked into his room, where he sat in his wheel chair watching TV. He smiled the most beautiful smile.

I asked him, "How do you do that?"

He said, "What?," still gleaming at me.

I said, "That!"

He chuckled and said, "No, really what!"

I said, "SMILE"...

"What do you mean," he asked.

I said, "How do you stay so happy, you smile everytime i see you". I look him up and down, "when your in this condition, It doesnt make you mad?"then I said I must confess, "Im not always happy coming to work, though I like it here, I just dont like working,

He chuckles again and said, "Well quit".

I said QUIT! What, I cant do that, how would I feed my family?," plus I like taking care of you.

He said, "Ok then dont quit and like it."

I frown with one eyebrow up, "I dont understand".

He said, "Ok, you asked me how to I smile in my situation". "Well I decided a long time ago to accept the fact I will be like this for the rest of my life, after trying every so called solution, I even questioned my beliefs". "

He went on to say, "So I have to tell myself every day, that I want to be here and I want to be like this, if not or I wouldnt survive. So when you come to work you make yourself smile on the inside and it will foward outward. You have to say I want to do this and I want to be here. Your alternative is to leave and find another job, or never work and live on the streets. You have a choice."

I said, "WOW what a rare but how true philosophy." So I decided from that day on... to Smile! Its not about things "could be worse" or being *complacent*... Satisfaction doesnt mean you can't strive, its about being happy no matter where you are in your life cycle. So my point is smile whether your going up or down. Truth is fact and nothing can change it.

Lets talk about positioning Residents but First lets put things in perspective, Do THIS!

I want you to close your eyes and imagine yourself unable to move you limbs (arms, legs) and only able to move your head. This means you can not do a simple task that we take for granted such as using the TV remote, or pushing your hair back away from your eyes. You can't take a shower, walk to the store, go jogging, dancing, or driving. All of your activities of daily living must be performed for you by someone else.

First, how would you want to be approached? With a smile or a sigh?

Some Nurse Aides wake up in a bad mood because they have to go to work and take care of people, maybe even have to deal with co-workers they dont get along with or maybe even their Charge Nurse. Some Nurse Aides are only in a bad mood for the first hour of work then they warm up and are fine the rest of the shift. There are some personalities that don't change because their one time passion has now became just a job. Now lets just say you were upset for only the first hour of your shift. Showing body language and facial expressions that represent you'd rather be somewhere else. Do you want to be you in your shoes?

Ok now imagine *Yourself* taking care of *Yourself*. *Your* that nurse aide with the bad attitude for at least an hour, and

you' re your first patient. You dont knock on the door or greet, first thing you do is flick on the lights in the room and its the very bright one over the bed. Still commencing to care for you without saying a word. you dont even pull the curtain between you and your roommate. You throw the covers off of you, then turn yourself over to change your brief with out saying one word, after your done, you turn off the light and leave. You as a resident were stripped of all dignity and respect, leaving yourself in shame and darkness. no one should suffer such fate, not even you (*the mean you:*).

So now that we have things in perspective. Let's talk about Positioning Residents

First before moving a Resident in bed make sure you lift the bed to proper ***your*** working height. For most people this would be about waist high, if possible. Please Note: Resident must be properly positioned and correctly aligned at all times.

Positioning residents inproper body alignment:

- o Promotes well-being and comfort
- o Promotes easier breathing
- o Promotes circulation
- o Prevents pressure ulcers and contractures

Residents that are bedridden must be reposition in bed or chair at least every two (2) hours (or more frequently - Follow care plan)

- ALWAYS Use good body mechanics
- Ask a co-worker for assistance as need, eg. some Residents require two people to lift/tranfer and **Always** two people to use the Hoyer (mechanical Lift)

Know the correct placement for variety of positions while resident is in bed

Use pillows for support and correct alignment

Semi Supine

Lateral

Supine

POSITIONS

heels, calves, buttocks, elbow, shoulder, head

Semi Supine

To turn a resident, its ideal to start with the resident in the supine position (facing up), which is laying flat in a good alignment; Residents head, trunk, arms, and legs are aligned with one another and the back is straight.

Now lets turn a patient q 2 hours

I coined a phrase “**Rock the Boat Positioning**” Lets say you start with a Resident in supine position its been two hours and its time to turn the resident. So we will turn the resident in a left side semi-supine position (shown above) , two more hours go by and you will now turn the resident back into supine position. Then after two more hours you will need to turn the resident onto their right side semi supine position.

FOWLER’S Position

For Positioning the Resident into the (Semi) Fowler’s position;

Resident is reclined sitting position 45 to 60 degrees

For Positioning the Resident into the (low)Fowler’s position;

Resident is reclined sitting position 15 to 35 degrees

For Positioning the Resident into the (High) Fowler’s position;

Resident is in a sitting up almost straight 60 to 90 degrees

LATERAL Position

For Positioning the Resident into the Lateral position;

Lying on right or left-side

PRONE Position

For Positioning the Resident into the Prone position;

Lying resident on abdomen. Please note: this is not a comfortable position for many people. Never leave resident in prone position very long

SIMS Position

The Sims' position, named after the gynaecologist James Marion Sims, is usually used for rectal examination, treatments and enemas. It is performed by having a patient lie on their left side, left hip and lower extremity straight, and right hip and knee bent. It is also called lateral recumbent position.

MOVING AND TRANSFERS

- Tell the person what you are going to do. Before starting a move, count with the person, "1-2-3."
- To feel in control, get close to the person you are lifting
- While lifting, keep your back in a neutral position (arched normally, not stiff), knees bent, weight balanced on both feet.
- Tighten your stomach and back muscles to maintain a correct support position.
- Use your arms to support the person.
- Again, let your legs do the lifting.

- Pivot (turn on one foot) instead of twisting your body.
- Breathe deeply.
- Keep your shoulders relaxed.
- When a lot of assistance is needed with transfers, tie a strong belt or a transfer belt around the person's waist

and hold it as you complete the transfer.

How to Transfer an Individual Using a Gait Belt

EQUIPMENT: Non skid shoes for both you and resident, Gait Belt

Assistive devices (if needed and appropriate for the individual)

- Wash Hands
- Explain to the individual what you are going to do.
- Apply the belt while the individual is in a comfortable sitting position around cloths, not on bare skin as this may create friction and tear skin, dont place around a jacket or sweater. If the individual is lying in bed and has poor sitting balance, apply the gait belt while they are lying down, but be careful with metal ends.
- Make sure the belt is applied tightly enough to prevent it from riding up or down on the individual's body, but loosely enough so you can grasp it firmly and comfortably. Be sure to have belt around waist, make sure residents breast are not under belt or belt not contraindicated such as a colostomy.
- If the individual complains of dizziness or symptoms when in an upright position, do not leave them for any reason. lay the resident back down and Call for assistance, if needed.
- If the individual has a weak side, make sure his or her stronger side is facing the destination(for example, toward the wheelchair or toilet)
- Lock brakes on all equipment (If it has wheels on it, LOCK IT!) that the individual is transferred from and will be transferred to.
- Stand as close to the individual as possible. (the closer the resident is the better your leverage and grip on resident) Stand in front keeping your back straight, your knees slightly bent, and your feet with a wide stance.
- Hold the individual at the waist rather than arms or shoulders. Lean forward and grasp the gait belt on both sides.
- Encourage the individual to participate by pushing up and against mattress with both hands, bearing some weight (if allowed), if resident ask resident to place arms around your shoulders to give you a hug.
- Turn toward the destination Make sure the individual can see or feel the surface to which they are transferring to.
- Always move your body in the direction in which the transfer is taking place.
- Make sure the individual is wearing shoes. (if resident is weak or partial weight bearing) place shoes on resident white they are laying down.
- When the destination has been reached, gently lower and encourage the individual to use his or her arms to reach toward the destination and bear some of the weight. Instruct the patient “when you feel the back of the when chair against the back of your legs it is safe to sit down
- Remove the belt once the individual is comfortably and safely seated
- Make sure resident is seating as far back as posible to promote good posture

and alignment, apply foot rest as indicated

How to use a draw sheet or lift/transfer pad (Please Note: you can not use a lift sheet with alone)

First, make sure person is awake and aware, before moving them, tell resident what will happen during the turn. (even if resident is not alert or oriented you must still give instructions and comfort touch). If resident can assist you tell him how they can help; such as grabbing side rail and assist in turn.

Make sure sheets or pads are not twisted, damp, or soiled. Change residents brief if skin is damp from sweat, wound drainage, or urine. Also change the person's bedding if needed and you know how, or get help to change it. Adjust urine drainage bags, tubes, drains, or medical devices before the turn.

Use a turning sheet or draw-sheet to protect the person's skin and make turns easier. This is an extra sheet secured under resident but on top of a regular bedsheet. It can extend from the patient's neck to knees. You also may be able to use a friction-reducing device with handles or pull straps to turn the person.

Gather plenty of pillows, bolsters and other comfort and alignment type cushions before the turn; they help keep a person in position and help prevent pressure ulcers. For example, you will need at least four to six pillows to keep a person on his side. Other cushions may support the feet, arms, and head. Remove pillows and cushions before the turn, and reposition them around the person after the turn.

Now you're ready to cross the resident's arms over their chest so they do not get trapped under their body during the turn. Place leg and foot over the other leg - pointing towards the way you want resident to turn. You and your assistant grasp the edge of the draw-sheet and roll the draw-sheet close to the resident. Using an overhand grip with hands placed at hips and shoulders...On the count of 3, lift and pull the draw-sheet toward you or your assistant. Keep your movements smooth.

To turn resident on side towards you (nurse aide 1) using draw-sheet, Nurse aide 1 will reach over resident a place one hand shoulder and the other on residents hip, the assistant nurse aide will grasp the rolled end of the draw-sheet. On the count of 3, Nurse aide 1 will pull resident toward then and the assistant will push the rolled draw-sheet agianst resident. So it a pull and push. Adjust the head of the bed for comfort.

