Acquired Immunodeficiency Syndrome (AIDS)

Acquired immunodeficiency (*im-YOUN-oh de-FISH-en-see*) **syndrome** (**AIDS**) is a disease caused by the **human immunodeficiency virus** (**HIV**). HIV attacks the body's immune system and gradually weakens and disables it. AIDS is caused by acquiring HIV through blood or body fluids from an infected person. AIDS is the final stage of HIV infection in which infections, tumors, and central nervous system symptoms appear due to a weakened immune system that is unable to fight infection. It can take years for HIV to develop into AIDS. However, not everyone who has HIV will get AIDS.

HIV is a sexually transmitted disease. It can also be spread through the blood by sharing needles from an infected person. More information on high-risk behaviors for contracting HIV, avoiding HIV, and transmission of HIV is in Chapter 5.

In general, HIV affects the body in stages. The first stage involves symptoms similar to flu, with fever, muscle aches, cough, fatigue, and swollen lymph glands. These are signs and symptoms of the body's immune system fighting the infection. As the infection worsens, the immune system overreacts and attacks not only the virus, but also normal tissue.

When the virus weakens the immune system in later stages, a group of problems may appear. These include opportunistic infections, tumors, and central nervous system symptoms that would not occur if the immune system were healthy. This stage of the disease is known as AIDS. The diagnosis of AIDS is made when a person's CD4+ lymphocyte (a type of white blood cell) count falls to 200 or below.

In the late stages of AIDS, damage to the central nervous system may cause memory loss, poor coordination, paralysis, and confusion. These symptoms together are known as **AIDS dementia complex**.

The following are the signs and symptoms of HIV infection and AIDS:

- Flu-like symptoms, including fever, cough, weakness, and severe or constant fatigue
- Appetite loss
- Weight loss
- Night sweats
- Swollen lymph nodes in the neck, underarms, or groin
- Severe diarrhea
- Dry cough
- Skin rashes
- Painful white spots in the mouth or on the tongue
- Cold sores or fever blisters on the lips and flat, white ulcers in the mouth
- Cauliflower-like warts on the skin and in the mouth
- Inflamed and bleeding gums
- Bruising that does not go away
- Susceptibility to infection, particularly pneumonia, but also to tuberculosis, herpes, bacterial infections, and hepatitis
- **Kaposi's sarcoma**, a rare form of skin cancer that appears as purple, red, or brown skin lesions
- ***Pneumocystis jirovecii* pneumonia** (*new-moh-SIS-tis yee-row-VET-zee new-MOH-nee-a*), a lung infection
- AIDS dementia complex

Opportunistic infections, such as pneumonia, tuberculosis, and hepatitis, invade the body because the immune system is weak and cannot defend itself. These illnesses complicate AIDS. They further weaken the immune system. It is difficult to treat these infections because generally, over time, a person with AIDS develops resistance to some antibiotics. These infections can cause death in people with AIDS.

There is no cure for this disease, and there is no vaccine to prevent the disease. People who are infected with HIV are treated with drugs that slow the progress of the disease. Without medication, however, a weakened resistance to infections may lead to AIDS and eventually to death.

Many people are living longer with HIV by taking combinations of medications every day. A treatment called antiretroviral therapy (ART) has been shown to control the HIV virus. Three or more medications are used for this therapy. Medicines must be taken at precise times. They have many unpleasant side effects: gastrointestinal symptoms like nausea, vomiting, and diarrhea, as well as fever and skin rashes. For some people, the medications are less effective than for others. Other aspects of HIV treatment include relief of symptoms and prevention and treatment of infection.

Guidelines: HIV and AIDS

- Follow Standard Precautions. Follow Transmission-Based Precautions in addition to Standard Precautions if ordered.
- People with poor immune system function are more sensitive to infections. Wash your hands often and keep everything clean.
- Involuntary weight loss occurs in almost all people who develop AIDS. High-protein, high-calorie, and high-nutrient meals can help maintain a healthy weight.
- Some people with HIV/AIDS lose their appetites and have difficulty eating. These clients should be encouraged to relax before meals and to eat in a pleasant setting. Serve familiar and favorite foods. Report appetite loss or difficulty eating to your supervisor. If appetite loss continues to be a problem, the doctor may prescribe an appetite stimulant.
- It is extremely important to carefully follow guidelines for safe food preparation and storage when working with a client who has HIV or AIDS. Foodborne illnesses caused by improperly cooking or storing food can cause death for someone with HIV or AIDS. (See Chapter 23 for safe food handling practices.) Wash your hands frequently. Keep everything clean, especially countertops, cutting boards, and knives after they have been used to cut meat. Thaw food in the refrigerator, and wash and cook foods thoroughly. When storing food, keep cold foods cold and hot foods hot. Use small containers that seal tightly. Check expiration dates, and remember, "When in doubt, throw it out."
- Clients who have infections of the mouth and esophagus may require food that is low in acid and neither cold nor hot. Spicy seasonings should be removed. Soft or pureed foods may be easier to swallow. Drinking liquid meals and fortified drinks, such as milkshakes, may ease the pain of chewing. Warm rinses may help painful sores of the mouth. Careful mouth care is essential.
- A person who has nausea or vomiting should eat small, frequent meals and should eat slowly. The person should avoid high-fat and spicy foods, and eat a soft, bland diet. This includes mashed potatoes, noodles, rice, crackers, pretzels, toast, gelatin, and clear soups. Cool foods that have little odor are usually easier to eat than hot foods. When nausea and vomiting persist, liquids and salty foods should be encouraged, including clear soups, clear juices, ginger ale, electrolyte supplements, saltines, and pretzels. Clients should drink fluids in between meals. Care must be taken to maintain proper intake of fluids to balance lost fluids.
- Clients who have mild diarrhea may have frequent small meals that are low in fat, fiber, and dairy products. High-fiber foods include seeds, nuts, wheat bran, whole grain bread, and the skins of fruits and vegetables. Fats,

milk, cheese, ice cream, beans, cabbage, and spicy foods may need to be avoided. The client's doctor may order a BRAT (bananas, rice, applesauce, and toast) diet. This diet is helpful for short-term use.

- G Diarrhea rapidly depletes the body of fluids. Fluid replacement is necessary. Good rehydration fluids include water, juice, caffeine-free soda, and broth. Caffeinated drinks should be avoided.
- G **Neuropathy** (*noor-AH-path-ee*), or numbness, tingling, and pain in the feet and legs, is usually treated with pain medications. Wearing loose, soft slippers may be helpful. If blankets and sheets cause pain, a bed cradle can keep sheets and blankets from resting on the legs and feet (Chapter 12).
- G Give emotional support, as well as physical care. Clients with HIV/AIDS may suffer from anxiety and depression. In addition, they are often judged by family, friends, and society. Some people avoid a person with AIDS due to intolerance, bias, or prejudice. Some people blame them for their illness. People with HIV/AIDS may experience tremendous stress. They may feel uncertainty about their illness, health care, and finances. They may also have lost friends who have died from AIDS. Listen closely to clients to understand their individual needs and concerns. This is part of providing person-centered care. Treat them with respect, and help provide needed emotional support.

  Clients with HIV/AIDS need support from others. This support may come from family, friends, religious and community groups, and support groups, as well as the care team. Report to your supervisor if you feel that clients need more resources and services.
- G Withdrawal, apathy, avoidance of tasks, and mental slowness are early symptoms of HIV infection. Medications may also cause side effects of this type. AIDS dementia complex may develop, causing further mental symptoms. There may also be muscle weakness and loss of muscle control, making falls a risk. Clients in this stage of the disease will need a safe environment and close supervision in their ADLs.

Cancer

Cancer is a general term used to describe a disease in which abnormal cells grow in an uncontrolled way. Cancer usually occurs in the form of a tumor or tumors growing on or within the body. A **tumor** (*TOO-mer*) is a cluster of abnormally growing cells. **Benign** (*bee-NINE*) **tumors** are considered noncancerous. They usually grow slowly in local areas. **Malignant** (*ma-LIG-nant*) **tumors** are cancerous. They can grow rapidly and invade surrounding tissues.

Cancer invades local tissue and can spread to other parts of the body. When cancer spreads from the site where it first appeared (metastasizes), it can affect other body systems. In general, treatment is more difficult and cancer is more deadly after this has occurred. Cancer often appears first in the breast, colon, rectum, uterus, prostate, lungs, or skin. There is no known cure for cancer. However, some treatments are effective. They are discussed later in the chapter.

Known causes of cancer include the following (Fig. 9-40):

- Genetic factors
- Tobacco use
- Alcohol use
- Poor diet/obesity
- Lack of physical activity
- Certain infections
- Environmental exposure, such as radiation
- Sun exposure

Fig. 9-40. Poor diet, obesity, and prolonged sun exposure are some of the causes of cancer.

Signs of Cancer

When diagnosed and treated early, cancer can often be controlled. The American Cancer Society (cancer.org) has identified some warning signs of cancer:

- Unexplained weight loss
- Fever
- Fatigue
- Pain
- Skin changes, such as change in skin color (e.g., reddened skin)
- Change in bowel or bladder function
- Sores that do not heal
- Unusual bleeding or discharge
- Thickening or lump in the breast, testicle, or other parts of the body
- Indigestion or difficulty swallowing
- New mole or change in the appearance of an existing mole, wart, or spot
- Nagging cough or hoarseness

Common Treatments for Cancer

People with cancer can often live longer and sometimes recover when treated using the following methods. These treatments are most effective when tumors are discovered early. Often these treatments are combined.

Surgery is the front line of defense for most forms of cancer. It is the key treatment for malignant tumors of the skin, breast, bladder, colon, rectum, stomach, and muscle. Surgeons attempt to remove as much of the tumor as possible to prevent cancer from spreading.

Chemotherapy refers to medications given, usually intravenously, to fight cancer. Certain drugs destroy cancer cells and limit the rate of cell growth. However, many of these drugs are toxic to the body. They destroy healthy cells as well as cancer cells. Chemotherapy can have severe side effects, including nausea, vomiting, mouth sores, diarrhea, temporary hair loss, fatigue, weakness, anxiety, depression, and decreased resistance to infection.

Radiation therapy (radiotherapy) directs radiation to a limited area to kill cancer cells. However, normal or healthy cells in the radiation's path are also destroyed. By controlling cell growth, radiation can reduce pain. Radiation can cause the same side effects as chemotherapy, including an increased risk of infection. The skin on the area exposed to radiation may become sore, irritated, and sometimes burned.

Targeted therapy is a specific type of chemotherapy. Traditional chemotherapy typically destroys healthy cells as well as cancer cells. Scientists have developed targeted chemotherapy drugs using the differences between cancer cells and normal cells. These drugs can attack cancer cells and the cells that help cancer grow. Side effects of these drugs can be similar to those associated with other chemotherapy drugs, and can also include high blood pressure, rashes or other skin changes, bleeding and clotting problems, and more.

Immunotherapy is a general term for treatment that uses a person's own immune system to fight disease. Immunotherapy can be helpful in treating some forms of cancer. It can work by making the immune system work harder to fight the cancer or by adding something to the

immune system, like man-made proteins, to change how it works. Immunotherapy for cancer includes cancer vaccines, which make the immune system attack specific types of cancer cells. These may be used to help treat cancer or to stop cancer from coming back after other treatments. Different immunotherapy drugs have different side effects, but in general they have fewer side effects than chemotherapy drugs.

Hormone therapy is used to treat cancers that use hormones to grow, like breast and prostate cancers. Hormone therapy blocks the body's ability to produce certain hormones or changes how hormones behave. This type of therapy is usually used along with other types of treatment for cancer. Side effects include hot flashes, nausea, diarrhea, and fatigue.

Care Guidelines for Cancer

Coping with cancer can be a tremendous challenge. Home health aides should follow these guidelines when working with clients who have cancer:

Guidelines: Cancer

- Each case is different. Cancer is a general term and refers to many individual situations. Clients may live many years or only several months. Treatment affects each person differently. Do not make assumptions about a client's condition.
- Clients may want to talk or may avoid talking. Respect each client's needs. Listen if a client wants to share feelings or experiences with you. However, never push a client to talk. Be honest. Never tell a client, "Everything will be okay." Be sensitive. Remember that cancer is a disease, and its cause is unknown. Maintain a positive attitude and focus on concrete details. For example, comment if a client seems stronger, or mention that the sun is shining outside.
- Proper nutrition is very important for clients with cancer. Follow the care plan instructions and your assignments carefully. Clients frequently have poor appetites. Encourage a variety of food and small portions. Serve favorite foods that are high in nutrition. Liquid nutritional supplements may be used in addition to, not in place of, meals. If nausea or swallowing is a problem, foods such as soups, gelatin, or starches may appeal to the client. Use plastic utensils for a client receiving chemotherapy. It makes food taste better. Metal utensils cause a bitter taste.
- Cancer can cause severe pain, especially in the late stages. It can affect the ability to sleep, eat, and move. Be alert for signs of pain. Assist with comfort measures, including repositioning and providing distractions such as conversation, music, or reading materials (Fig. 9-41). Observe the client's use of pain medication. The client may be using a patient-controlled analgesia (PCA) pump for pain relief. This pump allows the person to press a button that releases pain medication. Report to the supervisor if pain seems to be uncontrolled.

Fig. 9-41. *Give clients with cancer as much emotional support as possible. Distractions such as conversation can help a person deal with pain.*

- Offer back rubs to provide comfort and increase circulation. For clients who spend many hours in bed, special pads or other positioning devices may make them more comfortable. Moving to a chair for some

period of time may improve comfort as well. Clients who are very weak or immobile need to be repositioned at least every two hours.

- Check the skin often to help prevent pressure injuries. Keep the skin clean and dry. Use lotion regularly on dry or delicate skin. Do not apply lotion to areas receiving radiation therapy. Do not remove markings that are used in radiation therapy. Follow any special skin care orders (for example, no hot or cold packs; no soap, lotion, or cosmetics; or no tight stockings).
- Help clients brush teeth regularly. Chemotherapy medications, nausea, vomiting, or mouth infections may cause pain and a bad taste in the mouth. You can help ease discomfort by using a soft-bristled toothbrush, rinsing with baking soda and water, or using a prescribed rinse. Do not use a commercial mouthwash. Alcohol in mouthwash can further irritate a client's mouth. For clients with mouth sores, using oral swabs rather than toothbrushes may be preferable. The swabs can be dipped in a rinse and gently wiped across the gums. Mouth sores can make mouth care very painful; be very gentle when giving care.
- People with cancer may have a poor self-image because they are weak and their appearance has changed. For example, hair loss is a common side effect of chemotherapy. Assist with grooming if desired. Your concern and interest can help improve the client's self-image.
- If visitors help cheer your client, encourage them and do not intrude. If some times of the day are better than others, suggest them to the client's friends or family. It may help a person with cancer to think of something besides cancer and treatment for a while. Pursue other topics and get to know your clients' interests. As always, report any signs of depression immediately (see Chapter 18).
- Caring for a person with cancer at home can be very difficult for family members. Be alert to needs that are not being met or stresses created by the illness. Report observations. A list of community resources for additional help may be found in Chapter 3.

Report any of the following to your supervisor:

- Increased weakness or fatigue
- Weight loss
- Nausea, vomiting, or diarrhea
- Changes in appetite
- Fainting
- Shortness of breath
- Signs of depression
- Confusion
- Blood in stool or urine
- Change in mental status
- Changes in skin
- New lumps, sores, or rashes
- Increase in pain or unrelieved pain
- Blood in the mouth

Care after a Mastectomy

A *mastectomy* is the surgical removal of all or part of the breast and sometimes other surrounding tissue. This operation is usually performed because of a tumor.

After a mastectomy, the care plan may include arm exercises for the side of the body on which the surgery was performed. The goal of arm exercises is to strengthen the arm and chest muscles and reduce swelling in the arm and underarm. Exercises may include raising the arm, opening and closing the hand, and bending and straightening the elbow. The client should wear loose, comfortable clothing while doing arm exercises.

The care plan's instructions may include keeping the arm on the affected side raised on pillows to decrease swelling. The client may use a sling to keep the arm elevated. In addition, deep breathing exercises may be ordered. Blood pressure should not be measured on the arm on the affected side.