Walking Assitive Devices

BEGINNING STEPS

- a. Gather needed supplies such as positioning devices, linen.
- b. Knock on door and identify self by name and title.
- c. Greet resident by preferred name and identify resident per facility policy.
- d. Approach the resident in a calm and courteous manner.
- e. Explain procedure and encourage resident's participation as appropriate.
- f. Lock wheels of bed and lower head as tolerated.
- g. Wash hands. Wear gloves and follow Standard Precautions. if contact with blood or body fluids is likely.
- h. Provide privacy as appropriate such as closing door/curtains, and draping resident.
- i. Provide safety as appropriate such as using good body mechanics, and adjusting the bed to proper working height.
- j. If side rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from the bedside.

CLOSING STEPS

- a. Clean and store reusable items and discard disposables per facility policy.
- b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

- c. Provide for resident's comfort and safety before leaving as appropriate such as clothing/bedding, adjusting bed/side-rails.
- d. Always replace call signal and needed items within resident's reach and lower bed to a safe level.
- e. Inform resident when finished and ask if anything is needed before you go.

OBSERVE FOR, REPORT AND DOCUMENT TO NURSE

- a. Problems or complaints related to procedure.
- b. Changes in the resident's ability to participate in moving or positioning.
- c. Other significant observations.
- d. Always be alert to changes in skin condition and report.

Reference: <http://www.dads.state.tx.us/providers/NF/credentialing/NATCEP/cna.pdf>

ALWAYS BE PREPARED PRIOR TO TAKING CARE OF RESIDENT:

such as having gloves, trash can close to you, and bag for dirty linen and clothes.

"always take your trash out when you leave"

Lets talk about Observations "to notice" & Reporting "to describe what you observed" when it comes to transfers, moving a resident, and positioning. Report; weakness, syncope "fainting" a change in residents behaviour such as confusion,

nervousness or agitation, poor posture- stooped over and knee buckling, mobility when ambulating and balance.

CARE OF THE RESIDENTS ENVIROMENT

Respect resident's room as private space, it's their home. Residents needs are like your own. When you are in your room, you may like your door open or closed. So respect their wishes as well. which brings us to the next subject;

Respect resident's preferences and privacy. Some residents are very social and their are some that just naturally like to be left alone until they want to socialize. Also their are individuals, married or consenting couples that have emotional and physical desires. You must provide privacy for their needs. When providing care to resident, make sure their door is closed, curtains are pulled both around blinds and windows .

Respect resident's personal belongings as irreplaceable.

A page from My Nurse Aide diary:

I was working PRN (as needed) for a home health care company as an Aide. I was called in for another CNA that could not make the visit. This patient was at first very demanding, agitated and displayed a depressed mood. As I cared for her she started to open up and express herself. I soon learned the elements behind her behaviour. She informed me that she was once a Registered Nurse and she helped pioneer the mobile home health model. She acutally drove around wiht a Doctor in a mobile home to care for clients. None the less I was very impressed with her story and since she was the last patient of the day for me. I ended up spending some time with her. She took me through an elaborate journey through time, showing me pictures of her in her prestine white uniform and white hat with patients and even at State captiol advocating for home care.

She expressed her unhappiness of other agency nurse aides that have taken care of her and how they seem not to care about her or her personal items. So after an hour or so goes by I started to finish my work so I could leave. She very talkative at this point and thanked me for she said it made her believe in nurse aides again. She spoke about how they would come in and throw her

things around, not putting them BACK where they were. As she was talking I was making her bed and I noticed she had a deck of cards, hair, net, a note book, compression stockings and jewelry. I could tell jewelry was custom and of no monetary value but obviously a sentimental one. I asked her do you play cards, I was just wondering because she was partially blind. She said no, but please put every thing back the way I had it under my pillow when you complete my bed. No problem I said and let me know if anything is out of place. After I said my goodbyes, I learned the next morning she called in to my agency requesting me and giving me a plenty of praises. Although I never found out the significance of the playing cards and jewelry, I knew that they meant a lot to her and that was enough for me.

Maintain a safe environment. Again remember the residents room is their domain and home. It is the Nurse Aides Role maintaining a safe environment for resident not just their room but throughout the entire facility. Make sure they have an unobstructed path, wipe up spills quickly per facility policy. Place wet floor signs down, **DO NOT MOVE FURNITURE OR WALKING AIDES FROM THEIR NORMAL SPOT UNLESS REQUESTED BY RESIDENT.** For instance lets say a patient is used to getting up at night to use the restroom or even their bedside commode and you moved a cabinet or the bedside commode. When the resident reached for it and its not there what do you think may happen. If you guessed they have a very high risk of a fall, your correct. And **ALWAYS PROVIDE A CALL LIGHT, IT MUST BE WITHIN EASY REACH.** Making sure the resident bed is in lowest position before you leave, Use siderails as ordered. Only let down the siderail that you are working on. if you let down the side rail **DO NOT LEAVE OR TURN YOUR BACK ON YOUR RESIDENT, PUT THE SIDE RAIL BACK UP.**

CARE OF THE RESIDENTS ENVIRONMENT cont'

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Cleanliness of a residents environment is a team effort. if you see a bed unmade or trash cans full in a residents room that is not yours, by all means clean up. To control of odors; first don't mask the smell with air freshener. Make sure you toilet residents in timely manner and when they call. Clean briefs promptly and dispose of them into bin in soiled linen closet. A residents environment should be comfortable and needed items should be conveniently placed for safety and dignity.

How to make an unoccupied bed

Prepare

Always place needed items close to the you and bed. Check the residents bed to find out what they have on their bed before you begin.

Gather:

Clean sheets and pillow cases.

An extra folded sheet or a drawsheet, and or incontinent pad, or disposable waterproof pads.

Gloves are needed because you will take off dirty lined and clean off bed.

Plastic bags for the dirty linens.

Blanket and or Bedspread.

trash can

Start by locking wheels of bed. If needed move bed away from wall and then lock wheels.

Raise bed to proper or comfortable working height. Make bed flat (supine) by lowering the head of the bed (HOB) and foot of bed so the bed is flat.

Put on gloves to keep from getting urine, bowel movement (BM), or other body fluids on your hands. removing dirty sheets.

Remove comforter, blankets one at a time, if not soiled and reusable , place in semi clean like a clean chair

Remove the pillowcases from the pillows by the inside out method such as peeling the pillow slip down like a banana. place pillow in semi-clean area, such as recliner along with pillow if not soiled.

YOU MUST REMOVE LINENS ONE PIECE AT A TIME to Check the bed for items such as the person's glasses, dentures, hearing aides and put them in a safe place or take to resident.

Take the dirty sheets off the bed and put them in the plastic bag or laundry bag. first roll top sheet away from you, then roll in the draw sheet or incontinent pad, if disposable pad - throw away, last bottom sheet.

Do not shake the sheets to keep from spreading germs or contaminating clean linens.

Change gloves before you touch clean linens.

Put bottom sheet in the middle of the mattress. If the bottom sheet is fitted, fix the corners of the sheet on the side of the mattress nearest you. If the sheet is flat, mitter the corners; tuck the top part of the sheet under the mattress and do the following for the corners. Lift the hanging top side of the sheet from the corner of the mattress. Hold it at an angle of about 12 inches (30 cm) away from the mattress and form a triangle. Pull the triangle with one hand and with a finger from your other hand form a corner. Rest the part of the sheet with the triangle on top of the bed. With both hands tuck the sheet hanging near the corner under the mattress. Let the triangle hang straight on the side and tuck it under the mattress. Repeat the above steps for the other corner.

Put the drawsheet (if used) with the center fold in the middle of the bed. Tuck the rest of the drawsheet under the mattress on both sides. This sheet is used to move the person in bed.

Put the top sheet with the center fold along the middle of the bed. Line up the wide hem of the sheet with the top part of the mattress.

Put the bedspread over the top sheet with the center fold along the middle of the bed. Tuck the top sheet and the bedspread under the foot of the mattress, unless comforter is fitted.

Pull the top linens at the foot of bed to make a pleat of about 3 inches. This allows room for the person's feet to move and avoids skin sores or foot drop.

Change the pillowcases and fluff up the pillows by folding the top of pillow in half place inside of the opening- with tag inside. Make sure bed looks neat with seems lined up correctly.

After changing the bed place bed back against wall, Lock the wheels of the bed. Lower the bed enough so the person can safely get back in bed.

Help the person back in bed and make sure he is in a comfortable position. If necessary, raise the side rails. Take the dirty linens to the laundry area. Remove and put away all other items used..

Put call light on bed, easily accessible to resident.

Place bedside table with residents desired items on it, such as phones, water, literature, etc

How to make an occupied bed

Perform all the beginning steps of the unoccupied bed procedure

For resident's comfort, leave pillow under head and a clean top sheet or bath blanket in place

let siderail down on the side you are working on

Wear gloves when handling soiled linens, then discard gloves and wash hands, apply clean gloves

Loosen and roll all dirty bottom linens, one at a time and roll under resident

then discard gloves and wash hands, put on clean gloves before you touch clean linen

Secure bottom sheet (mitered-flat or elastic fitted) with minimal wrinkles on side you rolled dirty under resident

If necessary, secure a draw sheet (with minimal wrinkles) and tuck in sides

Flatten the rolled sheets and help the resident roll over the linen, by requesting the resident to grasp the siderail.

Raise the rail and go to the opposite side and lower the rail

Remove dirty linens; place in linen bag (at foot of bed in plastic bag or on wheel chair or chair w/barrier)

Pull clean bottom linens towards you and secure with minimal wrinkles

Center and comfortably align resident, then raise the rails

Cover resident with clean top sheet. They can hold it as you remove dirty one

Change pillow case

Place blanket/spread over top sheet and miter them at foot of bed; make toe pleat

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

Wear gloves to dispose of linens in hamper. Remove gloves and wash hands

perform all the closing steps of the unoccupied bed procedure

CARE OF THE RESIDENTS ENVIROMENT cont'

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ASSISTING RESIDENTS WITH BATHING

The Nurse Aide must promote residents' rights, privacy, independence and preferences in personal care. Such as closing doors, curtains, allowing personal choices to be made; what resident wants to wear that day; from color of clothing, jeans vs sweats pants or skirt vs dress, additional clothing; weaters, scarfs etc, jewlery/accessories; watch, eye glasses, a necklace, bracelets. Even the time they perfer to take their bath or need care.

Use bath time to give all personal care and to communicate with residents and to make observations. This is "your time to shine" bathing the resident is the perfect time to encourage resident to communicate. You may find out the resident has been abused verbally or physcially, or how happy they are, you may discover pressure sores, skin tears, open wounds, bruises, moles, redness, inflammation. It's very important to check the heels for redness, mushy, open sores, ulcers. Please report all abnormal observations/findings to charge nurse as soon as you have resident in safe condition or pull shower call light.

Before begining care tell the resident what you are going to do step by step and while you are doing it it as well.

ROLE OF THE NURSE AIDE IN ASSISTING RESIDENTS WITH BATHING

How to give a Shower Bath

PLEASE NOTE: You can imagine it can be very difficult to depend on someone else to perform your personal hygiene. Making sure your body language supports positivity, an engaging personality, and a smile would certainly make it less difficult.

BEGINNING STEPS include, COMMUNICATION; social, therapeutic, questioning, comfort and reassuring, explaining every step before and during care. GATHER: Wash cloths, Large towels, bath blanket, residents clothes, personal toiletries such as deodorant, perfume, cologne, undergarments; bras, t-shirts, briefs, socks, shoes.

Take resident to shower in wheel chair or clean shower chair. (Clean shower area and shower chair using facility approved disinfectant spray, following policy. This Reduces pathogens and prevents spread of infection)

Put on gloves and offer toileting, assist as indicated.

Help resident remove clothing if in room. If resident can stand encourage them to use grab bars for assistance in standing

Please drape resident with bath blanket or shower drapes, this maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm

TURN ON WATER so it came warm up while you prepare resident for shower

Nurse aides should put on shower shoes as required by facility - this helps maintain balance in slippery floors when wet.

Take off residents clothes or only brief if clothes were removed in room.

Remove any hearing aides, glasses, jewelry and put in safe place preferably a cabinet

Take or assist resident into shower LOCK WHEELS (chair may slide if resident attempts to get up or move) PLACE A TOWEL UNDER THEIR BARE FEET

HAVE RESIDENT CHECK WATER TEMPERATURE. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature. Make sure you bring their arm out and away from body when checking temperature.

LET and ENCOURAGE RESIDENT TO WASH AS MUCH AS POSSIBLE, STARTING WITH FACE - this Encourages resident to be independent

Wash or Help resident shampoo and rinse hair, make sure resident places clean towel over eyes, more than likely residents will be able to lean head down than backwards, so the towel may prevent water and soap going into eyes

STAY WITH RESIDENT DURING PROCEDURE this Provides for resident's safety.

wash rinse and dry residents from head to toe with pericare being last USING A NEW WASH CLOTH FOR PERI CARE (see peri care in our section after Bed Bath)

GIVE RESIDENT TOWEL AND ASSIST TO PAT DRY, Patting dry prevents skin tears and reduces chaffing

Take or Assist resident out of shower

Help resident dress, comb hair and return to room 11. Combing hair in shower room allows resident to maintain dignity

when returning to room. Remember to put non skid sock or socks and shoes on resident before they stand.

DO CLOSING STEPS; cleaning shower chair, placing soiled linen and trash in appropriate containers. Finish grooming, mouth care, shaving in room - this will free up shower stall for other residents.

Complete Bed Bath

DO INITIAL STEPS as above in the shower. Gather all your necessary items (towels, toiletries, clothing, undergarments or briefs) before you get your water, so it wont get cold before you start.

Offer resident urinal or bedpan this reduces chance of urination during procedure which may cause

discomfort and embarrassment.

Cover resident preferably with bath blanket or clean sheet this maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.

Remove resident's gown by placing bath blanket or clean sheet over dirty gown and rolling it down underneath bath blanket or clean sheet .

FILL BATH BASIN WITH WARM WATER AND HAVE RESIDENT CHECK WATER TEMPERATURE. You may choose to use two basins one for wash and one for rinse.

Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature so you may have to wet the towel and place it on their forearm for testing. Adjust temperature accordingly.

Put on gloves you never know If resident has open lesions or wounds or may have or have had a BM (bowel movement) or void, this protects you from contamination by bodily fluids

Now fold washcloth and wet in clean water without soap. **GENTLY WASH EYE FROM INNER CORNER OUT. USING A DIFFERENT PART OF CLOTH WASH OTHER EYE** this helps prevent eye infections.

Always wash from cleanest to dirtiest, Using separate area of cloth reduces contamination

WET WASHCLOTH AND APPLY SOAP TO TOWEL, IF REQUESTED. WASH, RINSE AND PAT DRY FACE (please ask resident if they want soap on face normally they do not) **NECK, EARS AND BEHIND EARS,** Patting dry prevents skin tears and reduces chaffing

PLACE TOWEL UNDER FAR ARM this Prevents linen from getting wet. **WASH, RINSE AND PAT DRY HAND, ARM, SHOULDER AND UNDERARM.** **DO NOT** put too much soap on your towel this may cause to much soap left on the skin which may cause itching and irritation

REPEAT STEPS ON OTHER ARM

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BED BATH CONTINUES

PLACE TOWEL OVER CHEST AND ABDOMEN. LOWER BATH BLANKET TO WAIST this maintains resident's right to privacy. LIFT TOWEL AND WASH, RINSE AND PAT DRY CHEST AND ABDOMEN (and sides of upper chest and abdomen so when you turn resident over you will only have the middle of the back to clean this prevents additional turning. Please observe residence skin under breasts and folds of abdomen skin, umbilicus.

ALWAYS remember never to overexpose, only expose the areas of the body necessary to do the procedure, this maintains resident's dignity and right to privacy. Pull up bath blanket and remove towel

PLACE TOWEL UNDER FAR LEG this Prevents linen from getting wet

WASH, RINSE AND PAT DRY LEG AND FOOT again paying close attention to heels and between toes, Always tell a patient you are washing feet and toes for they may be very painful. REPEAT WITH OTHER LEG AND FOOT. Clean and trim toenails per facility policy.

Turn resident on side, if resident can help have resident grasp side rails or get some assistance

WASH, RINSE AND PAT DRY FROM NECK TO end of BACK not touching buttocks for this is a dirty area

Turn resident back into supine to PROVIDE PERINEAL CARE (see in next subject)

CHANGE BATH WATER AND GLOVES. USE CLEAN WASHCLOTH AND TOWEL OR WIPES OR PERI WASH AND A CLEAN TOWEL. (PERI WIPES AND WASH are considered wash and rinse so you would dry next)

Turn resident on side, if resident can help have resident grasp side rails or get some assistance and wash rinse and dry anal area and buttocks

change gloves and place or help resident put on clean gown

DO FINAL STEPS including Applying deodorant to underarms and lotion to dry skin. Remove excess lotion. do not put lotion between toes this may cause too much moisture which may cause breakdown, fungus, increased bacteria

PERINEAL CARE

Additional supplies as needed if heavy soiling is present. Remove heavy soiling prior to perineal care.

BEGINNING STEPS . Lower head of bed and position the resident on their back (SUPINE) with legs flexed

Always wash from cleanest to dirtiest

Offer resident urinal or bedpan- Reduces chance of urination during procedure which may cause discomfort and embarrassment, and running water may induce sensation to urinate. (see bed pan procedure)

Place waterproof pad and or towel or incontinent pad slightly under resident's hips just enough to Prevent linen from getting wet.

DRAPE RESIDENT Maintains resident's right to privacy by not exposing body this Keeps resident warm

FILL CLEAN WASH BASIN WITH comfortably WARM WATER AND HAVE RESIDENT CHECK WATER TEMPERATURE TO VERIFY COMFORT OF WATER.

PUT ON GLOVES PRIOR TO CLEANING GENITAL AREA and placing barrier between legs, this Protects you from contamination by bodily fluids

ASSIST RESIDENT SPREAD LEGS AND LIFT KNEES IF POSSIBLE to Expose perineal area

WET AND SOAP FOLDED WASHCLOTH, Folding creates separate areas on cloth to reduce contamination

IF RESIDENT HAS CATHETER, DRAIN FIRST. CHECK FOR LEAKAGE, SECRETIONS OR IRRITATIONS. GENTLY WIPE FOUR INCHES OF CATHETER FROM MEATUS OUT. Washes pathogens away from the meatus

HOLDING AT THE CATHETER MEATAL JUNCTURE, this helps support catheter placement

WIPE FROM FRONT TO BACK AND FROM CENTER OF PERINEUM TO THIGHS. CHANGE WASHCLOTH WITH EACH STROKE.

FOR FEMALES:

SEPARATE LABIA. WASH URETHRAL AREA FIRST from clean to dirty by WASHING downward the middle of the labia from meatus down then the right and left inner side of labia, the outside of the labia the from pubic/pelvic area downward between groin areas. USING A DIFFERENT PART OF WASHCLOTH FOR EACH STROKE- Females: Removes secretions in skin folds which may cause infection and odor.

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FOR MALES:

A. PULL BACK FORESKIN IF MALE IS UNCIRCUMCISED. Removes secretions from beneath foreskin which may cause infection and odor. WASH AND RINSE THE TIP OF PENIS USING CIRCULAR MOTION BEGINNING AT URETHRA

CONTINUE WASHING DOWN THE SHAFT OF THE PENIS TO THE SCROTUM AND GROIN/INNER THIGHS Prevents spread of infection

USE A CLEAN TOWEL TO RINSE

RINSE AREA THOROUGHLY IN THE SAME DIRECTION AS WHEN WASHING

Water used during washing contains soap and pathogens. Soap left on the body can cause irritation and discomfort

GENTLY PAT AREA DRY IN SAME DIRECTION AS WHEN WASHING If areas are left wet, pathogens can grow more quickly. Patting dry prevents skin tears and reduces chaffing and preventing skin maceration.