Chapter Review

1. What is homeostasis?
2. What is an acute illness? What is a chronic illness?
3. What are three functions of the skin, or integument?
4. Why is preventing pressure injuries extremely important?
5. How many bones make up the skeleton of the human body?
6. What type of exercises can help prevent contractures and muscle atrophy?
7. What are two functions of the nervous system?
8. When helping a client who has had a stroke with transfers or walking, on which side should an HHA stand—the weaker or stronger?
9. Why may people with Parkinson's disease have trouble eating and bathing themselves?
10. When a person has multiple sclerosis, what covering breaks down over time?
11. What is paraplegia? What is quadriplegia?
12. When a client has a hearing impairment, on whose face should the light be shining while communicating—the client's or the home health aide's?
13. How can a home health aide explain the position of objects in front of a client who has a visual impairment?
14. What is phantom limb pain? What is phantom sensation?
15. What are four functions of the circulatory system?
16. What consistent blood pressure measurement is classified as hypertension?
17. What is the medical term for chest pain, pressure, or discomfort?
18. What does respiration mean? What are the two parts involved in respiration?
19. What position might a client with COPD prefer to be in?
20. What are two functions of the urinary system?
21. How should clients wipe after elimination in order to prevent infection?
22. Define the following terms related to the gastrointestinal system: digestion, absorption, and elimination.
23. What may need to be increased in a client's diet if she is prone to constipation?
24. What are glands?
25. Why is proper foot care especially important for a client with diabetes?
26. What is the function of the reproductive system?
27. What is a sexually transmitted infection?
28. What is nonspecific immunity? What is specific immunity?
29. What is the function of the lymphatic system?
30. How is HIV spread?
31. Which stage of HIV infection is classified as AIDS?
32. What are common side effects of chemotherapy and radiation?

10 Confusion, Dementia, and Alzheimer's Disease

1. Discuss confusion and delirium

Confusion is the inability to think clearly and logically. A confused person has trouble focusing his attention and may feel disoriented. Confusion interferes with the ability to make decisions. The person's personality may change. He may not know his name, the date, other people, or where he is. A confused person may be angry, depressed, or irritable.

Confusion may come on suddenly or gradually. It can be temporary or permanent. Confusion is more common in the elderly. It may occur when a person is in the hospital. Some common causes of confusion include the following:

- Urinary tract infection (UTI)
- Low blood sugar
- Head trauma or head injury
- Dehydration
- Nutritional problems
- Fever
- Sudden drop in body temperature
- Lack of oxygen
- Medications
- Infections
- Brain tumor
- Diseases or illnesses
- Loss of sleep
- Seizures

Guidelines: Caring for Clients Who are Confused

- G Do not leave a confused client alone.
- G Stay calm. Provide a quiet environment.
- G Speak in a lower tone of voice. Speak clearly and slowly.
- G Introduce yourself each time you see the client. Remind the client of his location, name, and the date. A calendar can help.
- G Explain what you are going to do, using simple instructions.
- G Be patient. Do not rush the client.
- G Talk to the client about plans for the day. Keeping a routine may help.
- G Encourage the use of eyeglasses and hearing aids. Make sure they are clean and are not damaged.
- G Promote self-care and independence.
- G Do not leave cleaning agents, such as liquid soap, or personal care products, such as lotions or toothpaste, where the client can access them. A person who is confused may try to eat or drink these products.
- G Report observations to the supervisor.

Delirium is a state of severe confusion that occurs suddenly; it is usually temporary. Some causes are infections, disease, fluid imbalances, and poor nutrition. Drugs and alcohol may also cause delirium. Symptoms of delirium include the following:

- Agitation
- Anger
- Depression
- Irritability
- Disorientation
- Trouble focusing
- Problems with speech
- Changes in sensation and perception
- Changes in consciousness
- Decrease in short-term memory

Report these signs to your supervisor. The goal of treatment is to control or reverse the cause. Emergency care may be needed, as well as a stay in a hospital.

2. Describe dementia

As a person ages, some of the ability to think logically and clearly may be lost. This ability is called **cognition** (*kog-NI-shun*). When some of this ability is lost, a person is said to have **cognitive impairment** (*KOG-ni-tiv im-PAYR-ment*). How much cognition is lost depends on the individual. Cognitive impairment affects concentration and memory. Elderly clients may lose their memories of recent events, which can be frustrating for them. HHAs can help by encouraging them to make lists of things to remember and by writing down names, events, and phone numbers. Other normal changes of aging in the brain are slower reaction time, difficulty finding or using the right words, and sleeping less.

Dementia (*di-MEN-sha*) is a general term that refers to a more serious loss of mental abilities such as thinking, remembering, reasoning, and communicating. As dementia advances, these losses make it difficult to perform activities of daily living, such as eating, bathing, dressing, and eliminating. Social skills may be affected. **Dementia is not a normal part of aging.**

Alzheimer's disease is the most common cause of dementia in the elderly. Dementia may also be caused by these disorders:

- Multi-infarct or vascular dementia (a series of strokes causing damage to the brain)
- Lewy body dementia (abnormal structures, called Lewy bodies, develop in areas of the brain, causing a variety of symptoms)
- Parkinson's disease
- Huntington's disease (an inherited disease that causes certain nerve cells in the brain to waste away)

3. Describe Alzheimer's disease and identify its stages

Alzheimer's disease (**AD**) is a progressive, degenerative, and irreversible disease. AD causes tangled nerve fibers and protein deposits to form in the brain, eventually causing dementia. **Progressive** and **degenerative** mean the disease gets worse, causing greater and greater loss of health and abilities. **Irreversible** means the disease cannot be cured. Clients with Alzheimer's disease will never recover. They will need more care as the disease progresses.

Symptoms of AD appear gradually. It generally begins with memory loss. As the disease progresses, it causes greater and greater loss of health and abilities. People with AD may get disoriented. They may be confused about time and place. Communication problems are common. They may lose their ability to read, write, speak, or understand. Mood and behavior change. Aggressiveness, wandering, and withdrawal are all part of AD. Alzheimer's disease generally progresses in stages. In each stage, the symptoms become progressively worse. The majority of people who have this disease are eventually completely dependent on others for care.

Each person with Alzheimer's disease may show different symptoms at different times. For

example, one person may continue to read, but not be able to recognize a family member. Another person can play a musical instrument but does not know how to use the phone. Skills that a person has used over a lifetime are usually retained longer (Fig. 10-1).

Fig. 10-1. *A person with AD may retain skills she has used her whole life.*

The Alzheimer's Association (alz.org) identifies three general stages of Alzheimer's disease:

Mild Alzheimer's disease (early stage)

At this stage, the person may show some problems, such as memory loss and forgetting some words and the location of familiar objects. The person's medical examination may show problems with memory and concentration. However, the person may still be independent and able to work, drive, and do other activities.

Moderate Alzheimer's disease (middle stage)

Generally speaking, this stage has the longest duration. At this stage, the person may show signs and symptoms such as forgetting recent events, forgetting some of one's own past experiences and background, changes in personality and behavior, and being moody or withdrawn. Other changes include needing help with some activities of daily living, such as with elimination needs and helping to choose clothing appropriately. There may be changes in sleep patterns, increased wandering, suspiciousness or delusions, and confusion about time and place.

Severe Alzheimer's disease (late stage)

During this final stage, a person may be unable to communicate with others, control movement, or respond to his surroundings. The person needs significant help with activities of daily living, including eating and eliminating. The ability to walk, sit, and swallow may be affected.

It is important for home health aides to encourage independence, regardless of what signs and symptoms a client with Alzheimer's disease shows. The client should be encouraged to do whatever he is able to do. This helps keep the client's mind and body as active as possible. Working, socializing, reading, problem solving, and exercising should all be encouraged (Fig. 10-2).

Fig. 10-2. *Home health aides should encourage clients with AD to socialize, read, work, problem solve, and exercise to keep their minds and bodies active.*

4. Identify personal attitudes helpful in caring for clients with Alzheimer's disease

The following attitudes will help HHAs give the best possible care to clients with AD:

Do not take things personally. Alzheimer's disease is a devastating mental and physical disorder. It affects everyone who surrounds and cares for the person with AD. People with Alzheimer's disease do not always have control over their words and actions. They may often be unaware of what they say or do. A client with Alzheimer's disease may not recognize a caregiver or do what he is supposed to do. He may ignore, accuse, or

insult care team members. When this happens, it is important to remember that the behavior is due to the disease.

Be empathetic. It is helpful if the HHA thinks about what it would be like to have Alzheimer's disease. She can imagine being unable to do activities of daily living and being dependent on others for care. It would be very frustrating for anyone to have no memory of recent events or to be unable to find words for what one wants to say. Home health aides should assume that people with AD have insight and are aware of the changes in their abilities. They should treat clients with AD with dignity and respect.

Work with the symptoms and behaviors noted. Each person with Alzheimer's disease is an individual. Clients with AD will not all show the same symptoms at the same times. Each client will do some things that others will never do. The best strategy is to work with the behaviors that are seen on any particular day. For example, a client with Alzheimer's disease may want to go for a walk one day, when the day before he did not want to go to the bathroom without help. If allowed by the care plan, the HHA should try to go for a walk with him.

Work as a team. Symptoms and behavior change daily. When home health aides observe and report carefully, as well as listen to others' reports, the care team may be better able to develop solutions. HHAs are in a great position to give details about clients. Being with clients often allows them to have insights that others may not have. HHAs should make the most of this opportunity.

Be aware of difficulties associated with caregiving. Caring for someone with dementia can be physically and emotionally exhausting, as well as incredibly stressful. Home health aides should take care of themselves so they can continue to provide the best care (Fig. 10-3). Being aware of the body's signals to slow down, rest, or eat better is important. Each HHA's feelings are real; they have a right to them. Mistakes should be viewed as learning experiences. Unmanaged stress can cause physical and emotional problems. When stress feels overwhelming, an HHA should talk to her supervisor.

Fig. 10-3. *Regular exercise is an important part of taking care of oneself.*

Work with family members. Family members can be a wonderful resource. They can help caregivers learn more about a client. They also provide familiarity and comfort to the person with Alzheimer's disease. Home health aides should build relationships with family members and keep the lines of communication open.

In addition, HHAs should be reassuring to family members. It is very difficult for families to see a loved one's health and abilities decline. When clients with AD exhibit problem behaviors, it can be stressful for the family. HHAs can help by reassuring family members that they understand that this behavior is part of the disease.

Remember the goals of the care plan. In addition to the practical tasks home health aides perform, the care plan will also call for maintaining clients' dignity and self-esteem. HHAs should help clients be as independent as possible.

5. List strategies for better communication with clients with Alzheimer's disease

Many things can be done to improve communication with clients who have Alzheimer's

disease. Providing person-centered care for clients with AD means responding to each client as an individual. The guidelines below can help with communication:

Guidelines: Communicating with Clients Who Have Alzheimer's Disease

- Always approach from the front, and do not startle the client.
- Smile and look happy to see the client. Be friendly.
- Determine how close the client wants you to be.
- If possible, communicate in a calm place with little background noise and distraction.
- Always identify yourself, and use the client's name. (Do not touch first; this may upset the person.) Continue to use the client's name during the conversation.
- Speak slowly, using a lower tone of voice than normal. This is calming and easier to understand.
- Repeat yourself, using the same words and phrases, as often as needed.
- Talk about only one subject at a time. Be patient. Use short, simple sentences.
- Use signs, pictures, gestures, or written words to help communicate.
- Break complex tasks into smaller, simpler ones. Give simple, step-by-step instructions as necessary.

Communication with clients with AD can also be helped by using these specific techniques:

If the client is frightened or anxious:

- Speak slowly in a low, calm voice. Speak in a quiet area with few distractions.
- Try to see and hear yourself as the client might. Always describe what you are going to do.
- Use simple words and short sentences. If helping with care, list steps one at a time.
- Check your body language; make sure you are not tense or hurried.

If the client forgets or shows memory loss:

- Repeat yourself, using the same words if you need to repeat an instruction or question. However, you may be using a word the client does not understand, such as *tired*. Try other words like *nap*, *lie down*, and *rest*. Repetition can also be soothing for a client with Alzheimer's disease. Many people with AD repeat words, phrases, questions, or actions. This is called **perseveration**. Do not try to stop a client who is perseverating. Answer the questions, using the same words each time, until he stops. Even though responding over and over may frustrate you, it communicates comfort and security.
- Keep messages simple. Break complex tasks into smaller, simpler ones.

If the client has trouble finding words or names:

- Suggest a word that sounds correct. If this upsets the client, learn from it and try not to correct a client who uses an incorrect word. As words (written and spoken) become more difficult, smiling, touching, and hugging can help show care and concern (Fig. 10-4). Remember, however, that some people find touch frightening or unwelcome.

Fig. 10-4. *Touch, smiles, hugs, and laughter will be understood longer, even after speaking abilities decline.*

If the client seems not to understand basic instructions or questions:

- Ask the client to repeat your words. Use short words and sentences, allowing time to answer.
- Note the communication methods that are effective and use them.
- Watch for nonverbal cues as the ability to talk lessens. Observe body language—eyes, hands, and face.
- Use signs, pictures, gestures, or written words. For example, a picture of a toilet on the bathroom door can help remind a person where the bathroom is. Combining verbal and nonverbal communication is helpful. For example, you can say, "Let's get dressed now," while holding up clothes.

If the client wants to say something but cannot:

- Encourage the client to point, gesture, or act it out.
- If the client is obviously upset but cannot explain why, offer comfort with a smile, or try to distract him. Verbal communication may be frustrating.

If the client does not remember how to perform basic tasks:

- Break each activity into simple steps. For instance, "Let's go for a walk. Stand up. Put on your sweater. First the right arm..." Always encourage clients to do what they can.

If the client insists on doing something that is unsafe or not allowed:

- Redirect activities toward something else. Try to limit the times you say "Don't."

If the client hallucinates (sees or hears things that are not really happening), or is paranoid or accusing:

- Try not to take it personally.
- Try to redirect behavior or ignore it. Because attention span is limited, this behavior often passes quickly.

If the client is depressed or lonely:

- Take time, one-on-one, to ask how he is feeling. Really listen to the response.
- Try to involve the client in activities. Always report signs of depression to your supervisor (Chapter 18).

If the client is verbally abusive or uses bad language:

- Remember it is the dementia speaking, not the person. Try to ignore the language, and redirect attention to something else.

If the client has lost most verbal skills:

- Use nonverbal skills. As speaking abilities decline, people with AD will still understand touch, smiles, and laughter for much longer. Remember that some people do not like to be touched. Approach touching slowly and be gentle. Softly touching the hand or smiling can express affection and say you want to help (Fig. 10-5).
- Even after verbal abilities are lost, signs, labels, and gestures can reach people with dementia.
- Assume people with AD can understand more than they can express. Do not talk about them as though they were not there or treat them like children.

Fig. 10-5. *Smiling can communicate positivity and a willingness to help.*

6. Explain general principles that will help assist clients with personal care

Home health aides should use the same procedures for personal care and activities of daily living for clients with Alzheimer's disease as they would with other clients. However, here are some general principles that will help HHAs give the best care:

1. **Develop a routine and stick to it.** Being consistent is important for clients who are confused and easily upset.
2. **Promote self-care.** Helping clients care for themselves as much as possible will help them cope with this difficult disease.
3. **Take care of themselves, both mentally and physically.** This will help HHAs give the best care.

7. List and describe interventions for problems with common activities of daily living (ADLs)

As Alzheimer's disease worsens, clients will have trouble doing their activities of daily living. Below are interventions to help clients with these problems. An **intervention** means a way to change an action or development.

Guidelines: Assisting with ADLs for Clients Who Have Alzheimer's Disease

If the client has problems with bathing:

- Schedule bathing when the client is least agitated. Be organized so the bath can be quick. Give sponge baths if the client resists a shower or tub bath.
- Prepare the client before bathing. Hand him the supplies (washcloth, soap, shampoo, towels). This serves as a visual aid.
- Take a walk to the bathroom with the client, rather than asking directly about the bath.
- Make sure the bathroom is well lit and is at a comfortable temperature.
- Provide privacy during the bath.
- Be calm and quiet when bathing a client. Keep the process simple.
- Be sensitive when talking to a client about bathing.
- Give the client a washcloth to hold. This can distract him while you finish the bath.
- Always follow safety precautions. Ensure safety by using nonslip mats, tub seats, and handholds.
- Be flexible about when to bathe a client. A client may not always be in the mood. Also, be aware that not everyone bathes with the same frequency. Understand if a client does not want to bathe.
- Be relaxed and allow the client to enjoy the bath. Offer encouragement and praise.
- Let the client do as much as possible during the bath.
- Observe the skin for any signs of irritation or breakdown during the bath.