BE SURE TO TO PUTT SKIN SKIN BACK IN PLACE or a condition called Paraphimosis can happen, which is an uncommon medical condition where the foreskin becomes trapped behind the glans penis, and cannot be reduced (pulled back to its normal flaccid position covering the glans penis). If this condition persists for several hours or there is any sign of a lack of blood flow, paraphimosis should be treated as a medical emergency, as it can result in gangrene.

TAKE TOWEL OUT Assist resident to turn onto side away from you. PLACE SAME TOWEL UNDER BUTTOCKS

WET AND SOAP WASHCLOTH CLEAN ANAL AREA FROM FRONT TO BACK. RINSE AND PAT

DRY THOROUGHLY Prevents spread of infection and skin maceration

REMOVE PAD, ASSIST RESIDENT TO TURN ONTO BACK AND PLACE BRIEF OR UNDERGARMENTS ON RESIDENT. CONTINUING TO AVOID EXPOSURE. REMOVE GLOVES AND WASH HANDS.

DO CLOSING STEPS- clothing, mouth or denture care. reporting. Place signaling device within reach and bed in low position. Inform resident when finished and ask if anything is needed before you go.

Remember The role of a nurse aide in Bathing and Perineal Care is Providing assistance or total support bathing which is a very sensitive personal care activity for the resident.

Nurse aide will clean residents body from head to toe.

If resident can assist encourage them to clean as much as they can.

Perineal care (meaning the genital and anal (rectum) area, or “private parts.”)

Bathing helps prevent body odor, discomfort, and infection. Remember, good personal hygiene is important to promoting good health.

Use standard precaution including wearing gloves

SKIN CARE

Skin changes associated with aging, certain medical conditions and other chronic illnesses

Skin is the body's largest organ. About six pounds of skin cover eighteen square feet on an average adult.

Your skin does many things. The top layer of skin is called the epidermis. It protects the underlying skin layers from the outside environment and contains cells that make keratin, a substance that waterproofs and strengthens the skin. The epidermis also has cells that contain melanin, the dark pigment that gives skin its color. Other cells in the epidermis allow us to feel the sensation of touch and provide the body with immunity against foreign invaders like germs and bacteria.

The very bottom layer of the skin is the hypodermis. It contains the fat cells, or adipose tissue, that insulate the body and help it conserve heat. The layer between the epidermis and the hypodermis is the dermis. It contains the cells that give skin strength, support, and flexibility. As a person ages, the cells in the dermis lose their strength and flexibility, causing the skin to lose its youthful appearance.

Located in the dermis are sensory (NERVE) receptors. They allow the body to receive stimulation from the outside environment and experience pressure, pain, and temperature and fluid and electrolyte balance. Small blood vessels provide the skin with nutrients, and remove its waste products.

Sebaceous glands produce the oil in the skin, which keeps it from drying out. The oil from the sebaceous glands also helps to soften hair and kill bacteria that get in the skin's pores. These oil glands are all over the body, except on the palms of the hands and the soles of the feet.

Aging changes in the skin are a group of common conditions and developments that occur as people grow older.

Skin changes are among the most visible signs of aging. Evidence of increasing age includes wrinkles and sagging skin. Whitening or graying of the hair is another obvious sign of aging.

Although skin has many layers, it can be generally divided into three main parts:

- The outer part (epidermis) contains skin cells, pigment, and proteins.
- The middle part (dermis) contains blood vessels, nerves, hair follicles, and oil glands. The dermis provides nutrients to the epidermis.
- The inner layer under the dermis (the subcutaneous layer) contains sweat glands, some hair follicles, blood vessels, and fat. Each layer also contains connective tissue with collagen fibers to give support and elastin fibers to provide flexibility and strength.

With aging, the outer skin layer (epidermis) thins.

A number of pigment-containing cells decreases, but the remaining melanocytes increase in size. Aging skin thus appears thinner, more pale, and clear (translucent).

Large pigmented spots (called age spots, liver spots, or lentigos) may appear in sun-exposed areas.

Changes in the connective tissue reduce the skin's strength and elasticity. This is known as sun-exposed areas, It produces the leathery, weather-beaten appearance.

The blood vessels of the dermis become more fragile. This leads to bruising, bleeding under the skin (often called senile purpura), and similar conditions.

Sebaceous glands produce less oil as you age. Men experience a minimal decrease, usually after the age of 80. Women gradually produce less oil beginning after menopause. This can make it harder to keep the skin moist, resulting in dryness and itchiness.

The subcutaneous fat layer thins, reducing its normal insulation and padding. This increases your risk of skin injury and reduces your ability to maintain body temperature. Because you have less natural insulation, you can get hypothermia in cold weather.

Some medications are absorbed by the fat layer, and loss of this layer changes the way that these medications work.

The sweat glands produce less sweat. This makes it harder to keep cool, and you are at increased risk for becoming overheated or developing heat stroke.

Growths such as skin tags, warts, and other blemishes are more common in older people.

EFFECT OF CHANGES

As you age, you are at increased risk for skin injury. Your skin is thinner, more fragile, and the protective subcutaneous fat layer is lost. In addition, your ability to sense touch, pressure, vibration, heat and cold may be reduced. Thus, your skin is at higher risk for injury. Rubbing or pulling on the skin can cause skin tears. Fragile blood vessels are easily broken. Bruises, flat collections of blood (purpura), and raised collections of blood (hematomas) may form after even a minor injury. This is most easily seen on the outside surface of the forearms, but can occur anywhere on the body. Skin changes and loss of subcutaneous fat, combined with a tendency to be less active, as well as some nutritional deficiencies and other illnesses contribute to pressure ulcers.

Aging skin repairs itself more slowly than younger skin. Wound healing may be up to 4 times slower. This contributes to pressure ulcers and infections. Diabetes, blood vessel changes, lowered immunity, and similar factors also affect healing.

COMMON PROBLEMS

Skin disorders are so common among older people that it is often difficult to tell normal changes from those related to a disorder. More than 90% of all older people have some type of skin disorder.

Skin disorders can be caused by many conditions, including:

- Blood vessel diseases such as arteriosclerosis
- Diabetes
- Heart disease
- Liver disease
- Nutritional deficiencies
- Obesity
- Reactions to medications
- Stress

Other causes of skin changes:

- Allergies to plants and other substances
- Climate
- Clothing
- Exposures to industrial and household chemicals
- Indoor heating

Sunlight can cause:

- Loss of elasticity (elastosis)
- Noncancerous skin growths (keratoacanthomas)
- Pigment changes such as liver spots
- Thickening of the skin

Sun exposure has also been directly linked to skin cancers, including basal cell cancer, squamous cell carcinoma, and melanoma.

PREVENTION

Because most skin changes are related to sun exposure, prevention is a lifelong process.

- Increased fluids. • Increased fluids Prevent sunburn if at all possible.
- Use of lotions and moisturizers • Good nutrition.
- Wear protective clothing and hats as necessary • nutrients, vitamins and minerals as necessary.

Good nutrition and adequate fluids are also helpful. Dehydration increases the risk of skin injury. Sometimes minor nutritional deficiencies can cause rashes, skin lesions, and other skin changes, even if you have no other symptoms. Keep skin moist with lotions and other moisturizers. Do not use soaps that are heavily perfumed. Bath oils are not recommended because they can cause you to slip and fall. Moist skin is more comfortable and will heal more quickly.

Skin Care Cont'

Key Terms and Definitions:

Cells-Basic building blocks of the body. The “bricks” that make up the wall that we call a body.

Tissue-A group of cells that work together. Skin, muscle, and nerves are examples.

Bony Prominences-Bony areas of the body that have a thin covering of skin and little protective fat.

Ulcer-A defect or hole in tissue caused by shedding of inflamed, dead cells.

Nutrient-Substances in food that are necessary for cell growth and repair.

Oxygen-A colorless, odorless gas necessary for life.

Pressure Ulcer/Bedsores/Decubitus ulcer-A local ulcer of skin tissue or deeper structures that occurs when nutrient and oxygen flow are impaired to an area due to prolonged pressure.

Bacteria-Can cause disease by producing substances that inflame body areas.

A pressure ulcer occurs when skin tissue breaks down due to lack of blood flow that carries nutrients and oxygen to the skin cells. All body cells need the constant supply of nutrients and oxygen that blood flow brings. Skin tissue covering bony prominence with little protective fat can experience a decrease in blood flow, and therefore nutrients and oxygen, when trapped between a bony prominences or bony areas of the body such as the heel, ankles, hips or buttocks and a poorly chosen support surface. Bacteria can invade the area and infections will develop.

People most at risk of bedsores are those with a medical condition that limits their ability to change positions, requires them to use a wheelchair or confines them to a bed for prolonged periods. Bedsores can develop quickly and are often difficult to treat.

The pressure ulcer formation process is:

Pressure causes....

Decreased blood flow to trapped skin due to flattened small vessels causes...

Decreased nutrients and oxygen to cells causes....

Cellular death causes....

Shedding of dead skin cells causes....

Ulcer begins

Bacteria invades

Infection may form causes

The ulcer deepens causes....

Underlying structures such as muscle and bone become involved

uncontrolled infection can involve the whole body (sepsis)

Common sites of pressure areas and skin breakdown

In Wheel chair:

Tailbone or buttocks

Shoulder blades and spine

Backs of arms and legs where they rest against the chair

Residents confined to a bed:

Back or sides of the head

Rim of the ears

Shoulders or shoulder blades

Hip, lower back or tailbone

Heels, ankles and skin behind the knees

Bedsore fall into one of four stages based on their severity. The National Pressure Ulcer Advisory Panel, a professional organization that promotes the prevention and treatment of pressure ulcers, has defined each stage as follows.

Stage I The beginning stage of a pressure sore has the following characteristics:

The skin is intact.

The skin appears red on people with lighter skin color, and the skin doesn't briefly lighten (blanch) when touched.