If the client has problems with grooming and dressing:

- Assist with grooming to help the client feel attractive and dignified.
- Avoid delays or interruptions while dressing.
- Show the client some of his clothing. This brings up the idea of dressing. Tell him you are going to help him get dressed.
- Provide privacy by closing doors and curtains.
- Encourage the client to pick clothes to wear. Simplify this by giving just a few choices. Make sure the clothing is clean and appropriate. Lay out clothes in the order in which they are to be put on (Fig. 10-6). Choose clothes that are simple to put on, such as

slip-on instead of lace-up shoes and pants or skirts instead of dresses. Some people with Alzheimer's disease make a habit of layering clothing regardless of the weather.

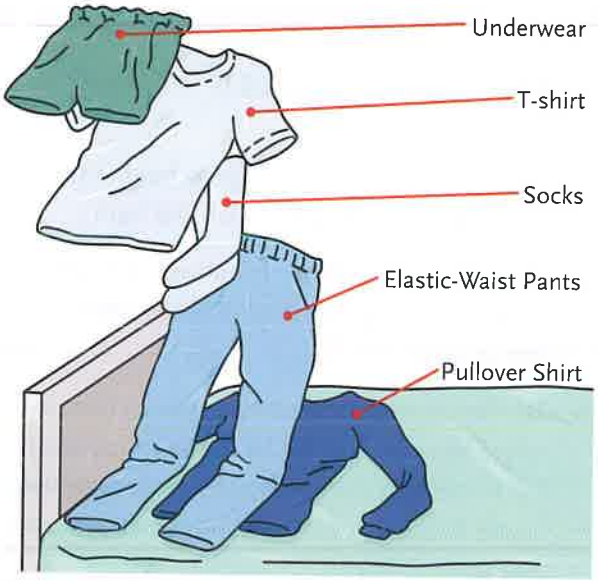

Fig. 10-6. *Lay out clothes in the order in which they should be put on.*

- Break the task down into simple steps. Introduce one step at a time. Do not rush the client.
- Use a friendly, calm voice when speaking. Praise and encourage the client at each step.

If the client has problems with elimination:

- Encourage fluids. Never withhold or discourage fluids because a client has urinary incontinence. Report to your supervisor if the client is not drinking fluids. Follow schedules in the care plan for drinking fluids.
- Mark the bathroom with a sign or a picture as a reminder of where it is and to use the toilet.
- Make sure the path to the bathroom and the bathroom are well lit.
- Note when the client is incontinent over two to three days. Check him every 30 minutes. This can help determine "bathroom times." Take the client to the bathroom just before his bathroom time.
- Take the client to the bathroom after drinking fluids. Take the client to the bathroom before and after meals and before bedtime. Make sure the client actually urinates before getting off the toilet.
- Put lids on trash cans, wastebaskets, or other containers if the client urinates or defecates in them.
- Follow the elimination schedule carefully and document urination and bowel elimination as required.
- Family or friends may be upset by their loved one's incontinence. Be professional when cleaning after episodes of incontinence. Do not show any disgust or irritation.

If the client has problems with nutrition:

- Encourage nutritious food. Food may not interest a client with Alzheimer's disease or he may forget to eat. It may be of great interest, but he may only want to eat a few types of food. A client with AD is at risk for malnutrition.
- Serve meals at regular, consistent times each day. You may need to remind the client that it is mealtime. Serve familiar foods that look and smell appetizing.
- Make sure there is adequate lighting.
- Keep noise low and distractions to a minimum during meals.
- Keep the task of eating simple. If the client is restless, try smaller, more frequent meals. Finger foods (foods that are easy to pick up with the fingers) work best. Examples of finger foods that may be good to serve are sandwiches cut into fourths, chicken nuggets or small pieces of cooked boneless chicken, fish sticks, cheese cubes, halved hard-boiled eggs, and fresh fruit and soft vegetables cut into bite-sized pieces.
- Do not serve steaming or very hot foods or drinks.

- Use a simple place setting with a single eating utensil and remove other items from the table (Fig. 10-7). Plain plates without patterns or colors work best.

Fig. 10-7. *Plain white plates on a contrasting-colored surface may help avoid confusion and distraction.*

- Put only one item of food on the plate at a time. Multiple kinds of food on a plate may be overwhelming.
- Give simple, clear instructions. Clients with AD may not understand how to eat or use utensils. Help the client taste a sample of the meal first. Place a spoon to the lips. This will encourage the client to open his mouth. Ask the client to open his mouth.
- Guide the client through the meal, providing simple instructions. Offer regular drinks of water, juice, and other fluids to prevent dehydration.
- Use assistive devices for eating, such as special spoons and bowls, as needed.
- If a client needs to be fed, do so slowly. Offer small pieces of food. (Chapter 22 explains the procedure for feeding a client.)
- Make mealtimes simple and relaxed, not rushed. Give the client time to swallow before each bite or drink.
- Observe and report eating or swallowing problems, as well as changes in eating habits.
- Report changes in intake and output. Monitor weight accurately and frequently.

To promote the client's physical health:

- Prevent infections and follow Standard Precautions. Follow proper procedures for food preparation and storage and household management.
- Help clients wash their hands frequently.
- Observe the client's physical health. Report any potential problems. People with dementia may not notice their own health problems.
- Give careful skin care to prevent pressure injuries.
- Watch for signs of pain. People who have Alzheimer's disease may not be able to express that they are in pain. Nonverbal signs that a client may be in pain include grimacing or clenching fists (Fig. 10-8). A client may be agitated or have an angry outburst. Report possible signs of pain to your supervisor. (Chapter 14 contains information about pain and pain management.)
- Maintain a daily exercise routine.

Fig. 10-8. *Be aware of nonverbal signs of pain, such as holding or rubbing a body part. Report these signs to your supervisor.*

To promote the client's mental and emotional health:

- Maintain self-esteem by encouraging independence in activities of daily living.

G Share in enjoyable activities, such as looking at pictures, talking, and reminiscing.

G Reward positive and independent behavior with smiles, hugs, and warm touches.

8. List and describe interventions for common difficult behaviors related to Alzheimer's disease

Below are some common difficult behaviors that home health aides may face when working with clients who have Alzheimer's disease. Each client is different. HHAs should work with each person as an individual and should provide person-centered care.

Agitation: A client who is excited, restless, or troubled is said to be **agitated**. Feeling insecure or frustrated, encountering new people or places, and changing a routine can all trigger this behavior. A **trigger** is a situation that leads to agitation. Even watching television can cause agitation, as a person with AD may lose his ability to distinguish fiction from reality. If a client is agitated, the HHA should

- Try to eliminate triggers, keep a routine, and avoid frustration. Redirecting the client's attention may help.
- Reduce noise and distractions. Focusing on a familiar activity, such as sorting things or looking at pictures, may help.
- Remain calm and use a low, soothing voice to speak to and reassure the client.
- Pat the client's arm or back if it is soothing.

Sundowning: When a person with AD becomes restless and agitated in the late afternoon, evening, or night, it is called **sundowning**. Sundowning may be triggered by hunger or fatigue, a change in routine or caregiver, or any new or frustrating situation. If a client experiences sundowning, the HHA should

- Provide adequate lighting before it gets dark.
- Avoid stressful situations during this time. Limit activities, appointments, trips, and visits.
- Play soft music.
- Try to discourage daytime napping.
- Set a bedtime routine and keep it.
- Recognize when sundowning occurs and plan a calming activity just before.
- Serve the evening meal long before bedtime.
- Eliminate caffeine from the diet.
- Provide snacks.
- Give a soothing back massage.
- Distract the client with a simple, calm activity like looking at a magazine.
- Maintain a daily exercise routine.

Catastrophic Reactions: When a person with AD overreacts to something, it is called a **catastrophic** (*kat-a-STRAH-fik*) **reaction**. Many situations can cause this reaction, but it is most often triggered by the following:

- Fatigue
- Change of routine, environment, or caregiver
- Overstimulation (too much noise or activity)
- Difficult choices or tasks
- Physical pain or discomfort, including hunger or a need to use the toilet

An HHA can respond to catastrophic reactions as she would to agitation or sundowning. For example, she can remove triggers and help the client focus on a soothing activity.

Violent Behavior: A client who attacks, hits, or threatens someone is using **violence**. Violence may be triggered by many situations, including frustration, overstimulation, or a change in routine, environment, or caregiver. If a client is violent, the HHA should

- Call for help if needed.
- Block blows but never hit back.

- Not try to restrain the client.
- Step out of reach and stay calm.
- Not leave client in the home alone.
- Try to remove triggers.
- Use the same techniques to calm clients as for agitation.

Pacing and Wandering: A client who walks back and forth in the same area is **pacing**. A client who walks aimlessly around the house or neighborhood is **wandering**. Pacing and wandering can have many causes, including the following:

- Restlessness
- Hunger
- Disorientation
- Incontinence or the need to use the toilet
- Constipation
- Pain
- Forgetting how or where to sit down
- Too much daytime napping
- Need for exercise

If a client paces and wanders, the HHA should

- Eliminate causes when possible. For example, provide nutritious snacks, encourage an exercise routine, and maintain an elimination schedule.
- Let the client pace or wander in a safe and secure (locked) area, such as in a level, fenced area (Fig. 10-9). The client should not be restrained.
- Redirect attention to something the client enjoys, such as taking a walk together.
- Mark rooms with signs or pictures, such as stop signs or "closed" signs, as this may prevent clients from wandering into areas where they should not go.
- Report to the supervisor immediately if a client wanders away from a protected area and does not return, or **elopes**.

Fig. 10-9. Make sure a client is in a safe area if he paces or wanders.

Hallucinations or Delusions: A client who sees, hears, smells, tastes, or feels things that are not there is having **hallucinations**. A client who believes things that are not true is having **delusions**. If a client is experiencing hallucinations or delusions, the HHA should

- Ignore harmless hallucinations and delusions.
- Reassure a client who seems agitated or worried.
- Not argue with a client who is imagining things. Challenging the client serves no purpose and can make matters worse. The feelings are real to the client. The HHA should not tell the client that she sees or hears his hallucinations. She should redirect attention to other activities or thoughts.

Depression: People who become withdrawn, isolated, lack energy, and stop eating or doing things they used to enjoy may be depressed. Losing independence and facing the reality of an incurable disease can cause depression. Feelings of failure and fear are other causes. Chemical imbalances can cause depression. Chapter 18 provides more information on depression. If a client is depressed, the HHA should

- Report signs of depression to your supervisor immediately. It is an illness that can be treated with medication.

- Observe for triggers that cause changes in mood.
- Encourage independence, self-care, and activity.
- Listen to clients if they want to share their feelings or talk about their moods.
- Find ways to help foster social interaction and relationships.

Perseveration or Repetitive Phrasing: Clients who have dementia may repeat words, phrases, questions, or activities over and over again. This is called perseveration (*per-SEV-er-ay-shun*) or repetitive phrasing. Such behavior may be caused by several factors, including disorientation or confusion. The HHA should be patient with this behavior and not try to silence or stop the client. She should answer questions each time they are asked, using the same words each time.

Disruptiveness: Disruptive behavior is anything that disturbs others, such as yelling, banging on furniture, and slamming doors. Often this behavior is triggered by pain, constipation, frustration, or a wish for attention. To prevent or respond to disruptive behavior, the HHA should

- Be calm and friendly, and try to find out why the behavior is occurring. There may be a physical reason, such as pain or discomfort.
- Notice and praise improvements in the client's behavior, being sensitive to avoid treating the client like a child.
- Tell the client about any changes in schedules, routines, or the environment in advance. Involving the client in developing routine activities and schedules may help.
- Encourage the client to join in independent activities that are safe (for example, folding towels). This helps the client feel in charge and can prevent feelings of powerlessness. Independence is power.
- Help the client find ways to cope. Focusing on activities the client may still be able to do, such as knitting or crafts, can provide a diversion.

Inappropriate Social Behavior: Inappropriate social behavior may include cursing, name-calling, or yelling. As with violent or disruptive behavior, there may be many reasons why a client is behaving this way. The HHA should try not to take this behavior personally. The client may only be reacting to frustration or other stress. The HHA should remain calm and be reassuring. She can try to find out what caused the behavior (possible causes include too much noise, too many people, too much stress, pain, or discomfort). Any physical abuse or serious verbal abuse should be reported to the supervisor.

Inappropriate Sexual Behavior: Inappropriate sexual behavior, such as removing clothing, touching one's own genitals in public, or trying to touch others can disturb or embarrass those who see it. It is helpful to stay calm and be professional when this behavior occurs. The HHA should not overreact, as this may reinforce the behavior. Trying to determine the cause of the problem may help. Is the behavior actually intentional? Is it consistent? A client may be reacting to a need for physical stimulation or affection. Ways to provide physical stimulation include giving backrubs, offering a soft doll or stuffed animal to cuddle, providing comforting blankets, or giving physical touch that is appropriate.

Hoarding and Rummaging: Hoarding is collecting and putting things away in a guarded way. **Rummaging** is going through drawers, closets, or personal items that belong to oneself or to other people. These behaviors are not within the control of a person who has Alzheimer's disease. Hoarding and rummaging should not be considered stealing. Stealing is planned and requires a conscious effort. In most cases, the person with AD is only collecting something that catches his attention. It is common for those with AD to wander and collect things. They may carry these objects around for a while, and then leave them

in other places. This is not intentional. If the client hoards or rummages, the HHA should

- Regularly check areas where clients store items. They may store uneaten food in these places.
- Provide a rummage drawer—a drawer with items that are safe for the client to take with him.

Sleep Disturbances: Clients who have AD may experience a number of sleep disturbances. If a client experiences sleep problems, the HHA should

- Make sure that the client gets moderate exercise and participates in activities he enjoys throughout the day.
- Allow the client to spend some time each day in natural sunlight if possible. Exposure to light and dark can help establish restful sleep patterns.
- Discourage sleeping during the day if possible.

Suspicion: A person with Alzheimer's disease often becomes suspicious as the disease progresses. Clients may accuse caregivers or family members of lying to them or stealing from them. Suspicion may escalate to paranoia (having intense feelings of distrust and believing others are "out to get" them). When a client is acting suspicious, the HHA should not argue with him. Arguing just increases defensiveness. Instead, the HHA should offer reassurance and be understanding and supportive.

Safe Environments for Clients with AD

A nurse should assess a home's safety before the home health aide visits a client with Alzheimer's disease. She will suggest changes that need to be made. Examples include using gates on stairways, putting locks on certain doors, and removing clutter. When the client's condition changes, the HHA should report it. Another visit will be made to reassess the home and make further changes. In general, the HHA can follow these safety guidelines:

For disoriented clients

- Use signs to mark rooms, including stop signs on rooms that should not be entered.
- Use calendars and other reminders of day, date, and location.
- Put bells on the door to indicate when someone is coming or going.
- Keep pictures and familiar objects around.
- Put stickers or brightly colored tape on glass doors, large windows, or glass furniture.

For clients who wander

- Use locks on doors. These can be installed lower or higher than usual, so the client will not see them.
- Install alarms that sound when exit doors are opened.
- Have clients wear identification. Labels can be affixed to or sewn into clothing.
- Alert neighbors that client may wander. Show them a recent photo of the client. Keep a recent photo handy, as well as a piece of clothing the client has worn. These can help police and police dogs track a client who has wandered away.

For clients who pace

- Remove clutter and throw rugs.
- Do not rearrange furniture.
- Do not wax floors.
- Be sure shoes and slippers fit and have nonslip soles.

For clients who have difficulty walking

- Keep areas well lit, even at night.
- Block access to stairs with a gate.
- Clear walkways of electrical cords and clutter.

General tips include the following:

- Keep medications and other chemicals out of reach.
- Display emergency numbers, including Poison Control, and the client's home address where they can be easily seen.
- Use red tape around radiators or heating vents to prevent burns.

- Check the refrigerator and hiding places for spoiled food.
- Prevent kitchen accidents by removing knobs on the stove, unplugging the toaster and other small appliances, and supervising activities.

9. Describe creative therapies for clients with Alzheimer's disease

Although Alzheimer's disease cannot be cured, there are techniques to improve the quality of life for clients who have AD, including the following:

Validation therapy means letting clients believe they live in the past or in imaginary circumstances. **Validating** means giving value to or approving and making no attempt to reorient the client to actual circumstances. Validating can provide comfort and reduce agitation. Validation therapy is useful in cases of advanced dementia.

Example: Mr. Baldwin tells his HHA he does not want to eat lunch today because he is going out to a restaurant with his wife. The HHA knows his wife has been dead for many years and that Mr. Baldwin can no longer eat out in restaurants. Instead of telling him that he is not going out to eat, the HHA asks what restaurant he is going to and what he will order. The HHA can also suggest that he eat a good lunch now because sometimes the service is slow in restaurants (Fig. 10-10).

Fig. 10-10. Validation therapy accepts a client's fantasies without attempting to reorient him to reality.

Benefits: By playing along with Mr. Baldwin, the HHA lets him know that she takes him seriously and does not think of him as a crazy person or a child who does not know what is happening in his own life. She also learns more about her client, such as that he used to enjoy eating in restaurants and liked certain dishes. Eating out is something he probably associates with being with his wife. This knowledge can help the HHA give better care in the future.

Reminiscence therapy involves encouraging clients to remember and talk about past experiences. The HHA can explore memories by asking about details. Reminiscence therapy can help elderly people remember pleasant times in their past and allow caregivers to increase their understanding of clients. It is useful in many stages of Alzheimer's disease, but especially with moderate to advanced dementia.

Example: Mr. Benavidez, an 86-year-old man with Alzheimer's disease, fought in the Korean War. In his home are many mementos of the war—pictures of his war buddies, a medal he was given, and more. The HHA asks him where he was sent in the war. The HHA asks him more detailed questions about his experiences. Eventually the client shares a lot: the friends he made in the service, why he was given the medal, times when he was scared, and how much he missed his family (Fig. 10-11).

Fig. 10-11. Reminiscence therapy encourages a client to remember and talk about his past.

Benefits: By asking questions about Mr. Benavidez's experiences in the war, the HHA shows an interest in him as a person, not just as a client. This lets the client show that he is a person who was competent, social, responsible, and brave. This boosts his self-esteem. The HHA also learns that Mr. Benavidez cared very much for his wife and daughter.

Activity therapy uses activities the client enjoys to prevent boredom and frustration. These activities also promote self-esteem. The HHA can help the client take walks, do puzzles, listen to music, cook, read, or do other activities she enjoys (Fig. 10-12). Activity therapy is useful throughout most stages of AD.

Fig. 10-12. Activities that are not frustrating can be helpful for clients with AD. They promote mental exercise.

Example: Mrs. Hoebel, a 70-year-old woman with AD, raised four children and ran a household for almost 50 years before being diagnosed with Alzheimer's disease. She loves cooking and baking. She misses being in the kitchen now that she cannot cook for herself. The HHA learns that she always used to bake cookies at Christmas. The HHA purchases some pre-made cookie dough and rolls out the dough. Mrs. Hoebel uses her old cookie cutters to cut out the shapes. The HHA bakes the cookies for her.

Benefits: Mrs. Hoebel can enjoy an activity that always brought her pleasure. She feels competent, because the HHA gave her small tasks, such as cutting out the cookies, that she could handle. The HHA showed care for Mrs. Hoebel by taking the time to help her bake the cookies. This may lead the client to associate positive feelings with the HHA.

10. Discuss how Alzheimer's disease may affect the family

Alzheimer's disease requires the client's family to make adjustments, which may be difficult. The disease progresses at different rates, and people with AD will need more care as the disease progresses. Eventually most people with AD need constant care. How well the family is able to cope with the effects of the disease depends, in part, on the family's emotional and financial resources.

The client who has Alzheimer's disease may be living alone, which can cause the family to worry about her health and safety. Financial resources may be limited, which adds to stress levels. Finding money needed to pay the expenses of home care or adult day services can be difficult. Families do not know what goes on when no one is in the home. They may be afraid that the person is not caring for herself, is not taking medications properly, could wander away, or could cause a fire.

The client may be living with the family, which can cause stress and other emotional difficu' for all involved. The household schedule ' o change; family members will ' edom to come and go as they please. Family members must monitor the loved one's activities and provide constant care. They may lose sleep, as well as lose time to do their own activities and time to relax.

Alzheimer's disease introduces other stressors, too. It is very difficult to watch a loved one's personality change and her health and abilities deteriorate. It is also hard to switch roles—to go from being a child who was once cared for by the parent to being the one caring for the parent.

Home health aides should be sensitive to the big adjustments clients and their families may be making. There are many resources, such as organizations, books, counseling, and support groups, available for people with Alzheimer's disease and their families. The Alzheimer's Association has a helpline that is available 24 hours a day, seven days a week for information, referral, and support. The number is 800-272-3900, and the website is alz.org. The National Institute on Aging provides information by phone at 800-438-4380 or on their Alzheimer's & Related Dementias Education and Referral (ADEAR) Center website, nia.nih.gov/alzheimers. If an HHA thinks that more help is needed, she can inform her supervisor.

Chapter Review

1. How can confusion affect a person?
2. Define *delirium* and list five possible causes.
3. What is dementia?
4. Alzheimer's disease is a progressive, degenerative, and irreversible disease. What does this mean?
5. What type of skills does a person with Alzheimer's disease usually retain?
6. Why should an HHA work with the symptoms and behaviors she observes about a client who has Alzheimer's disease?
7. What is the best way for an HHA to respond to a client who is perseverating (repeating words, phrases, questions, or actions)?
8. When a client with Alzheimer's disease has lost most of her verbal skills, what can the HHA do?
9. Why may developing a routine be helpful for a client who has Alzheimer's disease?
10. When serving a meal to a client who has Alzheimer's disease, how many items of food should the HHA put on the plate at a time?
11. How might an HHA remind a client who has Alzheimer's disease where the bathroom is?
12. What are six ways that an HHA can respond to a client who is experiencing sundowning (becoming restless and agitated in the late afternoon, evening, or night)?
13. Describe these creative therapies for Alzheimer's disease: validation therapy, reminiscence therapy, and activity therapy.
14. What difficulties might families of people who have Alzheimer's disease face?

11 Human Development and Aging

Throughout their lives, people change physically and psychologically. Physical changes occur in the body. Psychological changes occur in the mind and also in the person's behavior. These changes are called human growth and development.

Everyone will go through the same stages of development during their lives, but no two people will follow the exact same pattern or rate of development. The age ranges given here provide a general idea of developmental stages, not an exact description. Each client must be treated as an individual and a whole person who is growing and developing, rather than as someone who is merely ill or disabled.

1. Describe the stages of human development and identify common disorders for each group

Infancy (Birth to 12 Months)

Infants grow and develop very quickly. In one year, a baby moves from total dependence to the relative independence of moving around, communicating basic needs, and feeding herself. Physical development in infancy moves from the head down. For example, infants gain control over the muscles of the neck before they are able to control the muscles in their shoulders. Control over muscles in the trunk area, such as the shoulders, develops before control of the arms and legs (Fig. 11-1). This head-to-toe sequence should be respected when caring for infants. For example, newborns must be supported at the shoulders, head, and neck. Babies who cannot sit or crawl should not be encouraged to stand or walk.

Fig. 11-1. *An infant's physical development moves from the head down.*

Common Disorders: Infancy

CD Babies who are born before 37 weeks gestation (more than three weeks before the due date) are considered **premature**. These babies may weigh from one to six pounds, depending on how early they are born. Often, premature babies will remain in the hospital for some time after birth. At home, premature babies may need special care. This includes medication, heart monitoring, and frequent feedings to ensure weight gain.

CD Babies born at full term but weighing less than five pounds are called **low-birth-**

weight babies. Low-birth-weight babies can have many of the same problems that premature babies have. They are cared for in much the same way as premature babies.

CD The term **birth defect** refers to a physical or structural defect that affects an infant from birth. Some birth defects are inherited from parents. Injury or disease during pregnancy causes others. Some of the conditions include cerebral palsy, Down syndrome, and cystic fibrosis. Chapter 17 contains more information.

CD **Viral** or **bacterial infections** can cause fever, runny nose, coughing, rash, vomiting, diarrhea, or secondary infections of the sinuses or ears. Viral infections are treated with extra rest, fluids, and sometimes medications for cough or congestion. Bacterial infections can be treated with antibiotics.

CD **Sudden infant death syndrome** (**SIDS**) is a condition in which babies stop breathing and die for no known reason while asleep. Doctors do not know how to prevent SIDS. However, studies have shown that putting the baby to sleep on his back can reduce the risk of this syndrome. Because SIDS is more common among premature or low-birth-weight babies, these infants often wear apnea (*AP-nee-a*) monitors to alert parents if breathing stops. Another factor that may contribute to SIDS is secondhand smoke. Parents and caregivers should never smoke around infants or children.

Toddler (Ages 1 to 3)

During the toddler years, children gain independence. One part of this independence is new control over their bodies. Toddlers learn to speak, gain coordination of their limbs, and learn to control their bladders and bowels (Fig. 11-2). Toddlers assert their new independence by exploring. Poisons and other hazards, such as sharp objects, must be locked away. Psychologically, toddlers learn that they are individuals, separate from their parents. Children at this age may try to control their parents. They may try to get what they want by throwing tantrums, whining, or refusing to cooperate. This is a key time for parents to establish rules and standards.

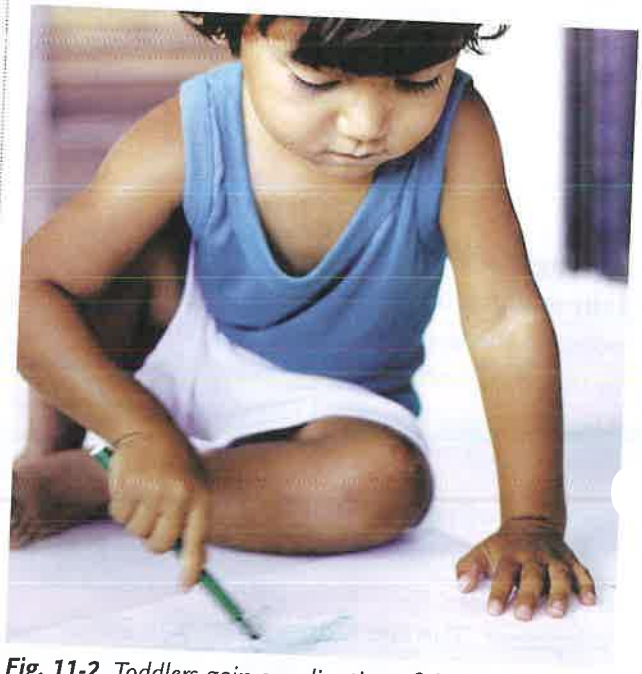

Fig. 11-2. Toddlers gain coordination of their limbs.

Preschool (Ages 3 to 5)

Children in their preschool years develop skills that help them become more independent and have social relationships. They develop a vocabulary and language skills. They learn to play in groups. They become more physically coordinated and learn to care for themselves. Preschoolers also develop ways of relating to family members. They begin to learn right from wrong.

School-Age (Ages 5 to 10)

School-age children's development is centered on **cognitive** (*KOG-ni-tiv*) (related to thinking and learning) and social development. As children enter school, they also explore the environment around them. They relate to other children through games, peer groups, and classroom activities. In these years, children learn to get along with one another (Fig. 11-3). They also begin to develop a conscience, morals, and self-esteem.

Fig. 11-3. School-age children develop social relationships and learn to get along with one another.

Common Disorders: Childhood

CD **Chickenpox** is a highly contagious, viral illness. It generally has no serious effects for healthy children. However, in adults or in anyone with a weakened immune system it can have more serious effects. Taking the varicella-zoster vaccine, commonly called the chickenpox vaccine, can prevent chickenpox.

CD Children, as well as infants, may be susceptible to infections caused by viruses or bacteria. Bacterial infections can be treated with antibiotics. Viral infections are treated with extra rest, fluids, and medications for cough or congestion.

CD **Leukemia** (*loo-KEE-mee-a*) is a form of cancer. It refers to the inability of the body's white blood cells to fight disease. Children with leukemia may be susceptible to infections and other disorders. Chemotherapy can be used to fight this disease. See Chapter 9 for more information on cancer.

Measles, mumps, rubella, diphtheria, smallpox, whooping cough, and polio are diseases that were once common during childhood. They can all be prevented now with vaccinations.

Abuse and neglect were first discussed in Chapter 3. **Child abuse** refers to physical, emotional, and sexual mistreatment of children, as well as neglect. Physical abuse includes hitting, kicking, burning, or intentionally causing injury to a child. Psychological abuse includes withholding affection, constantly criticizing, or ridiculing a child. Sexual abuse includes engaging in or allowing another person to engage in a sexual act with a child. Abuse also includes allowing children to use alcohol or drugs, leaving young children alone, or exposing them to danger. **Child neglect** includes not providing adequate food, clothing, or support. The HHA's responsibility is to report any abuse or suspected abuse immediately to the supervisor. A home care agency and/or the state may have additional guidelines for reporting child abuse or neglect. Chapters 3 and 19 contain more information.

Preadolescence (Ages 10 to 12)

During the years between 10 and 12, children enjoy a growing sense of self-identity and a strong sense of identity with their peers. They tend to be very social. This is usually a relatively calm period, and preadolescents are often easy to get along with and able to handle more responsibility at home and school. Childhood fears of ghosts or monsters will give way to fears based in the real world. It is important that preadolescents feel able to trust in the attention and care of parents or other adults.

Girls may reach puberty in the later years of this stage. During **puberty** (*PYOO-ber-tee*), a person develops secondary sex characteristics. In females, secondary sex characteristics include growth of body hair and development of breasts and hips. In males, they include growth of body hair, growth of the testes and the penis, broadening of the shoulders, and a lower voice.

Adolescence (Ages 12 to 18)

During adolescence, genders become sexually mature. Boys usually reach puberty during this stage. If girls did not reach puberty during the previous stage, it will start here. Many teenagers have a hard time adapting to the rapid changes that occur in their bodies after puberty. Peer acceptance is important to them. Adolescents

(*ad-o-LES-ents*) may be afraid that they are unattractive or abnormal. This concern for body image and peer acceptance, combined with changing hormones that influence moods, can cause rapid mood swings. Conflicting pressures develop as they remain dependent on their parents and yet need to express themselves socially and sexually (Fig. 11-4). This can cause conflict and stress.

Fig. 11-4. *Adolescence is a time of adapting to change.*

Common Disorders: Adolescence

CD As their bodies change, adolescents, especially girls, may develop eating disorders. **Anorexia** (*an-or-EX-ee-a*) is an eating disorder in which a person does not eat or exercises excessively to lose weight. A person with **bulimia** (*boo-LIM-ee-a*) **binges**, eating huge amounts of foods or very fattening foods, and then **purges**, or eliminates the food by vomiting, using laxatives, or exercising excessively. Eating disorders can be serious and even life-threatening. These disorders must be treated with therapy and, in some cases, hospitalization.

CD Teenagers can contract sexually transmitted infections (STIs), such as chlamydia (*kla-MID-ee-a*), genital herpes (*HER-peez*), and AIDS, if they are sexually active. If teenagers are sexually active, condoms can reduce, but not eliminate, the risk of STI transmission. Chapter 9 contains more information.

CD Girls who are sexually active and do not use birth control, or do not use it properly, can become pregnant. **Teenage pregnancy** can have terrible consequences for adolescents, their families, and the babies born to teenage parents. Teenagers should understand that they can avoid pregnancy by using birth control or by practicing abstinence (abstinence means not having sexual contact with anyone). Teenagers who choose to be sexually active should know what birth control methods are available and how to use them. Pregnancy puts a great deal of stress on teenage bodies, which are still developing. In most cases they are not physically ready to bear a child. It is common for teenage mothers to give birth to premature or low-birth-weight babies.

CD Because of the many physical and emotional changes they are experiencing, adolescents may become anxious or depressed and even attempt suicide. Parents, teachers, and friends should watch for the signs of depression. These include withdrawal, loss of appetite, weight gain or loss, sleep problems, moodiness, and apathy. Teenagers who are anxious or depressed should see a doctor, counselor, therapist, minister, or other trusted adult who can get them the help they need.

CD Adolescents can sustain **trauma** (*TRAW-ma*), or severe injury, to the head or spinal cord in car accidents or sports injuries. These injuries can be temporarily or permanently disabling or even fatal.

Young Adulthood (Ages 18 to 40)

Physical growth has usually been completed by this time. Adopting a healthy lifestyle in these years can make life better now and prevent health problems in later adulthood. Psychological and social development continues, however. The tasks of these years include the following:

- Selecting an appropriate education
- Selecting an occupation or career
- Selecting a mate (Fig. 11-5)
- Learning to live with a mate or others
- Raising children
- Developing a satisfying sex life

Fig. 11-5. Young adulthood often involves finding mates.

Middle Adulthood (Ages 40 to 65)

In general, people in middle adulthood are more comfortable and stable than they were in previous stages. Many of their major life decisions have already been made. In the early years of middle adulthood, people sometimes experience a "midlife crisis." This is a period of unrest centered on an unconscious desire for change and fulfillment of unmet goals.