On people with darker skin, there may be no change in the color of the skin, and the skin doesn't blanch when touched. Or the skin may appear ashen, bluish or purple.

The site may be painful, firm, soft, warmer or cooler compared with the surrounding skin.

Stage II ulcer is an open wound:

The outer layer of skin (epidermis) and part of the underlying layer of skin (dermis) is damaged or lost.

The pressure ulcer may appear as a shallow, pinkish-red, basin-like wound.

It may also appear as an intact or ruptured fluid-filled blister.

Stage III At this stage, the ulcer is a deep wound:

The loss of skin usually exposes some amount of fat.

The ulcer has a crater-like appearance.

The bottom of the wound may have some yellowish dead tissue (slough).

The damage may extend beyond the primary wound below layers of healthy skin.

Stage IV ulcer exhibits large-scale loss of tissue:

The wound may expose muscle, bone and tendons.

The bottom of the wound likely contains slough or dark, crusty dead tissue (eschar).

The damage often extends beyond the primary wound below layers of healthy skin.

ROLE OF THE NURSE AIDE IN PREVENTING SKIN BREAKDOWN

Inspection of the skin should be a part A Nurse Aides routine especially anyone who is confined for a long time to a wheelchair or bed or for anyone who has limited ability to reposition himself or herself. Contact your Charge Nurse right away if you notice any signs or symptoms of a pressure ulcer; signs of infection, such as fever, drainage or foul odor from a sore, or increased heat and redness in the surrounding skin.

1. Keep skin, bedding and clothing clean and dry
2. Use skin moisturizers and creams sparingly
3. Provide frequent change of position according to patient plan of care
4. Avoid trauma, friction or shearing
5. Encourage proper hydration and nutrition
6. Use of special devices to prevent skin breakdown according to individual's plan of care
 - a) Special mattresses
 - b) Pads
 - c) Off load heels

Careful observation, early reporting and documentation

Prevention

Bedsore are easier to prevent than to treat, but that doesn't mean the process is easy or uncomplicated. And wounds may still develop with consistent, appropriate preventive care.

Your Nursing team and other members of the health care team will help develop a strategy that's appropriate called a Care Plan.

Position changes are key to pressure sore prevention. These changes need to be frequent, repositioning every 2 hours helps to avoid stress on the skin, and body positions need to minimize the risk of pressure on vulnerable areas. Other strategies include skin care, regular skin inspections and good nutrition.

Repositioning in a wheelchair includes the following recommendations:

Frequency. People using a wheelchair should change position as much as possible on their own every 15 minutes and should have assistance with changes in position every hour. **Specialized wheelchairs.** Pressure-release wheelchairs, which tilt to redistribute pressure, provide some assistance in repositioning and pressure relief. **Cushions.** Various cushions — including foam, gel, and water- or air-filled cushions — can relieve pressure and help ensure that the body is appropriately positioned in the chair. A physical therapist can advise on the appropriate placement of cushions and their role in regular repositioning.

Other strategies that can help decrease the risk of pressures sores include the following:

proper nutrition, dietitian or other members of the care team can recommend dietary changes that can help improve the health of a residence skin. Such as high protien diets/shakes.

Skin careProtecting and monitoring the condition of the skin is important for preventing pressure sores and identifying stage I sores before they worsen.

Repositioning for a person confined to a bed includes the following recommendations:

- **Diet.** calories, protein, vitamins and minerals may need to be increased. The doctor may also prescribe dietary supplements, such as vitamin C and zinc.
- **Fluids.** Promote adequate hydration is important for maintaining healthy skin. Your Charge Nurse can advise on how much fluid to drink and signs of poor hydration, such as decreased urine output, darker urine, dry or sticky mouth, thirst, dry skin, or constipation.
- **Feeding assistance.** Some people with limited mobility or significant weakness may need assistance with eating in order to get adequate nutrition.
- **Bathing.** Skin should be cleaned with mild soap and warm water and gently patted dry. Or a no-rinse cleanser can be used.
- **Protecting skin.** Skin that is vulnerable to excess moisture can be protected with talcum powder. Dry skin should have lotion applied.

- Inspecting skin. Daily skin inspection is important for identifying vulnerable areas of skin or early signs of pressure sores. Care providers usually need to help with a thorough skin inspection, but people with more mobility may be able to inspect their skin with the use of a mirror.
- Managing incontinence. (involuntary leakage of urine or bowel) Urinary or bowel incontinence should be managed to prevent moisture and bacterial exposure to skin. Care may include frequently scheduled assistance with urinating, frequent diaper changes, protective lotions on healthy skin, urinary catheters or rectal tubes.
- Bed elevation. Hospital beds that can be elevated at the head should be raised no more than 30 degrees to prevent shearing.
- Protecting bony areas. Bony areas can be protected with proper positioning and cushioning. Rather than lying directly on a hip, it's best to lie at an angle with cushions supporting the back or front. Cushions should also be used to relieve pressure against and between the knees and ankles. Heels can be cushioned or "floated" with cushions below the calves.
- Frequency. Repositioning should occur every two hours.
- Repositioning devices. People with enough upper body strength may be able to reposition themselves with the assistance of a device such as a trapeze bar. Using bed linens to help lift and reposition a person can reduce friction and shearing.
- Special mattresses and support surfaces. Special cushions, foam mattress pads, air-filled mattresses and water-filled mattresses can help a person lie in an appropriate position, relieve pressure and protect vulnerable areas from damage. Your doctor or other care team member can recommend an appropriate mattress or surface.

Complications

- Sepsis. Sepsis occurs when bacteria enters your bloodstream through the broken skin and spreads throughout your body — a rapidly progressing, life-threatening condition that can cause organ failure.
- Cellulitis. This acute infection of your skin's connective tissue causes pain, redness and swelling, all of which can be severe. Cellulitis can also lead to life-threatening complications, including sepsis and meningitis — an infection of the membrane and fluid surrounding your brain and spinal cord.
- Bone and joint infections. These develop when the infection from a pressure sore burrows deep into your joints and bones. Joint infections (septic or infectious arthritis) can damage cartilage and tissue, and bone infections (osteomyelitis) may reduce the function of your joints and limbs.
- Cancer. Another complication is the development of a type of squamous cell carcinoma that develops in chronic, nonhealing wounds (Marjolin ulcer). This type of cancer is aggressive and usually requires surgical treatment.
- Friction and Shearing
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- What is the difference between friction and shear?
- Friction and shear are forces that can come into play when a person has limited mobility. They can, and often do, contribute to the development of pressure ulcers.
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- So, what are they?
- First of all, keep in mind that it is not possible to have shear without friction, but it is possible to have friction without shear.
- Shear is a combination of friction and gravity. For example, if you raise the head of the bed of a patient, the structures under the skin (organs, muscle, bones) are pulled down by gravity, while the skin sticks to the surface due to friction. This causes tremendous pressure in the sacral/coccyx area (tailbone and the area just above the

tailbone), and when the skin opens up, there is more damage than the opening would indicate, often with undermining (tissue damage under the skin that makes ledges of skin along the borders of the wound).

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- Shear is prevented by keeping the head of the bed as low as possible.
- When I worked at a hospital and was the infection control practitioner AND the wound/ostomy nurse, I felt torn when I went into the ICU and saw patients on vents. The infection control nurse wanted the head of the bed up. The wound nurse wanted the head of the bed down!
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- So then, what is friction?
- Friction is caused by dragging the skin across the surface and only damages the epidermal and upper dermal skin layers, like with a “sheet burn.” It is prevented by having the patient assist as much as possible when moving in bed, or using two caregivers and a lift sheet to avoid dragging across the bed.

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HYGIENE AND GROOMING

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- **Personal hygiene** is keeping the body clean, and helps prevent the spread of germs. it also promotes physical and emotional well-being. The most important aspect of maintaining good health is good personal hygiene such bathing and showering, hair, fingernail, foot, genital and dental care. **Grooming** is caring for fingernails and hair examples of these activities would be styling hair, shaving, trimming and painting fingernails.

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- The Role of the Nurse Aide is to support residents to be more independent. Very few residents are able to bathe, shave, dress, and otherwise take care of themselves with no support. Most residents will need assistance or support to complete their personal care activities. Depending on the abilities of each resident, the Nurse Aide will need to provide more or less support. It is important to remember that promoting independence by allowing residents to make choices is a key to leading a healthy happy life. Give residents the opportunity to make choices about what clothes they want to wear and what to eat; they need to have the choice of how and when they complete their personal care activities. For example, one residents might like to bathe at night, while another likes to shower in the morning. Having choices about personal care also involves letting the individual make choices about whom or which will provide the personal care. Residents also have the right to choose the Nurse Aidethe they trust, feel comfortable, and safe with to assist with personal care. If your a new hire, you should develop a relationships with the residents before providing personal care. This may mean that giving the resident the choice to wait until the next day to shower after meeting with them. The Nurse Aide needs to be aware of these individual preferences and support them.

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Hair Grooming

- Having clean, well groomed hair is important to everyone, and is no less so for your residents. Residents may like different brands of shampoo or conditioner or have a preferred style. Residents may also go to beauty shop once or twice a week. All of these

choices should be respected and supported. Ask the individual if he or she has a preference for his or her hair style today. Teach and assist with drying wet hair with dryer and applying gels, hair spray, and other hair products as appropriate. If hair is long, divide into sections before combing or brushing. Teach and assist the individual to comb or brush hair from scalp to ends of hair. If the hair is tangled or curly, gently start at the ends of the hair to assure that all tangles are removed before brushing from the scalp to the ends. Encourage the resident to look in a mirror when finished styling. Having hair clean and groomed looks great, increases self esteem.

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• **FINGERNAIL CARE**

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- 1. Most residents need assistance with fingernail and foot care.
- 2. Nurse aides must not cut fingernails or toenails of resident with diabetes, circulatory impairment of the hands or feet, ingrown nails, infected nails, painful nails or nails that are too hard, thick or difficult to cut easily.
- 3. Nurse aides should always check care plan and follow the facility policy for fingernail and foot care. Some facilities do not allow nurse aides to cut nails or to clean nails with sharp objects such as nail files or orange sticks.
- 4. Nurse aides should always check the care plan and receive permission and instructions from the nurse prior to cutting fingernails and/or toenails.