Physical changes related to aging also occur in middle adulthood. Adults in this age group may notice that they have difficulty maintaining their weight or notice a decrease in strength and energy. Metabolism and other body functions slow down. Wrinkles and gray hair appear. Vision and hearing loss may begin. Women experience **menopause** (*MEN-o-paws*), the end of menstruation (occurs when a woman has not had a menstrual period for 12 months). This occurs when the ovaries stop secreting hormones. Many diseases and illnesses can develop in these years. These disorders can become chronic and life-threatening.

Late Adulthood (65 years and older)

Persons in late adulthood must adjust to the effects of aging. These changes can include the loss of physical strength and health, the death of loved ones, retirement, and preparation for their own death. Although the developmental tasks of this age may appear to deal entirely with loss, solutions often involve new relationships, friendships, and interests.

Because so many of the people receiving home health care are older adults, the rest of this chapter contains more information about aging and the needs of elderly clients. Common disorders of this age group (arthritis, Alzheimer's disease, cancer, diabetes, and stroke) are covered in Chapters 9 and 10.

2. Distinguish between fact (what is true) and fallacy (what is not true) about the aging process

Geriatrics is the branch of medicine that deals with the diagnosis, treatment, and prevention of disease in older and elderly adults, as well as problems related to aging. **Gerontology** is the study of the aging process in people from midlife through old age. Gerontologists look at the impact of the aging population on society.

Because later adulthood covers an age range of as many as 25 to 35 years, people in this age category can have very different capabilities, depending on their health. Some 70-year-old people still enjoy active sports, while others are not active. Many 85-year-old people can still live alone, though others may live with family members or in skilled care facilities.

Ideas and stereotypes about older people are often false. They create prejudices against the elderly that are as unfair as prejudices against racial, ethnic, or religious groups. In movies, older people are often shown as helpless, lonely, disabled, slow, forgetful, dependent, or inactive. However, research indicates that most older

people are active and engaged in work, volunteer activities, learning programs, and exercise regimens. Aging is a normal process, not a disease. Most older people live independent lives and do not need assistance (Fig. 11-6). Prejudice toward, stereotyping of, and/or discrimination against older persons or the elderly is called **ageism**.

Fig. 11-6. Most older people lead active lives.

Home health aides are likely to spend much of their time working with elderly clients. They must be able to know what is true about aging and what is not true. Aging causes many physical, psychological, and social changes. However, normal changes of aging do not mean an older person must become dependent, ill, or inactive. Knowing normal changes of aging from signs of illness or disability will allow HHAs to better help elderly clients.

3. Discuss normal changes of aging and list care guidelines

Each person ages in a unique way, influenced by genetics and lifestyle. Although a person cannot choose her genetic makeup, she can choose the lifestyle she leads. Habits of diet, exercise, attitude, social and physical activities, and health maintenance affect well-being later in life.

Some older clients will need assistance in performing activities of daily living (ADLs). Clients who are chronically ill and need a lot of help still benefit from living at home. Home health aides perform an important role in letting older clients stay in familiar surroundings while getting the help they need. Remembering the changes that occur in the elderly will help HHAs provide the right care. Over the next several pages, there is information describing normal changes of aging for each body system.

Integumentary System

Changes: Skin is thinner, drier, and more fragile. It is more easily damaged. Skin is less elastic. Much of the fatty layer beneath the skin is lost, so the person may feel colder. Hair thins and may turn gray. Wrinkles and brown spots, or "liver spots," appear. Nails are harder and more brittle. Dry, itchy skin may result from lack of oil from the sebaceous glands.

Guidelines: Care for the Integumentary System

- G Older adults perspire less and do not need to bathe as often. Most elderly people generally need a complete bath only twice a week, with sponge baths every day.
- G Use lotions as ordered for moisture to relieve dry skin. Be gentle; elderly clients' skin can be fragile and tear easily.
- G Hair becomes drier and needs to be shampooed less often. Gently brush dry hair to stimulate the scalp and distribute the natural oils (Fig. 11-7).

Fig. 11-7. Brushing hair helps stimulate the scalp and distribute natural oils.

- G Layer clothing and bed covers for additional warmth.
- G Keep bed linens wrinkle-free.
- G Encourage fluids.

Musculoskeletal System

Changes: Muscles weaken and lose tone. Body movement slows. Bones lose density. Bones may become more brittle, making them more susceptible to breaks. Joints may stiffen and become painful. There is a gradual loss of height.

Guidelines: Care for the Musculoskeletal System

- Falls can cause life-threatening complications, including fractures. Prevent falls by keeping items out of clients' paths. Keep furniture in the same place. Keep walkers and canes where clients can easily reach them. Be sure the client is wearing nonskid shoes and that the laces are tied. Immediately clean up spills.
- Encourage regular movement and self-care. Assist with range of motion (ROM) exercises as needed. Chapter 16 contains more information on these exercises. Encourage the client to perform as many ADLs as possible. For example, encourage clients to eat at the table and walk to the bathroom until these activities are no longer possible. Encourage clients to make decisions and dress themselves, with assistance if necessary, no matter how long it takes.
- To prevent or slow **osteoporosis** (*os-tee-oh-po-RO-sis*), the condition that is responsible for fragile bones, encourage clients to walk and do other light exercise. Exercise can strengthen bones as well as muscles.

Nervous System

Changes: Aging affects the ability to think quickly and logically. How much ability is lost depends on the individual. Aging can also affect concentration and memory. Elderly clients may experience memory loss of recent events. This short-term memory loss may cause anxiety in older clients. Long-term memory, or memory for past events, usually remains sharp. Elderly clients usually have slower responses and reflexes. Sensitivity of nerve endings in the skin decreases.

Guidelines: Care for the Nervous System

- Help with memory loss by suggesting clients make lists or write notes about things they want to remember. Keeping a calendar close by may help.
- If clients enjoy reminiscing, take an interest in their past by asking to see photos or hear stories.
- Allow time for decision-making and avoid sudden changes in schedule.
- Allow plenty of time for movement; never rush the person.
- Encourage reading, thinking, and other mental activities.

Changes in vision, hearing, taste, and smell: Failing vision may make reading or other activities difficult for many elderly clients. Failing hearing may make it frustrating for older adults to try to communicate. A weakened sense of smell, taste, and touch may present dangers for older adults.

Guidelines: Care for the Sense Organs

- Digital books and audiobooks are available. There are many websites, as well as smartphone apps, that sell, rent, or share these books: bookshare.org, audible.com, and amazon.com. Assist with these types of digital options if needed. Many books and some magazines are available in large type print.
- Encourage the use of eyeglasses and keep clients' eyeglasses clean. Bright colors and proper lighting will also help clients with poor eyesight. When going into another room, be sure the lights are on before the client enters.
- If a client is having trouble hearing, speak in a low-pitched voice. For some people, low-pitched sounds are easier to hear. You may

also need to repeat words to help the client understand them. Some clients need hearing aids and should be encouraged to use them. Excess earwax can make hearing difficult. If excess earwax is suspected, tell your supervisor. A nurse can treat this problem.

- If a client has difficulty hearing, face him and speak slowly, simply, and clearly. Do not shout. Do not assume that all elderly clients are hard of hearing. Speaking loudly or oversimplifying your speech when it is not necessary can make clients feel they are being treated like children.
- Because taste buds are lost as a person ages, older people often cannot taste as well. Decreased sense of smell may contribute to the altered sense of taste. Encourage careful mouth care. Make sure food in the house is fresh because older clients may not be able to smell or taste that food is spoiled. Older clients should always have smoke detectors in their homes, since they may not smell smoke.
- Loss of smell may make clients unaware of increased body odor. Assist as needed with regular bathing.
- Be careful with hot drinks and hot bath water. Clients sometimes cannot tell if something is too hot for them. The elderly client who is confined to bed may not feel uncomfortable, but because of decreased circulation and dry skin, he is at risk for developing pressure injuries. The sense of pain may also be diminished in the elderly. Be alert to changes in clients' health.

Circulatory System

Changes: As a person ages, the heart pumps less efficiently. Increased activity places greater demand on the heart, which it may not be able to meet. Older people may need more rest to reduce demand on the heart. They may not be able to walk long distances, climb stairs, or exert themselves. Less efficient circulation of blood in older people causes older adults to be more sensitive to the cold.

Guidelines: Care for the Circulatory System

- Moderate exercise is necessary and helpful (Fig. 11-8). Walking, stretching, and even lifting light weights can help older people maintain strength and promote circulation. Assist as needed.

Fig. 11-8. *Moderate exercise promotes circulation and can help older adults maintain strength.*

- Help with active or passive ROM exercises as directed for clients who cannot get out of bed. Each client's care plan will specify what kinds of exercise he should be doing. Abilities can vary a great deal from client to client.
- Clients with heart conditions, particularly heart failure, must avoid vigorous activity or exercise. This includes carrying heavy objects. Some clients may experience dizziness when they stand up too quickly.

  Encourage clients to rise slowly and to stand still for a few moments, supporting themselves by holding on to a piece of furniture (Fig. 11-9).
- Houses may need to be kept at a higher temperature than normal. Layer clothing to keep clients warm. Some clients who are concerned about the cost of heating may actually lower the thermostat to a dangerous level.
- Poor circulation causes the feet to feel cold. Be sure the client wears nonskid slippers or shoes and socks.

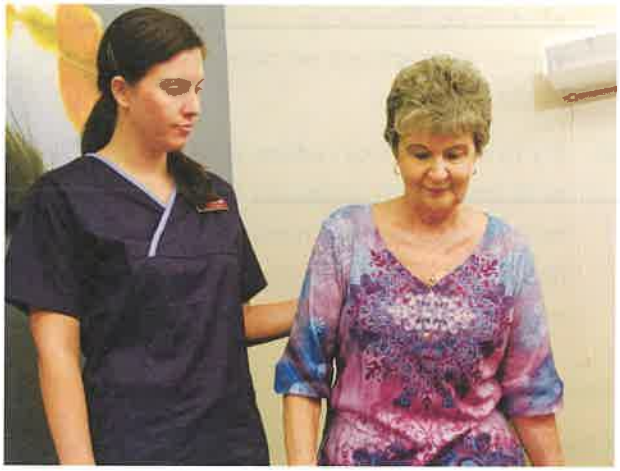

Fig. 11-9. An older adult may need to rise slowly and stand still for a moment to keep from getting dizzy.

- Do not use hot water bottles or heating pads. Poor circulation causes dry skin that is fragile and can burn easily. In addition, because of the dulled sense of pain, an older person may not realize he is being burned until it is too late.

Respiratory System

Changes: As the body ages, lung strength and lung capacity decrease. The lungs have fewer alveoli in which oxygen/carbon dioxide exchange can take place. Oxygen in the blood decreases. Older clients may have a harder time coughing up mucus. The voice weakens.

Guidelines: Care for the Respiratory System

- Provide rest periods as needed when assisting a client with ADLs.
- Follow the care plan's exercise and activity instructions carefully. Moderate exercise is helpful, but overdoing it can be very dangerous for an older adult. If you have a question about activity, talk to your supervisor.
- Assist with deep breathing exercises as ordered in the care plan.
- Make sure people with acute or chronic upper respiratory conditions are not exposed to cigarette smoke or polluted air.
- People who have difficulty breathing will usually be more comfortable sitting up than lying down.

Urinary System

Changes: The ability of the kidneys to filter blood decreases. The bladder's muscle tone weakens. The bladder is not able to hold the same amount of urine as it did when clients were younger. Older clients may need to urinate more often and may awaken several times during the night to urinate. The bladder may not empty completely, making it susceptible to infection.

Guidelines: Care for the Urinary System

- Encourage clients to drink plenty of fluids. Offer frequent trips to the bathroom.
- **Urinary incontinence** is the inability to control the bladder, which leads to an involuntary loss of urine. Incontinence is *not* a normal part of aging. Always report incontinence. It may be a sign of an illness. Cleanliness and regular skin care are important. Keep clients clean and dry. Encourage fluids even if incontinence is a problem.

Gastrointestinal System

Changes: Older people may have a dulled sense of taste. This is often made worse by side effects of medications, and may result in a poor appetite. Decreased saliva production affects the ability to chew and swallow. Absorption of vitamins and minerals decreases. Digestion takes longer and is less efficient in older adults. Many older adults have trouble with indigestion, or an upset stomach. **Peristalsis** (muscular contractions that push food through the gastrointestinal tract) slows. Constipation, the inability to have a bowel movement or the infrequent, difficult, and often painful elimination of a hard, dry stool, may occur.

Guidelines: Care for the Gastrointestinal System

- Encourage fluids and nutritious, appealing meals. Well-seasoned foods may increase food intake.
- Older people who have trouble chewing may require soft foods. Make sure dentures fit properly and are cleaned regularly. Give regular mouth care.
- Allow time to eat and make mealtime enjoyable. Make simple conversation during meals if the client desires. Talk about the food that is being served in a positive way.
- Clients who have trouble chewing and swallowing are at risk of choking. Provide plenty of fluids with meals. Cut food into smaller pieces if ordered.
- Some clients need to eat several small meals a day or have the largest meal in the middle of the day.
- Clients should eat a high-fiber diet and drink plenty of fluids to help prevent constipation.

Dehydration is a condition that results from inadequate fluid in the body. It is not a normal change of aging. However, many older people do not feel thirsty and may not be aware that they are dehydrated. Dehydration can cause constipation, weight loss, dry skin, infection, dizziness, weakness, and other illnesses that require medical attention. Chapter 22 has more information on dehydration.

Endocrine System

Changes: Levels of hormones, such as estrogen and progesterone, decrease. Insulin production lessens. The body is less able to handle stress.

Guidelines: Care for the Endocrine System

- Older clients may need to take insulin or eat certain foods to regulate blood sugar. The client's doctor or nurse will teach the client what to do. Encourage proper nutrition. Any special instructions on care will be included in the care plan.
- Try to eliminate or reduce stressors. A stressor is anything that causes stress. Exercise can help reduce stress. Encourage exercise if it is ordered in the care plan. In addition, offer encouragement and listen to clients.

Reproductive System

Changes: In females, menstruation ends. A decrease in estrogen may lead to a loss of calcium, which can cause brittle bones and, potentially, osteoporosis. Vaginal walls become drier and thinner. In males, sperm production decreases. The prostate gland enlarges, which can interfere with urination. Though the reproductive organs change, sexual needs and desires do not necessarily change.

Guidelines: Care for the Reproductive System

- Avoid too many hot baths to help prevent discomfort in the genital area.
- Despite changes in the reproductive organs, older adults remain sexual beings. Provide privacy whenever necessary for sexual activity. Respect clients' sexual needs. Do not make any generalizations about the sexual feelings of older adults.
- Do report any behavior that makes you uncomfortable or that seems inappropriate. Inappropriate behavior is not a normal sign of aging and could be a sign of illness.

Immune and Lymphatic Systems

Changes: As a person ages, his immune system gradually weakens, increasing the risk of all types of infections. It also may take longer to recover from an illness. Bone marrow activity (which produces white blood cells that fight infections) decreases. Changes in the respiratory system's protective surface may result in in-

creased respiratory infections. The number and size of lymph nodes are reduced. This results in the body being less able to develop a fever to fight infection. The body's response to vaccines decreases.

Guidelines: Care for the Immune and Lymphatic Systems

- **G** Follow rules for preventing infection. Wash your hands often. Keep the client's environment clean.
- **G** Encourage and help with personal hygiene. Encourage proper nutrition and fluid intake. Promote a comfortable environment that allows for enough rest.
- **G** An older adult fighting an infection may not experience a fever. Even a slight temperature increase may indicate that the person is fighting an infection. Measure vital signs accurately (Chapter 14).

Psychological Changes

Some forgetfulness is a normal part of aging, but constant memory lapses or forgetting basic information, such as family members' names, are not normal changes of aging. Temporary changes in mental function may occur and may be caused by any of the following:

- Urinary tract infections
- Mild strokes
- Some diseases of the heart, lungs, liver, and kidneys
- Head injuries
- Brain infections or tumors
- High fever
- Diabetes
- Pneumonia
- Poor nutrition
- Alcohol use
- Drugs and drug interactions

Observing and Reporting: Psychological Changes

Report any of the following to your supervisor:

- O/R **Disorientation**, or change in ability to remember who they are, where they are, what month or season of the year it is, or other basic facts
- O/R Difficulty concentrating
- O/R Signs of depression
- O/R Dementia, or a loss of mental abilities that interferes with activities of daily living
- O/R Confusion
- O/R Suicidal thoughts
- O/R Insomnia (inability to sleep)

Depression is very common among the elderly, but it is not a normal sign of aging. Elderly persons may not admit feelings of depression to themselves or others. According to the National Center for Health Statistics, the elderly are at higher risk for suicide than other age groups. A home health aide must report any signs of depression to his supervisor. In many cases, depression may be successfully treated. Chapter 18 contains more information.

Observing and Reporting: Depression

Report any of the following to your supervisor:

- O/R Loss of appetite or overeating
- O/R Lack of attention to basic personal care tasks, such as bathing or combing hair
- O/R Pain, including headaches, stomach pain, and other body aches
- O/R Acting moody or withdrawn

- O/R Other changes in appearance, speech, movement, and behavior
- O/R Comments about suicide
- O/R Sleep disorders and emotional changes, such as hopelessness, anxiety, apathy, agitation, restlessness, withdrawal, and demanding or violent behavior, are particularly important to report.

Lifestyle Changes

Changes: Aging brings many social, physical, and mental changes. Friends, colleagues, and relatives die. Physical strength and stamina diminish. Fears of illness, injury, and death may increase. Retirement causes changes in what and how much people do each day. Living arrangements may also change. These changes require adjustment, which can become more difficult as people age.

Care:

- Help clients adjust to change by listening to them and caring about their feelings. Report to the supervisor if clients express a need to speak to a counselor or therapist, or if you think a client may benefit from talking with a specialist.
- Ensuring that clients are safe is another way you can help them adapt to changing lifestyles. Chapter 6 has more information.

4. Identify attitudes and habits that promote health

Staying active, maintaining self-esteem, and living independently promote physical and mental health for older adults. The following are ways that a home health aide can encourage clients to be healthy:

Encourage clients to pursue activities they enjoy and can succeed in. Many older people enjoy reading, playing cards and other games, gardening, doing crafts, or listening to music (Fig. 11-10). Working with others on charity or community service projects can allow older people to share their knowledge and experience. Senior centers or community centers offer classes, hobby groups, exercise, and field trips that some older clients may enjoy. Many older people are involved in activities through their places of worship. Encourage clients by asking them about what they are doing, admiring their work, or even participating in games or crafts when time permits.

Fig. 11-10. *Continuing to participate in activities they enjoy promotes mental and physical health for older adults.*

Help clients develop a routine for the day. Structuring the day around meals, activities, rest, and self-care can help fight depression and give older people a sense of purpose. Older people who do not have a routine may simply stay in bed or become bored and lonely.

Encourage self-care. Clients should do as much for themselves as they possibly can. An HHA's job is to assist with or perform activities the client cannot do alone. The more clients can care for themselves, the better they will feel about themselves. Follow the care plan. Keep in touch with your supervisor about changes in the client's abilities.

Help clients to be well-groomed. Appearance affects the way a person feels about herself. Help clients style hair, dress neatly, and use cosmetics or shave (Chapter 13) (Fig. 11-11).

Address clients respectfully. Do not call clients by their first names unless they ask you to. Do

not call them *honey, sweetie,* or *dear.* Use their last names with whatever title they prefer (Mr., Ms., Miss, Mrs., or Dr.). Use the pronouns they prefer (she/her, he/him, they/them). Speak to them with respect and provide person-centered care. Ask for their opinions and let them make their own decisions as much as possible. The more independent and capable they feel, the more independent and capable they will be. Never treat a client like a child or talk about a client as if he were not there.

Fig. 11-11. *A well-groomed appearance helps people of all ages feel good about themselves.*

Respect the needs for privacy and for social interaction. Let a client be alone to read, study, pray, meditate, or work if he seems to want this. Knock before entering the room, even if the door is open (Fig. 11-12).

Fig. 11-12. *Respect clients' privacy. Knock before entering any room, even if the door is open.*

Remember that clients may not want to talk all the time. When visitors come, let the client visit undisturbed. Do not try to participate in the conversation. Treat visitors respectfully and make them feel welcome. Even if an unannounced visit disrupts your schedule, remember how important social contact is for your client. Try to be flexible.

Chapter Review

1. Name at least two common disorders for each stage of human development.
2. In the movies, elderly people are often shown as helpless, lonely, disabled, slow, forgetful, dependent, or inactive. What is actually true of most older adults?
3. For each body system listed in Learning Objective 3, list two normal changes of aging.
4. How can an HHA help prevent or slow osteoporosis?
5. Name five signs and symptoms an HHA needs to report about a client's psychological health.
6. How can an HHA help a client who is hard of hearing?
7. What can an HHA do to help clients with a poor sense of touch?
8. What should an HHA do if her client experiences dizziness when she stands up?
9. Why might older clients need to urinate more frequently?
10. What are two things that can help prevent constipation?
11. Describe two ways that an HHA can help properly care for clients' immune systems.
12. What are possible signs of depression?
13. How can an HHA help her clients adjust to lifestyle changes due to aging?
14. Why should an HHA encourage her clients to do as much for themselves as possible?
15. Name one way an HHA can show respect for her clients' privacy.

12 Positioning, Transfers, and Ambulation

1. Explain positioning and describe how to safely position clients

Clients who spend a lot of time in bed often need help getting into comfortable positions. They also need to change positions periodically to avoid muscle stiffness and skin breakdown. Too much pressure on one area for too long can cause a decrease in circulation, which can lead to pressure injuries and other problems like muscle contractures. **Positioning** means helping clients into positions that promote comfort and health. Bedbound clients should be repositioned at least every two hours. Clients in wheelchairs or chairs should be repositioned at least every hour. Each time there is a change of position, the home health aide should document the position and the time.

Which position a client uses depends on the diagnosis, the condition, and the client's preference. The care plan will give specific positioning instructions. It is important to remember that even immobile clients must not remain in the position in which they are placed for long. They should be checked regularly. When positioning residents, HHAs must use proper body mechanics to help prevent injury. HHAs should also check the skin for any problems such as whiteness, redness, or warm spots, especially around bony areas, each time they reposition clients.

The following are guidelines for positioning clients in the five basic body positions:

Supine (*SUE-pine*): In this position, the client lies flat on her back. To maintain correct body position, the head and shoulders should be supported with a pillow (Fig. 12-1). Pillows, rolled towels, or washcloths can also be used to support her arms (especially a weak or immobilized arm) or hands. A pillow should be placed under the calves so the heels are elevated ("floating") and do not touch the bed. Pillows or a footboard (padded board placed against the client's feet) can keep the feet positioned properly.

Fig. 12-1. *A person in the supine position is lying flat on her back.*

Lateral/side: A client in the lateral position is lying on either side (Fig. 12-2). There are many variations of this position. Pillows can support the arm and leg on the upper side, the back, and the head. Ideally, the knee on the upper side of the body should be flexed. The leg is brought in front of the body and supported on a pillow. There should be a pillow under the bottom foot so that the toes and ankle are not touching the bed. If the top leg cannot be brought forward, it should be placed slightly behind the bottom leg, not resting directly on it. Pillows should be used between the two legs and ankles to relieve pressure and avoid skin breakdown.

Fig. 12-2. A person in the lateral position is lying on his side.

Prone: A client in the prone position is lying on the stomach or front side of the body (Fig. 12-3). This is not a comfortable position for many people, especially elderly people. The HHA should never leave a client in a prone position for very long and should check the care plan before using the prone position. In this position, the arms are either placed at the sides or raised above the head, or one is raised and one is by the side. The head is turned to one side and a small pillow may be used under the head and legs. A pillow under the legs helps keeps the feet from touching the bed.

Fig. 12-3. A person in the prone position is lying on his stomach.

Fowler's: A client in the Fowler's position is in a semisitting position (45 to 60 degrees) (Fig. 12-4). The head and shoulders are elevated. The client's knees may be flexed and elevated, using a pillow or rolled blanket as a support.

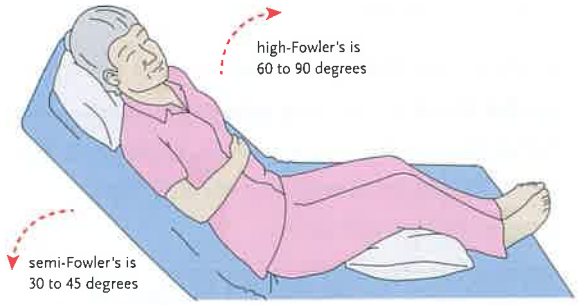

Fig. 12-4. A person in the Fowler's position is partially reclined.

The feet may be supported using a footboard or other support. The spine should be straight. In a high-Fowler's position, the upper body is sitting nearly straight up (60 to 90 degrees). In a semi-Fowler's position, the upper body is not raised as high (30 to 45 degrees).

Sims': The Sims' position is a left side-lying position (Fig. 12-5). The lower arm is behind the back, and the upper knee is flexed and raised toward the chest, using a pillow as support. There should be a pillow under the bottom foot so that the toes and ankle do not touch the bed.

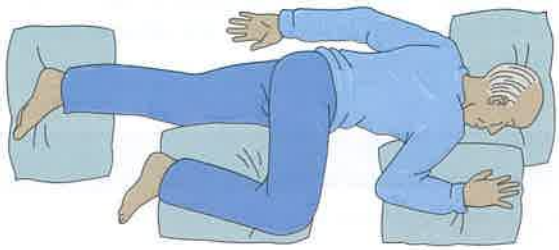

Fig. 12-5. A person in the Sims' position is lying on his left side with one leg drawn up.

The positions indicated in the care plan should be used. If an HHA has questions about how to position a client, she should ask her supervisor. In general, positions that are natural and comfortable for the client should be used.

When moving or positioning a client, the HHA should use proper body mechanics (Chapter 6). Lifting should be avoided whenever possible. It is safer to push, roll, slide, or pivot, rather than bearing the client's weight. Using proper body mechanics promotes safety.

Helping a client move up in bed helps prevent skin irritation that can lead to pressure injuries. An HHA should get help if she thinks it is not safe to move the client by herself. If the client cannot help with moving, a draw sheet, turning sheet, transfer sheet, or glide sheet should be used (Fig. 12-6). A **draw sheet** is an extra sheet placed on top of the bottom sheet when the bed is made. Draw sheets help prevent skin damage caused by shearing. **Shearing** is rubbing or friction that results from the skin moving one way and the bone underneath it remaining fixed or moving in the opposite direction.

Fig. 12-6. There are different types of devices used for positioning and transferring. This photo shows a draw sheet that can be left in place after the move or transfer is complete. (PHOTO © MEDLINE INDUSTRIES, INC. 2020)

Moving a client up in bed

Equipment: draw sheet or other device

When the client cannot assist, and there is no one else around to help you move her up in bed, take the following steps:

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy if the client desires it.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If the bed is movable, lock bed wheels.
5. Lower the head of the bed to make it flat. Move the pillow to the head of the bed.
6. Stand behind the head of the bed with your feet shoulder-width apart and one foot slightly in front of the other.
7. Roll and grasp the top edge of the draw sheet.
8. Bend your knees and keep your back straight. Rock your weight from the front foot to the back foot in one smooth motion, while pulling the draw sheet and client toward the head of the bed (Fig. 12-7).

Fig. 12-7. *While grasping the draw sheet, pull the client toward the head of the bed.*

9. Put the pillow back under the client's head and arrange the blankets for her. Unroll the draw sheet and leave it in place for the next repositioning. If using another type of device (other than a draw sheet), you will need to remove it. If you raised an adjustable bed, return it to its lowest position.
10. Wash your hands.
11. Document the procedure and any observations.

When you have help from another person, you can modify the procedure as follows:

1. Follow steps 1 through 5 above.
2. Stand on one side of the bed with your feet shoulder-width apart. Face the head of the bed. The foot that is closer to the head of the bed should be pointed toward the head of the bed. Your helper should be standing on the other side of the bed.
3. Both of you should roll the draw sheet up to the client's side and grasp the sheet. One hand should be at the client's shoulders, the other about level with the client's hips. Use proper body mechanics.
4. Let the client know you will be moving her on the count of three. Shift your weight to your back foot (the foot closer to the foot of the bed). Have your helper do the same (Fig. 12-8). On the count of three, you and your

helper both shift your weight to the forward foot. Slide the draw sheet and client toward the head of the bed.

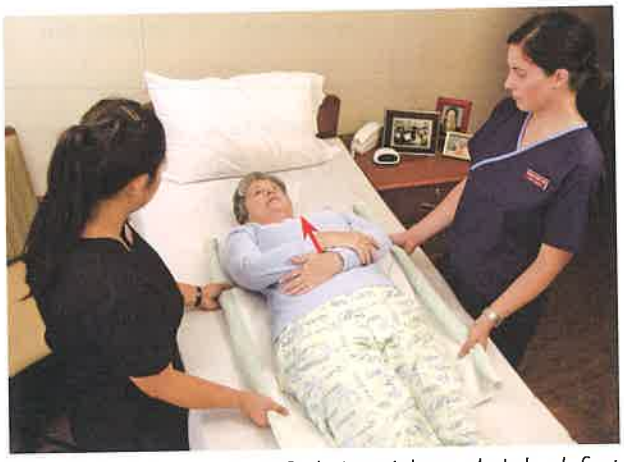

Fig. 12-8. *Both people shift their weight to their back foot and prepare to move.*

5. Put pillow back under client's head and arrange the blankets for her. Unroll the draw sheet and leave it in place for the next repositioning (Fig. 12-9). If using another type of device (other than a draw sheet), you will need to remove it. If you raised an adjustable bed, return it to its lowest position.

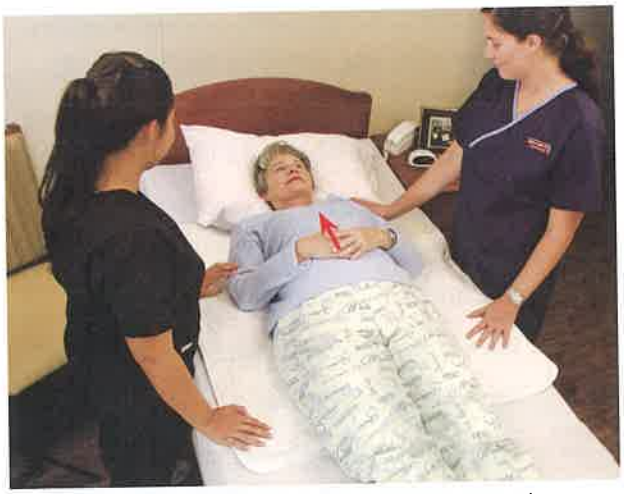

Fig. 12-9. *Unroll the draw sheet and leave it in place.*

6. Wash your hands.
7. Document the procedure and any observations.

Moving a client to the side of the bed

Equipment: draw sheet

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If the bed is movable, lock bed wheels.
5. Lower the head of the bed.
6. Stand on the side of the bed to which you are moving the client. Stand with feet shoulder-width apart. Bend your knees and keep your back straight.
7. **With a draw sheet**: Roll the draw sheet up to the client's side and grasp the sheet. One hand should be at the client's shoulders, the other about level with the client's hips. Place one knee against the side of the bed, and lean back with your body. Let the client know you will be moving her on the count of three. On the count of three, pull the draw sheet and client toward you.

   Unroll the draw sheet and leave it in place for the next repositioning. If using another type of device (other than a draw sheet), you will need to remove it.

   Without a draw sheet: Gently slide your hands under the client's head and shoulders and move them toward you. Gently slide your hands under her midsection and move it toward you. Gently slide your hands under the hips and legs and move them toward you (Fig. 12-10).
8. If you raised an adjustable bed, return it to its lowest position

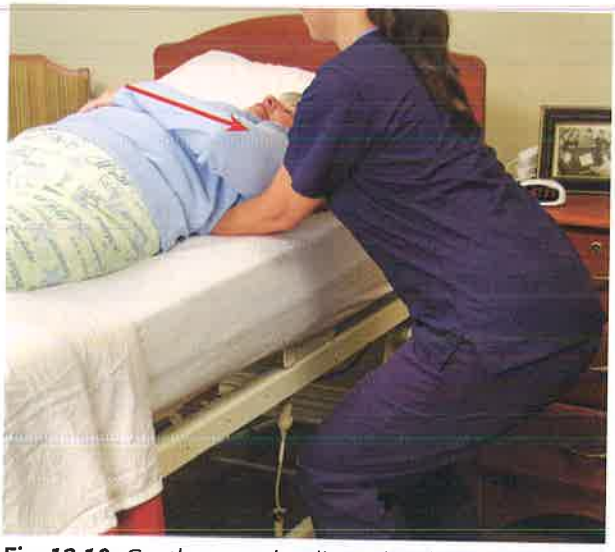

Fig. 12-10. Gently move the client's head and shoulders toward you.