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• **Fingernail and Toenail Care**

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- Germs often collect underneath the nails. It's a very important for residents to have Clean and trimmed fingernails and toenails for overall health. it also prevents germ or fungus buildup. Nails that become too long can scratch and cut an residents skin and may result in a local infection. Residents with diabetes should have their nail care
- completed by a health care professional like a Podiatrist. Fungus may cause
- inflammation, cracking, and peeling of the skin between the toes and must be treated as soon . nurse Aides must report this immediately . Its great when Nurse Aides take the time to paint nails with polish, moisturize and massage hands just like a manicure.

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• **TIPS ON CLEANING NAILS**

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- All nail supplies should be residents personal items such as nail clippers, orange sticks emesis basin, emery board
- the nails of hands and feet should be soaked water for at least 5 minutes and then washed hands or feet with soap.
- Soaking will soften the nails and make them easier to trim. nails They are made of a hard type of protein called keratin, which serves as a protector for your fingertips. taking care of your cuticles is important because it can lead to stronger, healthier nails. Also, if you neglect them, your cuticles can cause some problems, including painful infections.
- gently push nail cuticle back with orange stick , it also prevents hangnails.

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- Nurse Aides must clean under the nails (fingers or toes) with orange stick or tool on nail clipper for this purpose.
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- wash, rinse, and dry residents hands or feet. Please note: nail care does not need soapy water, unless needed. There are times when confused residents may have BM under fingernail , use standard precautions.
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- Nurse Aides should trim toe/ hand nails straight across. Fingernails can be trimmed with a slight curve. However Nurse Aides must use an emery board or nail file to shape and smooth the nails.
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- SHAVING
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- Please note shaving personal matter. There are cultural influences that play a important role in how a residents shaves. e.g. women may not shave their legs or underarms in some cultures or men don't shay their facial hair.
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- Tips
- **Safety is important while shaving.**
- When using an electric shaver Nurse Aides should not use in a room with oxygen in use Electric razors should not be used around water, no use of shaving cream, do not use water to soften beard. Again, water around an electric razor can cause injury or death by electric shock. Make sure there are no chips or rust on the blades or razors.
- Always dispose of used razor blades. they are disposable - RAZORS ARE CONSIDERED SHARPS SO DISPOSE OF THEM IN A BIOHAZARD SHARPS CONTAINER.
- ONLY Use the residents personal razor.
- Demonstrate how running one hand over the shaved area can locate missed hair.
- assist the residents to wash, rinse, and dry his or her hands after
- If residents can shave Nurse Aides should encourage the resident to do as much for him or herself as possible. However the resident must supervise closely for safe and correct handling this promotes independence.
- The individual should be comfortable and sitting or standing securely.
- Nurse Aides must check residents skin for moles, birthmarks, or cuts. Shaving over these areas may cause cuts so SHAVE AROUND THEM.
- Shaving over these areas can cause bleeding and infection. If any changes are observed in the size, shape, or color of a mole or birthmark, report to the Charge nurse it may indicate illness.
- Taking pride in completing personal care skills increases self-esteem.
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- Disposable razor

- **Using warm water or soapy warm water removes oil and bacteria from the skin and helps to raise the hair shafts, opens pores, and softens the beard so it will be easier to shave.**
- apply shaving cream or lather with soap generously, Shaving cream softens the skin and helps the razor glide over the skin to prevent nicking and cutting.
- Nurse Aides must use standard precautions including gloves.
- Never do a one handed shave, use your fingers of one hand to hold the skin
- tight and shave with short downward strokes, in the direction the hair grows. Short strokes give better control of the razor and help prevent nicks and
- cuts.
- Notice if Nurse Aide is removing shaving cream when shaving this will indicate is Nurse Aide effective in removing hair- applying just enough pressure.
- Make sure you use a clean warm towel , leaving shaving cream can irritate and dry the skin.
- Some residents may want aftershave ,Alcohol in aftershave acts as an antiseptic for tiny nicks and cuts. It also has a cooling and refreshing sensation.
- Please note freshly shaven skin can be irritating.
- Nurse Aides should offer the individual a mirror to inspect a job well done, give praises
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- Nurse Aides must clean razor and storing all shaving items per facility and manufacture instructions

• Hydration

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- **Always check if resident is on I & O before giving fluids or discarding specimens.**
-
- Fluid intake includes all fluids taken in by mouth, tube feeding and IVs. Oral intake includes fluids given during medication passes and fluids on meal trays. Most facilities count semi-liquid foods as fluid intake such as ice creams, popsicles, gelatins and puddings.
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- Fluid output includes all urine, vomitus, liquid stool and other measurable output such as drainage from wounds, tubes.
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- The recommended minimum total fluid intake is 1500-2000ml, (equivalent to 6-8 250ml cups) a day. This comes from all sources including soups and beverages. Fluid intake must replace measurable losses (urine, faeces and occasionally others such as drain tubes) and insensible
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- Signs of dehydration include dry mucous membranes, reduced tissue turgor (elasticity), reduced sweating, sunken eyes, tachycardia, low blood pressure and postural blood pressure drop, altered consciousness including confusion, increasing functional impairment, weakness, constipation, reduced urine output and more concentrated (darker) urine. Unfortunately many of these signs are quite subjective, with no defined “normal” ranges, and thus poor positive and negative predictive values for the diagnosis of dehydration. Some of these signs can be present in other conditions – for instance, low blood pressure can be due to over treatment with medications that lower blood pressure,

in cardiac failure and when there is autonomic neuropathy. Indeed, over-reliance on low blood pressure as a sign may lead to over diagnosis of dehydration.

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- Risk Factors for Dehydration
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- POOR ORAL INTAKE; Inability to feed independently
- Refusing oral intake
- Poor access to fluids
- Oro-pharyngeal disease
- INCREASED FLUID LOSS
- Febrile Illness
- Diarrhea and vomiting
- Diuretics
- Illnesses increasing urine output
- unstable diabetes
- hypercalcaemia
- hypokalaemia
- Inadequate staff training / awareness of hydration
- Female gender
- Older age
- Greater number of medications
- Impaired functional status Dementia and other confusional states (Alzheimers)
- Greater number of illnesses/chronic conditions
-
- Prevention
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- Ensure all staff are adequately trained in the importance of hydration. Regularly offer fluids – e.g. every 1 1/2 hours by day.
- Offer fluids at specific routine events before;After showering or washing after toileting before, After physiotherapy or other activity program
- Medication rounds Regular hydration cart rounds
- Offer residents their preferred drinks
- Prompt residents to drink at meal times
- Ensure fluid is within residents' reach
- Educate families / visitors to offer fluids when visiting
- Encourage “wet” foods such as jelly, custard, yoghurt, ice cream, soup, pureed fruit
- Have a social hour where fluids are offered
- Keep a fluid intake chart especially for at risk residents
- Use a symbol such as a drop of water on trays of residents who need to drink more, to prompt staff.
- Measure urine specific gravity monthly
- Nurses may measure osmolarity, sodium and/or blood urea/creatinine ratio when bloods are being taken for other reasons.
- Identify at risk residents and pay more attention to them – e.g. confused, refusing fluids, febrile, on diuretics
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- There were four signs that were significantly and independently associated with Dehydration (hypernatraemia/low sodium) – 1. abnormal shoulder blade and 2. thigh area skin turgor, 3. dry oral mucosa and 4. recent changes in consciousness.

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- **Nutrition**

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- **Calcium and Vitamin D**

- Older adults need more calcium and vitamin D to help maintain bone health. Have three servings of vitamin D-fortified low-fat or fat-free milk or yogurt each day. Other calcium-rich foods include fortified cereals and fruit juices, dark green leafy vegetables and canned fish with soft bones. If you take a calcium supplement or multivitamin, choose one that contains vitamin D.

- **Vitamin B12**

- Many people older than 50 do not get enough vitamin B12. Fortified cereal, lean meat and some fish and seafood are sources of vitamin B12. Ask your doctor or a registered dietitian if you need a vitamin B12 supplement.

- **Fiber**

- Eat more fiber-rich foods to stay regular. Fiber also can help lower your risk for heart disease, control your weight and prevent type 2 diabetes. Eat whole-grain breads and cereals, and more beans and peas. Fruits and vegetables also provide fiber.

- **Potassium**

- Increasing potassium along with reducing sodium (salt) may lower your risk of high blood pressure. Fruits, vegetables and low-fat or fat-free milk and yogurt are good sources of potassium. Also, select and prepare foods with little or no added salt.

- **Know Your Fats**

- Foods that are low in saturated fats, *trans* fats and cholesterol help reduce your risk of heart disease. Most of the fats you eat should be polyunsaturated and monounsaturated fats. Check the Nutrition Facts panel on food labels for total fat and saturated fat.

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- **Variety of Foods**

- People of all ages need more than 40 nutrients to stay healthy. With age, it becomes more important that diets contain enough calcium, fiber, iron, protein, and the vitamins A, C, D and Folic acid. Reduce calories, select nutrient-dense foods, and enjoy smaller portions of foods high in fat, sugar and sodium. Because no one food or pill provides all of the nutrients, eat a variety of foods to get the full spectrum of nutrients.

- Variety often is lacking in the diets of seniors, who often eat the same foods over and over again. Get out of this food rut by trying some of these suggestions:

- • Eat breakfast foods for lunch or lunch foods for dinner.

- • Use color as a guide for variety in a meal. A good meal should provide three distinct colors on the plate.

- • Increase the variety of texture in meals. Add whole grain breads (rye, wheat, pumpernickel), whole grain cereals, and cooked legumes (beans of all types, lentils, dried peas).