9. Wash your hands.
10. Document the procedure and any observations.

Positioning a client on his side

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If the bed is movable, lock bed wheels.
5. Lower the head of the bed to make it flat.
6. Move the client to the side of the bed near you, using the previous procedure.
7. If the bed has side rails, raise the far side rail.

Turning a client away from you:

a. Cross the client's arms over his chest. Cross the near leg over the far leg.

b. Stand with feet shoulder-width apart. Bend your knees.

c. Place one hand on the client's near shoulder. Place the other hand on the near hip.

d. While supporting the body, gently roll the client onto his side as one unit, toward the raised side rail.

If the bed does not have side rails, you may need to turn the client toward you. Follow agency policy.

Turning a client toward you:

a. Cross the client's far arm over his chest. Move the arm on the side the client is being turned to out of the way. Cross the far leg over the near leg.

b. Stand with feet shoulder-width apart. Bend your knees.

c. Place one hand on the client's far shoulder. Place the other hand on the far hip.

d. While supporting the body, gently roll the client onto his side as one unit, toward you. Use your body to block the client to prevent him from rolling out of bed.

8. Position the client properly and comfortably. Proper positioning includes the following:
   - Head supported by a pillow (client's face should not be obstructed by the pillow)
   - Shoulder adjusted so the client is not lying on his arm or hand
   - Top arm supported by a pillow
   - Back supported by a supportive device
   - Top knee flexed
   - Supportive device between legs with top knee flexed; knee and ankle supported
   - Pillow under the bottom foot so that toes and ankle are not touching the bed
9. If you raised an adjustable bed, return it to its lowest position. Leave side rails in ordered position.
10. Wash your hands.

11. Document the procedure and any observations.

Some clients' spinal columns must be kept in alignment. To turn these clients in bed, they have to be logrolled. **Logrolling** means moving a client as a unit, without disturbing the alignment of the body. The head, back, and legs must be kept in a straight line. This is necessary in cases of neck or back problems, spinal cord injuries, or after back or hip surgeries. It is safer for two people to perform this procedure together. A draw sheet helps with moving.

Logrolling a client

Equipment: draw sheet, second person

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust bed to a safe working level, usually waist high. If the bed is movable, lock bed wheels.
5. Lower the head of the bed to make it flat.
6. Both of you stand on the same side of the bed. One person stands at the client's head and shoulders. The other stands near the client's midsection.
7. Place a pillow under the client's head to support the neck during the move.
8. Place the client's arms across his chest. Place a pillow between the knees.
9. Stand with your feet shoulder-width apart. Bend your knees.
10. Grasp the draw sheet on the far side (Fig. 12-11).

Fig. 12-11. *Both of you grasp the draw sheet on the far side.*

11. Let the client know you will be moving him on the count of three. On the count of three, gently roll the client toward you. Turn the client as a unit (Fig. 12-12). Use your bodies to block the client to prevent him from rolling out of bed.

Fig. 12-12. *On the count of three, both workers should roll the client toward them, turning him as a unit.*

12. Reposition the client comfortably. Check the client's body alignment. Unroll the draw sheet and leave it in place for the next repositioning. If using another type of device (other than a draw sheet), you will need to remove it. Arrange pillows and covers for comfort. If you raised an adjustable bed, return it to its lowest position.

13. Wash your hands.
14. Document the procedure and any observations.

Before a client who has been lying down stands up, he should dangle. To **dangle** means to sit up on the side of the bed with the legs hanging over the side. This helps clients regain balance before standing up and allows blood pressure to stabilize. It helps prevent dizziness and lightheadedness that can cause fainting. For some clients who are unable to walk, sitting up and dangling the legs for a few minutes may be ordered.

Assisting a client to sit up on the side of the bed: dangling

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to lowest position. If the bed is movable, lock bed wheels.
5. Raise the head of the bed to a sitting position. Fanfold (fold into pleats) the top covers to the foot of the bed. Ask the client to turn onto his side, facing you. Assist as needed (see earlier procedure).
6. Tell the client to reach across his chest with his top arm and place his hand on the edge of the bed near his opposite shoulder. Ask him to push down on that hand to raise his shoulders up while swinging his legs over the side of the bed (Fig. 12-13).
7. Always allow the client to do all he can for himself. However, if the client needs assistance, follow these steps:

a. Stand with your feet shoulder-width apart. Bend your knees. Keep your back straight.

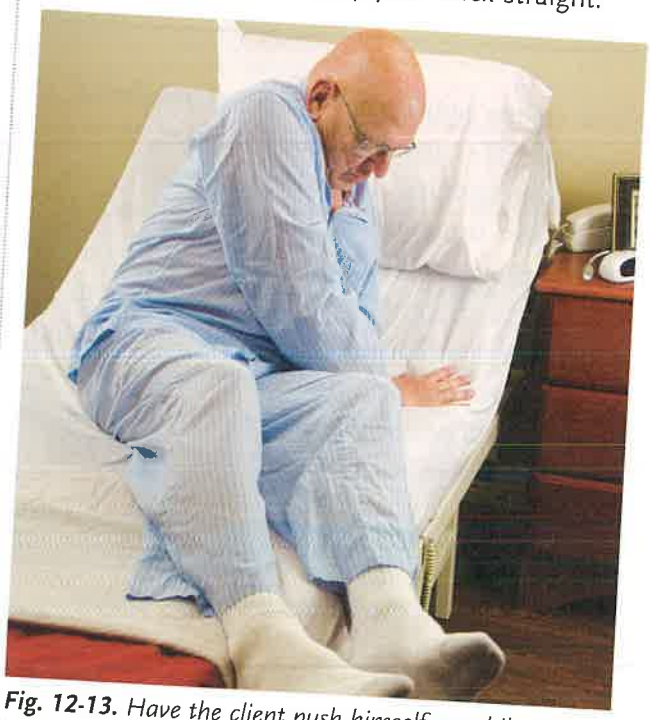

Fig. 12-13. *Have the client push himself up while swinging his legs over the side of the bed.*

b. Place one arm under the client's shoulder blades. Place the other arm under the client's thighs (Fig. 12-14).

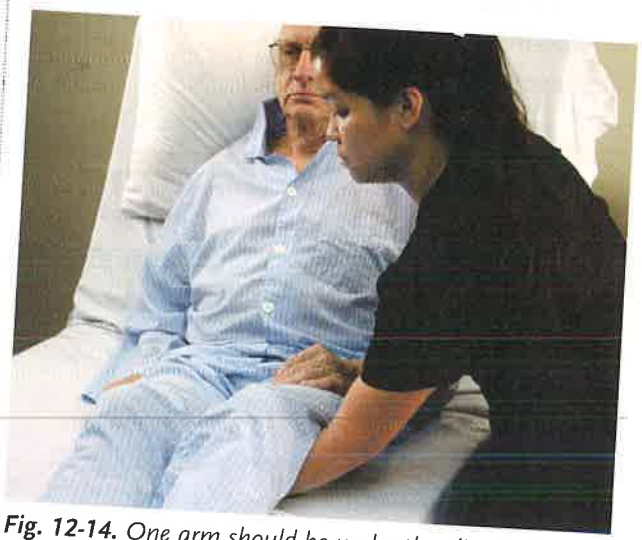

Fig. 12-14. *One arm should be under the client's shoulder blades and the other arm should be under the thighs.*

c. Let the client know you will be moving him on the count of three. On the count of three, slowly move the client into a sitting position with the legs dangling over the side of the

bed. The weight of the client's legs hanging down from the bed helps the client sit up (Fig. 12-15).

Fig. 12-15. *The weight of the client's legs hanging down from the bed helps the client sit up.*

8. Ask the client to sit as straight up as possible and to hold on to edge of mattress with both hands. Help the client to put on nonskid shoes or slippers if he is going to get out of bed.
9. Have client dangle as long as ordered. The care plan may direct you to allow the client to dangle for several minutes and then assist him to lie down again, or it may direct you to allow the client to dangle in preparation for walking or a transfer. Follow the care plan. Do not leave the client alone. If the client is dizzy for more than one minute, have him lie down again. Count his pulse and respiration rates and report to your supervisor according to your agency's policy. (You will learn how to measure vital signs in Chapter 14.)
10. Remove the client's slippers or shoes.
11. Gently assist the client back into bed. Place one arm around his shoulders and the other arm under his knees. Slowly swing the client's legs onto the bed.
12. If you lowered an adjustable bed, leave it in its lowest position.
13. Wash your hands.
14. Document the procedure and your observations. How did the client tolerate sitting up? Did the client become dizzy?

2. Describe how to safely transfer clients

Transferring a client means that a home health aide is moving him from one place to another. Transfers can move clients from a bed to a chair or wheelchair, from a wheelchair to a shower or toilet, and so on.

Safety is one of the most important things to consider during transfers. When transferring, it is important to know that some clients have a weaker side. The weaker side is called the *involved* or *affected* side. The HHA must plan the move so that the stronger side moves first and the weaker side follows. It is difficult for the weaker arm and leg to bear enough weight for the transfer if moved first.

A **transfer belt** is a safety device used to transfer clients who are weak, unsteady, or uncoordinated. It is also used to help clients walk. The belt is made of canvas or other heavy material, and it has a strong buckle and sometimes has handles. It fits around the client's waist, outside the clothing, with the buckle tightened until it is snug. It should never be placed on bare skin. It is important to check female clients to make sure the breasts are not caught under the belt.

The transfer belt gives the HHA something firm to hold on to when assisting with transfers. The HHA should grasp the belt securely on both sides, with hands in an upward position. Transfer belts cannot be used if a client has fragile bones, fractures, or has had certain kinds of surgery recently.

Guidelines: Wheelchairs

- Learn how each wheelchair works. Clients may use manual (requiring human power to move) or electric wheelchairs. Know how to apply and release the brake and how to operate the armrests and footrests. Always lock a wheelchair before assisting a client into or out of it (Fig. 12-16). After a transfer, unlock the wheelchair.

Fig. 12-16. *Always lock the wheelchair before a client gets into or out of it.*

- To unfold a standard wheelchair, tilt the chair slightly to raise the wheels on the opposite side. Press down on one or both seat rails until the chair opens and the seat is flat. To fold a standard wheelchair, lift up under the center edge of the seat.
- To remove an armrest, release the arm lock by the armrest, and lift the arm from the center. To replace the armrest, simply reverse the procedure.
- To move a footrest out of the way, press or pull the release lever. Swing the footrest out toward the side of the wheelchair. To remove the footrest, lift it off when it is toward the side of the wheelchair (Fig. 12-17). To replace a footrest, simply put it back in the side position. Then swing it back to the front position. It should lock into place.

Fig. 12-17. *To remove a footrest, swing the footrest toward the side of the wheelchair and lift it off.*

- To lift or lower a footrest, support the leg or foot. Squeeze the lever and pull up or push down.
- To transfer to or from a wheelchair, the client must use the side of the body that can bear weight to support and lift the side that cannot bear weight. Clients who can bear no weight with their legs may use leg braces or overhead trapezes to support themselves.
- Before any transfer, make sure the client is wearing nonskid shoes that are securely fastened. This promotes clients' safety and reduces the risk of falls.
- During wheelchair transfers, make sure the client is safe and comfortable. Ask the client how you can help. Some may only want you to bring the chair to the bedside. Others may want you to be more involved. Always be sure the chair is as close as possible to the client and is locked in place. Use a transfer belt if you are going to assist with the transfer. Be sure the transfer is done slowly, allowing time for the client to rest. Upon standing, check to see if the client is dizzy. If he is, help him sit back down. Measure vital signs as ordered and report to the supervisor.
- Check the client's alignment in the wheelchair once the transfer is complete. The client's body must be in proper alignment while in

a wheelchair or chair. Special cushions and pillows can be used for support. The hips should be well-positioned back in the chair. If the client needs to be moved back in the wheelchair, lock the wheelchair wheels. Stand in front of the wheelchair and ask the client to grasp the armrests while his feet are flat on the floor. Brace one or both knees against the client's knee(s). On the count of three, ask the client to push with his feet into the floor and move himself toward the back of the chair. Gently assist as needed.

G When a client is in a wheelchair or any chair, he or she should be repositioned at least every hour. The reasons for doing this are as follows:

- It promotes comfort.
- It reduces pressure.
- It increases circulation.
- It exercises the joints.
- It promotes muscle tone.

Transferring a client from a bed to a wheelchair

Equipment: wheelchair, transfer belt, nonskid shoes, and robe or folded blanket

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client. Check the area to be certain it is uncluttered and safe.
4. Place the wheelchair at the head of the bed, facing the foot of the bed, or at the foot of bed, facing the head of the bed. The arm of the wheelchair should be almost touching the bed. The wheelchair should be placed on client's **stronger**, or unaffected, side.
5. Remove both wheelchair footrests close to the bed.
6. Lock wheelchair wheels.
7. If the bed is adjustable, raise the head of the bed. Adjust the bed level to its lowest position. If the bed is movable, lock the bed wheels.
8. Assist the client to a sitting position, making sure his feet are flat on the floor. Adjust the bed height if needed (if possible). Let the client sit for a few minutes to adjust to the change in position.
9. Put nonskid shoes on the client and fasten them securely.
10. Stand in front of and face the client. Stand with feet about shoulder-width apart. Bend your knees. Keep your back straight.
11. Place the transfer belt around the client's waist over his clothing (not on bare skin). Tighten the buckle until it is snug. Leave enough room to insert flat fingers/hand comfortably under the belt. Check to make sure that skin or skin folds (for example, breasts) are not caught under the belt. Grasp the belt securely on both sides, with hands in an upward position.
12. Provide instructions to allow the client to help with transfer. Instructions may include: "When you start to stand, push with your hands against the bed," "Once standing, if you're able, you can take small steps in the direction of the chair," and "Once standing, reach for the chair with your stronger hand."
13. With your legs, brace (support) the client's lower legs to prevent slipping (Fig. 12-18). This can be done by placing one or both of your knees against the client's knees. Or you can stand toe to toe with the client. Bend your knees and keep your back straight.
14. Let the client know you will be moving him on the count of three. If possible, have the client rock while counting to three. On three, with hands still grasping the transfer belt on both sides and moving upward, slowly help the client to stand.

Fig. 12-18. *Brace the client's lower legs to prevent slipping by placing either one or two knees (shown) against the client's knees.*

15. Tell the client to take small steps in the direction of the chair while turning his back toward it. If more help is needed, help the client pivot (turn) to stand in front of wheelchair with the back of the client's legs against the wheelchair (Fig. 12-19). Always allow the client to do all he can for himself.

Fig. 12-19. *Help the client pivot to the front of the wheelchair. Pivoting is safer than twisting.*

16. Ask the client to put his hands on the wheelchair armrests if he is able. When the chair is touching the back of the client's legs, help him lower himself into the chair.
17. Reposition the client so that his hips touch the back of the wheelchair seat.
18. Attach footrests and place the client's feet on the footrests. Check that the client is in proper alignment. Gently remove the transfer belt. Place a robe or folded blanket over the client's lap as appropriate.
19. Wash your hands.
20. Document the procedure and your observations. How did the client feel or appear during the transfer? How much assistance was required?

When transferring back to bed from a wheelchair, the height of the bed should be equal to or slightly lower than the chair. When the client feels the bed with the back of his legs, help him sit down slowly.

A **slide board**, or transfer board, may be used to transfer clients who are unable to bear weight on their legs. Slide boards can be used for almost any transfer that involves moving from one sitting position to another (for example, from bed to chair). Slide boards should not be used against bare skin. Before beginning the transfer, the HHA should make sure that the client's fingers are not under the board.

Helping a client transfer using a slide board

Equipment: slide board

1. Follow steps 1 through 9 for transferring a client from a bed to a wheelchair.
2. Have the client lean away from transfer side to take the weight off her thigh (Fig. 12-20). Place one end of the slide board under the buttocks and thigh. Take care not to pinch the client's skin between the bed and the

board. Place the other end of the board on the surface to which the client is transferring.

Fig. 12-20. *Have the client lean away from the transfer side before placing the slide board.*

3. If the client is able, have her push up with her hands and scoot herself across the board. Stay close so you can provide support if needed. Allow the client to do all she can for herself.
4. If the client needs assistance, stand in front of her and brace one or both of your knees against her knees to keep them from buckling during the transfer. Keep your back straight.
5. Get as close to the client as possible and have her lean into you as you grasp the transfer belt from behind. Lean back with your knees bent. Using your legs rather than your back, pull the client up slightly and toward you to help her scoot across the board (Fig. 12-21).