- • Eat at least five servings of fruits and vegetables each day.
- • Build your diet as MyPyramid recommends

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- **Osteoporosis**

- Weight-bearing exercise and a diet high in calcium help protect against osteoporosis. Current treatments include estrogen replacement, exercise and calcium supplements. Suggestions:

- • Walk, lift weights, swim or enroll in a group fitness or water aerobics class. Exercise at least three times a week and have fun!
- • Include two to four daily servings of dairy products such as milk, yogurt or cheese.
- • If digesting milk is a problem, cultured dairy products, like buttermilk and yogurt, often are tolerated well. Use lactaid, available in most stores, to make reduced lactose milk.
- • Post-menopausal women may need a calcium supplement if they can't get enough through diet alone. Talk to a physician or registered dietitian.

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- **Healthy Eating for Seniors**

- There is so much confusion sometimes about what is good for you and what is not. In general, a good guideline is to stick to foods in their "whole" or natural state. The more a food looks like it did when it was picked, the better! Another good rule of thumb is to eat most of your calories from plant-based foods - nuts, grains, fruits, vegetables, and greens. It is not so much about subtracting the foods that are bad for us like candy and cakes; it is more about adding foods that are healthy and making healthy food the basis of our regular meals. Here are some ideas of what to add:

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- **Power Veggies**

- **Greens!** – get the organic kind. Apparently, dark leafy greens are often full of pesticides. Greens can be a wonderful late addition to soup for color and taste. Lightly wilted greens can also be added to omelets, stir-fry or casseroles.
 - • Kale can be included in a salad raw if cut up in very small pieces because it can be hard to chew.
 - • Spinach – Same advice as above for Kale – spinach offers a good source of multiple vitamins and minerals.
 - • Dandelion Greens – These are a little bitter – but can easily be added to salads and recipes calling for greens. Good source of calcium
 - • Collard Greens – Again – calcium is a big winner here.
- **Squash** – try the many varieties of squash for a healthy, filling, high-fiber meal. You can simply cut an acorn squash in half and place it flesh side down in a pan of water. Cook in a 350 degree oven for 30 minutes and serve with unsweetened applebutter. Delicious! Butternut squash can be added to soups to increase fiber and niacin as well!
- **Mushrooms** – these fungi have almost no calories and offer a powerhouse of potassium.
- **Garlic and onions** – These tasty additions to recipes are thought to help reduce bacteria in the body and support a healthy cardiovascular system.
- **Good Fruit**
- **Bananas** – easy for seniors to eat and offer great potassium and fiber to fill up when just needing a snack or having a sweet craving.
- **Berries** – These are also often heavily sprayed for pesticides. Shop for organic varieties when possible and/or wash thoroughly. Berries are powerful anti-oxidants and offer a good supply of potassium, calcium and magnesium
- **Apples** – They are best when eaten with the skin on – but get the organic variety to avoid pesticides. Apples contain a lot of pectin which helps to prevent cholesterol buildup in the lining of blood vessel walls.
- **Raisins** – These guys actually help reduce bacteria in your mouth that can lead to cavities and gum disease. Along with raisins, many types of dried fruits offer a good source of iron.
- **Go for the Grain:**

- **Whole grains** offer your body more nutrients than the “white” varieties of flour-based foods. When purchasing breads, pasta, muffins, and rolls, substitute “whole wheat” for “white”. It takes some getting used to, but most people adjust within a week. Also, try some of the following:
- **Good old Oatmeal.** Get the old-fashioned type and cook in the microwave in a bowl. Add nuts, cinnamon, fresh or dried fruit for variety. Nothing beats it. Bran cereals offer a lot of fiber to aid in digestion and serve up more nutrients than corn flakes! Brown and wild rice. These are easy to digest and offer more vitamins and fiber than the white variety.
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- **Other healthy ideas:**
 - **Green Tea:** Packed with phytochemicals thought to be good for preventing cancer and heart disease, Green Tea is a wonderful replacement for coffee.
 - **Egg Substitute:** Try “Egg-Beaters: Egg whites only” – 25 calories per serving and no cholesterol - easy for baked goods and other cooking to replace eggs which can be high in cholesterol and fats!
 - **Olive Oil:** They even make a “light” olive oil now that does not have an “olive-y” taste. You can bake with this and it contains omega-3 fatty acids.
 - **"Low-Fat" varieties** of the foods you like: While we should not be eating too many processed foods like cookies or other snack items, any time you can trade your processed food in for a “Low” fat option, do it. It tends to taste the same anyway.
 - **Water for Frying:** Yes – you can sauté vegetables in water for the basis of soups and other recipes. You won’t be able to tell the difference between carrots and onions sauted in water as opposed to butter if you are doing it for part of a recipe!
 - **Fish:** White fish and tuna are a good source of animal protein without the heavy saturated fats in other meats and provide brain-and-heart healthy omega-3 fatty acids.
 - **Nuts** have so much going for them! Too many nuts could be a problem because they are high in fat and calories. But, in moderation, they contain the good type of fat that can actually help lower cholesterol and improve your cardiovascular system. In addition, these are thought to be good for brain-health (especially almonds).
 - **Chocolate - Chocolate Can be Good For You!** Dark chocolate also contains anti-oxidants which play a role in repairing the cell damage which can lead to cancer. But that is still not all. Apparently, chocolate also contains substances like tryptophan and other substances that release endorphins – thought to be able to lift a low mood and/or depression.
- NURSE AIDE ROLE IN ASSISTING RESIDENTS WITH NUTRITION
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- First the Nurse Aide must set the stage for a pleasant mealtimes. This includes assisting with favorite Television channel or music. PLEASE DO NOT turn on TV if resident did not request or on something they you want to watch. PLEASE DO NOT play your own music while on duty or providing care, Your type of music may not suit resident. Most residents will like the music of their era such as Big Band, frank Sinatra, Billy Holiday, Gospel and others depending on cutlure.
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- Nurse Aide must sit down next or close to resident while feeding or assisting to set a more social environment.
- DONT FORGET TO ASK RESDIENT IF THEY NEED TO TOILET FIRST
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- When assisting a resident with Meals of feeding a dependent resident prepare the eating area; **CHECK NAME ON FOOD CARD AND ASK RESIDENT THEIR NAME, MAKE SURE IT IS THE RIGHT RESIDENT WITH THE RIGHT DIET.**
-
- clean off table or bed sied table,
- wash yours and the residents hands with wipes or warn towel
- place clothing protector on resident

- open condiments such as jelly, butter, salt, pepper, sugar
- ask resident if they want their meat and other foods cut up or butter/jelly on their toast or rolls
-
- GIVE FLUIDS PRIOR TO FEEDING TO WET THE RESIDENTS THROAT SO FOOD MAY GO DOWN MORE SMOOTHLY

Assistive feeding devices to maintain independence in eating

- Remove the food tray and place the tray in the designated dirty supply area when resident is done eating. before removing tray make sure resident is done, clean residents hands, take off clothing protector, put percentage of what resident ate and the amount of cc/mls resident drank. Assisting residents after meals; to bathroom or their room, living room at nurses station, activities
- Report if the resident did not eat or drink.
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- THICKENER & DYSPHAGIA
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- Nectar-like is a term to describe a liquid that is slightly thicker than water. Nectar-like is not a flavor and it has nothing to do with any particular fruit nectar. You can buy beverages called nectars like pear nectar but this does not mean that the item is nectar-like. A nectar-like beverage will be the consistency of an unset gelatin.
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- Honey-like is a term to describe a liquid that is as thick as honey but it is not honey, beverages are not honey flavored and do not contain any honey.
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- Spoon-thick or “pudding” consistency are terms used to describe a liquid that is as thick as a pudding.
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- Yes, you can thicken any liquid; however, thickening supplements is not always easy. Supplements are harder to thicken because they are higher in protein and fat than water, fruit juices, and other typical beverages. Liquid thickeners will work best when thickening supplements because they are already a liquid and will mix in easier. Powder thickeners can be used to thicken supplements but because they are powder they have more of a tendency to make lumps. You will need to stir the thickener into the supplement well. And, follow the manufacturer’s instructions for the amount of thickener to add to reach the consistency you need.
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- All thickeners are safe for diabetics to use. Different brands of thickeners will have slightly different amounts of carbohydrate and calories per serving so be sure to check the label of the thickener you are using. Thickeners add very few carbohydrates or calories to beverages. Generally it is the beverage itself that will have more of an impact on blood

sugar levels. If you are counting carbohydrates, you will want to include the amount of carbohydrate that the thickener adds to the meal occasion and treat it like you would any other carbohydrate.

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- Thirst is a mechanism that your body uses to let you know it needs water. Keeping in mind that thickened liquids are providing fluid feeling thirsty may mean you simply need to drink more – even if more means drinking another thickened beverage.
- Some people will say they do not feel as satisfied or quenched with only thickened liquids. We suggest including ‘lighter’ beverages – like water, lemonade, or tart fruit drinks - that might be more refreshing.
-
- Thickened liquids provide the same hydration that you would get from the unthickened liquid. The thickeners, whether powder or liquid, do not bind fluids. Powder thickeners are generally made from a modified cornstarch which begins to breakdown right away in the mouth. The process of starch digestion actually provides water into the system. The liquid thickeners do not begin to digest until they are in the colon but they still free up water for reabsorption by the body.
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- Dysphagia-Pureed (homogenous, very cohesive, pudding-like, requiring very little chewing ability).
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- Dysphagia-Mechanical Altered (cohesive, moist, semisolid foods, requiring some chewing).
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- Dysphagia-Advanced (soft foods that require more chewing ability).
- **Regular** (all foods allowed).

- **HIGH CALORIE/PROTEIN DIET**

- A high-calorie, high-protein diet may be recommended for recent weight lost, poor appetite, or have an increased need for protein, such as with a burn, pressure sores or infection. Eating a high-calorie, high-protein diet can help residents:
 - Have more energy
 - Gain weight or stop losing weight
 - Heal tissue
 - Resist infection
 - Recover faster from surgery or illness

- **LOW SODIUM DIET**

- A low sodium diet is important to achieve good blood pressure control for patients with high blood pressure. A low sodium diet can also be useful for certain patients with kidney disease or liver disease, particularly those with too much fluid on the body.
- **A low sodium diet is important for individuals with hypertension because lowering salt intake directly results in lower blood pressure.**

- **Second, taking in less salt makes the body more responsive to the blood pressure medications that may be required.** Most patients with high blood pressure still require blood pressure medicines in addition to diet, but they often need fewer medications or lower dosages than otherwise would be the case, and that is a good thing.
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- **DIABETES**
- There are basically two types of diabetes: Type I and Type II, although there are some variations. Type I diabetes usually occurs in young people and is very quickly diagnosed because the body is unable to produce insulin, causing blood sugar to rise to disastrous levels. Type I diabetes can only be controlled with insulin from an outside source, and patients must take insulin to live. No one knows exactly what triggers Type I in a susceptible person.
- The diagnosis for diabetes depends upon the level of blood sugar or plasma glucose. Normal blood sugar is about 60-115 mg/dl (milligrams per deciliter) in the fasting state. It is normal to have some blood glucose in the blood, and abnormal to have too much or too little. The brain requires blood glucose for normal function. If blood sugar drops too low (hypoglycemia) the brain's function is impaired and coma can result. It is normal for blood sugar to rise after eating, but in diabetes, the blood sugar rises higher and stays high longer than in people without diabetes. New criteria for diagnosis is a fasting blood sugar of 126 mg/dl or more, or a non fasting or "random" blood sugar over 200 with symptoms.
- Here are Some Examples of Foods that Contain Carbohydrates that need to be provided in moderation.
- Rice Fruits Pretzels/Popcorn Potato*
- Lentils Fruit juices Pasta/Noodles Yams*
- Dried beans Sugar/Honey Crackers Peas*
- Milk Desserts Bread Corn*
- Yogurt Sodas Cereals Lima beans*
- *These vegetables are starchy and raise blood glucose.
- Note: High fiber food choices are encouraged (for example, whole grain breads and cereals; fresh fruits and vegetables; beans and legumes).
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-
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- • Use color as a guide for variety in a meal. A good meal should provide three distinct colors on the plate.
- • Increase the variety of texture in meals. Add whole grain breads (rye, wheat, pumpernickel), whole grain cereals, and cooked legumes (beans of all types, lentils, dried peas).

- • Eat at least five servings of fruits and vegetables each day.
- • Build your diet as MyPyramid recommends
- Urinary incontinence – being unable to control your urination. Urinary incontinence is often a progressive condition associated with significant morbidity and embarrassment and it imposes a significant burden on affected residents, those who care for affected resident and health professionals.
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- Urinary retention – trouble urinating or not completely emptying your bladder. Urinary retention. This is when you do not completely empty your bladder. If untreated, it can lead to bladder stones, reflux (reverse flow of urine back to the kidneys) or a urinary tract infection (UTI). A UTI needs immediate treatment, so report to charge nurse as soon as you notice symptoms.
- Use of external catheters for males may be used however residents are still prone to backflow and UTI (urinary tract infection).
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- Urinals are a class of device which does not attach to the body. Instead, these external collection systems can be placed against the urinary opening during voiding and removed once voiding is complete.
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- **The Role of the nurse aide in bowel and/or bladder retraining program**
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- **NURSE AIDES REMEMBER: Damage to nerve pathways can interfere with signals from the bladder or bowel indicating the need to go to the toilet and/or the responding signals from the brain to the bowel or bladder to maintain normal functioning. Many people are too embarrassed to seek help over losing control of their bodily functions. Bowel incontinence can also be caused by diarrhea from overuse of laxatives. Bowel incontinence can also be a by-product of constipation, with poorly formed stools overflowing around impacted stool, Some NA mistake liquid stool for diarrhea when its just overflow going around hard stool.**
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- **Bladder training**
- People with urgency and frequency will often benefit from a training program. A baseline chart of toilet visits is kept for 4-7 days and then the time interval between visits is deliberately but gradually extended.
- **(Here are five major ways to treat incontinence)**
- 1. Behavioral modifications (we will only discuss toileting plans in this session)
- **Scheduled toileting/habit training.** The schedule should be based on a three day voiding I&O diary to determine the resident's voiding pattern.
- **Prompted voiding.** At least once an hour when awake, the resident should be asked if they need to go to the bathroom. If the resident says yes, take to bathroom.
- **Bladder training.** Some residents can regain bladder control through education, exercises, and close monitoring and coaching (asking them if they need to go to the bathroom more often) by staff.
- 2. Pelvic muscle exercises
- 3. Medications - such as Ditropan XL (oxybutynin) reduces muscle spasms of the bladder and urinary tract.
- 4. Surgery
-
- **Catheters**
- A long-term catheter can be associated with many problems. However, they still have a place where there is severe urinary incontinence or if toileting involves much difficulty and discomfort because of disability. Some people find that a catheter enables them to lead a much more active life as well as being more dignified than having to rely on carers to deal with the incontinence perhaps many times each day. If a catheter is used it is important to find both a brand or style of catheter and a care routine that minimises the problems for the user and

the carer. A suprapubic catheter which does not use the bladder outlet but enters the bladder via the abdominal wall, is often preferred.

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- Indwelling Urinary Catheter Care
- Catheters must be ordered by physician.
- Catheters must be inserted by licensed personnel.
- Catheters must never be used for convenience of staff.
- Catheters should always be secured with tape or leg strap.

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- Role of the nurse aide in preventing constipation

- Encouraging fluid intake
- Encouraging high fiber foods
- Encouraging exercise and activity
- Assisting with toileting promptly and at regular times

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- Role of the nurse aide in preventing urinary problems

- Encourage fluid intake. Assist with toileting frequently, promptly and regularly as needed.

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- COLLECTING SPECIMENS

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- **Midstream Clean Catch Specimen** This is the preferred type of specimen for culture and sensitivity testing because of the reduced incidence of cellular and microbial contamination. Patients are required to first cleanse the urethral area with a castile soap towelette. The patient should then void the first portion of the urine stream into the toilet. These first steps significantly reduce the opportunities for contaminants to enter into the urine stream. The urine midstream is then collected into a clean container (any excess urine should be voided into the toilet). This method of collection can be conducted at any time of day or night.

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- **Labels** Include the patient name and identification on labels. Make sure that the information on the container label and the requisition match. If the collection container is used for transport, the label should be placed on the container and not on the lid, since the lid can be mistakenly placed on a different container. Ensure that the labels used on the containers are adherent under refrigerated conditions.

- **Volume** Ensure that there is sufficient volume to fill the tubes and/or perform the tests. Underfilling or overfilling containers with preservatives may affect specimen-to-additive ratios.

- **Collection Date and Time** Include collection time and date on the specimen label. This will confirm that the collection was done correctly. For timed specimens, verify start and stop times of collection. Document the time at which the specimen was received in the laboratory for verification of proper handling and transport after collection.

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- 2. Measuring Intake:
 - a. Estimate or measure and record all fluid intake.
 - b. Check all serving containers for liquids.
 - c. Determine the amount of the serving from the equivalent list.
 - d. Accurately determine the amount of liquid remaining.
 - e. Subtract amount remaining from amount of serving to determine intake.
 - f. Record time and amount of intake on the I & O record.
- 3. Measuring Output:
 - a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7) prior to contact with bedpan urine, blood or other body fluids.
 - b. Pour fluid output into the measuring container.
 - c. Measure the amount in the container at eye level and on a level surface.
 - d. Discard fluid into toilet, unless a specimen should be collected or an unusual output should be shown to the nurse.
 - e. Empty and rinse measuring container, urinal or bedpan. Dump water used for rinsing into toilet and place containers in designated area following facility policy.
 - 150 f. Remove and discard gloves following facility policy promptly after use to avoid environmental contamination. Wash hands.
 - g. Record the time and amount of output on the I & O Record.
 - h. Check with the nurse if the output cannot be measured. You may be asked to estimate the number of times or the volume of the output. Indicate on I & O record if amount was estimated and why measurement was not done
- **STOOL SPECIMENS**
 - **Note:** Stools must not be contaminated by urine or toilet water. Sample areas of stool which appear bloody, slimy, or watery. If the stool is formed, try to sample small amounts from each end and the middle.
 - For collection cups with no preservative, use the tongue depressor provided or a plastic spoon to transfer the sample. A sample the size of a walnut is sufficient. **Note:** Do not fill the cup. Tighten the lid to prevent leakage and refrigerate the specimen or as per lab or facility policy, On each container write the patient name, birth date, date and time the specimen was collected. Collection containers with no preservative may have a different color lid must be refrigerated and kept cold from the time it is collected until it is delivered to the lab.
- **Measuring Intake:**
 - When estimating or measuring Nurse Aides must record all fluid intake. Check all serving containers for liquids.
 - Determine the amount of the serving from the equivalent list in your facility. Accurately determine the amount of liquid remaining. Subtract amount remaining from amount of serving to determine intake. Use cubic centimeters or milliliters (cc/ml) not cups or convert oz's to cc. **REMEMBER 1 OZ = 30 CC/ML.** Record time and amount of intake on the I & O record.
- **Measuring Output:**
 - Wash hands. Wear gloves and follow Standard Precautions prior to contact with bedpan urine, blood or other body fluids.
 - Pour fluid output into the measuring container (graduated cylinder)
 - **ALWAYS** Measure the amount in the container at eye level and on a level surface preferably with a paper towel under container as a barrier.
 - Discard fluid into toilet, unless a specimen should be collected or an unusual output should be shown to the nurse.
 - Empty and rinse measuring container, urinal or bedpan. Dump water used for rinsing into toilet and place containers in designated area following facility policy.
 - Remove and discard gloves following facility policy promptly after use to avoid environmental contamination.
 - Wash hands.
 - Record the time and amount of output on the I & O Record.
 - Check with the nurse if the output cannot be measured. You may be asked to estimate the number of times or the volume of the output. Indicate on I & O record if amount was estimated and why measurement was not done.