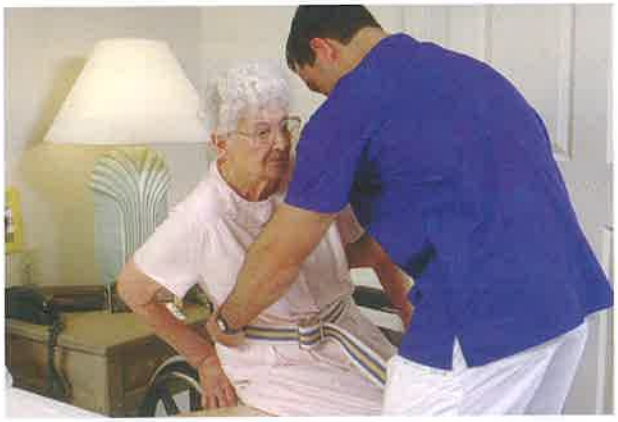

Fig. 12-21. *Keep a firm grasp on the transfer belt as you help the client to scoot across the board.*

6. Complete the transfer in two or three lifting and scooting movements. Never drag the client across the board. Friction from the client's skin dragging across the slide board can cause skin breakdown, which can lead to pressure injuries.
7. After the client is safely transferred, remove the slide board. Make sure the client is positioned safely and comfortably.
8. Wash your hands.
9. Document the procedure and any observations. How did the client feel or appear during the transfer? How much assistance was required?

Some clients may have a mechanical lift (also called a *hydraulic lift*) in the home. This equipment helps prevent injury to clients and caregivers. HHAs may assist clients with many types of transfers using mechanical lifts. Using these lifts requires special training. HHAs should not use equipment they have not been trained to use, as this could cause injury. There are many different types of mechanical lifts (Fig. 12-22).

Fig. 12-22. *There are many different types of lifts for transferring both completely dependent clients and clients who can bear some weight. This client can bear some weight on his legs.* (PHOTO COURTESY OF VANCARE INC., VANCARE.COM, 800-694-4525)

Guidelines: Mechanical or Hydraulic Lifts

- Be very careful when moving a client using a mechanical lift. If possible, have another person assist you when transferring with these lifts. It is safer to have at least two people doing these types of transfers.
- Keep the chair to which the client is to be moved close to the bed so that the client is only moved a short distance in the lift. Lock the wheels on the chair if it has wheels.
- Check that the valves are working on the lift before using it.
- Use the correct sling for the lift that is being used. Using an incorrect sling may result in serious injury or death. If you have questions about the sling, talk to your supervisor.
- Check the sling and straps for any fraying or tears. Do not use the lift if there are tears or holes.
- Open the legs of the stand to the widest position before helping the client into the lift.
- Once the client is in the sling and the straps are connected, pump up the lift only to the point where the client's body clears the bed or chair.
- Electric/battery-powered lifts have emergency releases. Be aware of where the release is located and how to operate this function. Talk to your supervisor if you do not know how to do this.

Transferring a client using a mechanical lift

Equipment: wheelchair or chair, lifting partner (if available), mechanical or hydraulic lift

The following is a basic procedure for transferring using a mechanical lift. Ask someone to help you before starting.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is movable, lock the bed wheels.
5. Position the wheelchair next to the bed. Lock the brakes.
6. Help the client turn toward you, as described in earlier procedure. Go to the far side of the bed. Position the sling under the client, with the edge next to the client's back. Fanfold if necessary. Adjust the bottom of the sling so that it is even with the client's knees. Help the client roll back to the middle of the bed, and then spread out the fanfolded edge of the sling.
7. Roll the mechanical lift to the bedside. Make sure the base is opened to its widest point, and push the base of the lift under the bed.
8. Position the overhead bar directly over the client (Fig. 12-23).

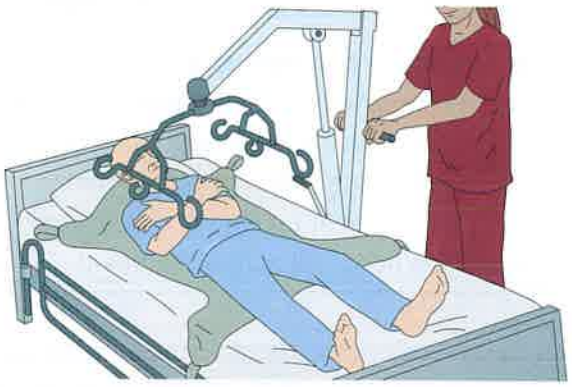

Fig. 12-23. *Position the overhead bar directly over the client.*

9. With the client lying on his back, attach one set of straps to each side of the sling and one set of straps to the overhead bar. If available, have a lifting partner support the client at the head, shoulders, and knees while the client is being lifted. The client's arms should be folded across his chest (Fig. 12-24). If the

device has S hooks, they should face away from client. Make sure all straps are connected properly and are smooth and straight.

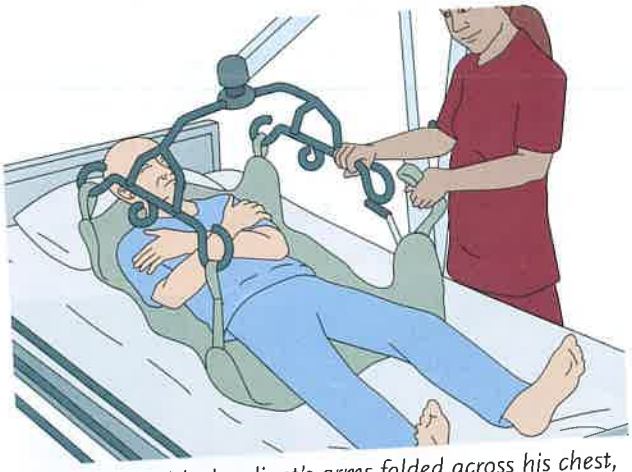

Fig. 12-24. *With the client's arms folded across his chest, attach the straps to the sling.*

10. Following manufacturer's instructions, raise the client two inches above the bed. Pause a moment for the client to gain balance.
11. Have the lifting partner help support and guide the client's body while you roll the lift so that the client is positioned over the chair or wheelchair (Fig. 12-25).

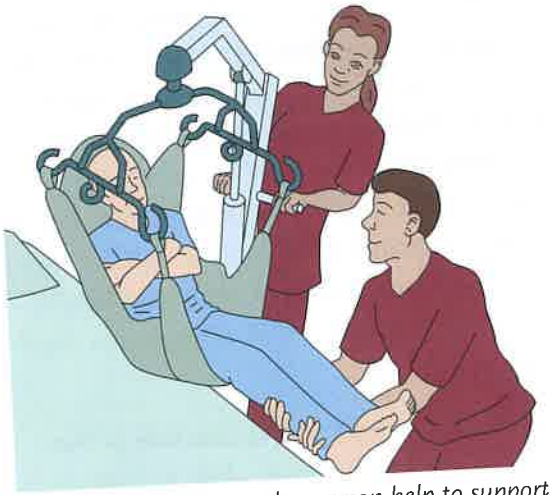

Fig. 12-25. *Having another person help to support and guide the client promotes safety during the transfer and reduces the chance of injury.*

12. Slowly lower the client into the chair or wheelchair. Push down gently on the client's knees to help the client into a sitting, rather than reclining, position.
13. Undo the straps from the overhead bar to the sling. Remove the sling or leave in place for transfer back to bed; follow the care plan.
14. Be sure the client is seated comfortably and correctly in the chair or wheelchair.
15. Wash your hands.
16. Document the procedure and any observations. How did the client tolerate the transfer? Were there any problems? Did the equipment operate properly?

A stand-up, or standing, lift is used when a person can bear some weight on his legs but has poor leg strength and/or balance (Fig. 12-22). The client must be able to stand and have some arm strength in order to use this lift. There are different types of stand-up lifts, including manual and battery-powered. The stand-up lift consists of both user and operator support bars (the user support bars may consist of two vertical bars or one crossbar), padded swivel swing-out seats (and/or straps, vest, or belt for some models), knee pads, a platform base with foot plate, and four small wheels with locking brakes.

If using a stand-up lift, the home health aide should be sure that the brakes are locked before beginning the transfer. The client should begin in a sitting position and place his feet firmly on the foot plate of the platform, with knees pressing against the knee pads. The client should grasp the support bar(s) and gently pull himself to a standing position, using his own strength. Then the HHA can lower both sides of the padded swing-out seat into position. The HHA should adjust straps, vest, or belt if these are used. The client should slowly lower himself onto the seat while holding the support bars and pressing knees against knee pads. The HHA should unlock the wheel brakes and use the operator bars to transfer the client to the location desired and then perform these steps in reverse order to release the client from the lift.

3. Discuss how to safely ambulate a client

Ambulation means moving or walking, with or without an assistive device. A client who is **ambulatory** is one who can get out of bed and move or walk. Many older clients are ambulatory but need assistance to walk safely. Several tools, including transfer belts, canes, walkers, and crutches, assist with ambulation. The HHA should check the care plan before helping a client ambulate. It is important to know the client's abilities, limitations, and disabilities. Any time an HHA helps a client, she should communicate what she would like to do and allow the client to do what he can.

Assisting a client to ambulate

Equipment: transfer belt, nonskid shoes for the client

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed level to its lowest position. If the bed is movable, lock the bed wheels.
5. Assist the client to a sitting position, making sure his feet are flat on the floor. Adjust the bed height if needed (if possible). Let the client sit for a few minutes to adjust to the change in position.
6. Put nonskid shoes on the client and fasten them securely.
7. Stand in front of and face the client. Stand with feet about shoulder-width apart. Bend your knees. Keep your back straight.
8. Place the transfer belt around the client's waist over his clothing (not on bare skin). Grasp the belt securely on both sides, with hands in an upward position.
9. Always allow your client to do whatever he is able to do for himself. If the client is unable to stand without help, brace (support) the client's lower extremities. This can be done by placing one of your knees against the client's knee, or it can also be done by placing both of your knees against both of the client's knees (Fig. 12-26). Or you can stand toe to toe with the client. Bend your knees. Keep your back straight.

Fig. 12-26. *If the client has a weak knee, brace it against your knee.*

10. Hold the client close to your center of gravity. Provide instructions to allow the client to help with standing. Tell the client to lean forward, push down on the bed with his hands, and stand on the count of three. When you start to count, begin to rock. On three, with hands still grasping the transfer belt on both sides and moving upward, rock your weight onto your back foot and slowly help the client to stand.
11. Walk slightly behind and to one side of the client for the full distance, while holding on to the transfer belt (Fig. 12-27). If the client has a weaker side, stand on the weaker side. Use the hand that is not holding the belt to offer support on the weak side. Ask the client to look forward, not down at the floor, during ambulation.

Fig. 12-27. Walk behind and stand on the weaker side, while holding onto the transfer belt, when assisting with ambulation.

12. Observe the client's strength while you walk together. Provide a chair if the client becomes dizzy or tired.
13. After ambulation, return the client to the bed or chair and remove the transfer belt. Make the client comfortable. Leave the bed in its lowest position.
14. Wash your hands.
15. Document the procedure and your observations. How far did the client walk? How did the client appear or say he felt while walking? How much help did you give?

When helping a client who has a visual impairment walk, the HHA should be beside and slightly ahead of the client. The client should be able to place his hand on the HHA's elbow. The HHA should walk at a normal pace and let the client know they are about to turn a corner or when a step is approaching. The HHA should state whether they will be stepping up or down.

Falls

If the client starts to fall during a transfer or while walking, the HHA should widen his stance. He can bring the client's body close to him to break the fall. The HHA should bend his knees and support the client as he lowers her to the floor (Fig. 12-28). He may need to drop to the floor with the client to avoid injury. The HHA should not try to reverse or stop a fall. Doing this can cause worse injuries.

If the client has fallen, the HHA should call for help if a family member is around. He should not attempt to get the client up or move the client after the fall. Many agencies do not allow helping a client up after a fall until the client has been evaluated by a nurse. Each agency's policies and procedures should be followed. The HHA must report the fall to the supervisor immediately. An incident report will need to be completed.

Fig. 12-28. Do not try to reverse or stop a fall. Bend your knees and support the client as you lower her to the floor.

Clients who have difficulty walking may use assistive devices, such as canes, walkers, or crutches, to help themselves. Canes help with balance. Clients using canes should be able to bear weight on both legs. If one leg is weaker, the cane should be held in the hand on the stronger side.

Types of canes include the C cane, the functional grip cane, and the quad cane. The **C cane** is a straight cane with a curved handle at the top. It has a rubber-tipped bottom to prevent slipping. A C cane is used to improve balance. A **functional grip cane** is similar to the C cane,

except that it has a straight grip handle, rather than a curved handle. The grip handle helps improve grip control and provides a little more support than the C cane. A **quad cane**, with four rubber-tipped feet and a rectangular base, is designed to bear more weight than the other canes (Fig. 12-29).

Fig. 12-29. *A quad cane has four rubber-tipped feet and can bear more weight than other canes.*

A **walker** is a type of walking aid used when the client can bear some weight on both legs. The walker provides stability for clients who are unsteady or lack balance. The metal frame of the walker may have rubber-tipped feet and/or wheels (Fig. 12-30). When using a walker, the walker is moved first, then the weak leg, then the strong leg.

Fig. 12-30. *The photo on the left shows a standard walker. The photo in the middle shows a "Hemi Walker," which is a walker that is designed for people who have difficulty using an arm or a hand. The photo on the right shows a walker with a seat and basket.* (© MEDLINE INDUSTRIES, INC. 2020)

Crutches are used by clients who can bear no weight or limited weight on one leg. Crutches have rubber-tipped feet to prevent sliding. Some people use one crutch, and some use two.

Whichever device is being used, the home health aide's role is to ensure safety. The HHA should stay near the person, on the weak side. The equipment must be in proper condition; it should be sturdy, and it must have rubber tips or wheels on the bottom.

Assisting with ambulation for a client using a cane, walker, or crutches

Equipment: transfer belt, nonskid shoes for the client, cane, walker, or crutches

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed level to its lowest position. If the bed is movable, lock the bed wheels.
5. Assist the client to a sitting position, making sure his feet are flat on the floor. Adjust the bed height if needed (if possible). Let the client sit for a few minutes to adjust to the change in position.
6. Put nonskid shoes on the client and fasten them securely.
7. Stand in front of and face the client. Stand with feet about shoulder-width apart. Bend your knees. Keep your back straight.
8. Place the transfer belt around the client's waist over his clothing (not on bare skin). Grasp belt securely on both sides, with hands in an upward position.
9. If the client is unable to stand without help, brace (support) the client's lower extremities. This can be done by placing one of your knees against the client's knee, or it can also be done by placing both of your knees against both of the client's knees. Or you can stand toe to toe with the client. Bend your knees. Keep your back straight.

10. Hold the client close to your center of gravity. Provide instructions to allow the client to help with standing. Tell the client to lean forward, push down on the bed with his hands, and stand on the count of three. When you start to count, begin to rock. On three, with hands still grasping the transfer belt on both sides and moving upward, rock your weight onto your back foot and slowly help the client to stand.

11. Assist as necessary with ambulation.

a. ***Cane***: Client places cane about six inches, or a comfortable distance, in front of his stronger leg. He brings his weaker leg even with the cane. He then brings his stronger leg forward slightly ahead of the cane (Fig. 12-31). Repeat.

Fig. 12-31. *The cane moves in front of the stronger leg first.*

b. ***Walker***: Client picks up or rolls the walker and places it about six inches, or a comfortable distance, in front of him. All four feet or wheels of the walker should be on the ground before client steps forward to the walker. The walker should not be moved again until the client has moved both feet forward and is steady. The client should never put his feet ahead of the walker.

c. ***Crutches***: Client should be fitted for crutches and taught to use them correctly by a physical therapist or a nurse. The client may use the crutches several different ways, depending on his weakness. No matter how they are used, the client's weight should be on his hands and arms. Weight should not be on the underarm area.

12. Walk slightly behind and to one side of the client for the full distance, while holding on to the transfer belt. If the client has a weaker side, stand on the weaker side.

13. Watch for obstacles in the client's path. Ask the client to look forward, not down at the floor, during ambulation.

14. Encourage the client to rest if tired. Allowing a client to become too tired increases the chance of a fall. Let the client set the pace. Discuss how far he plans to go based on the care plan.

15. After ambulation, return the client to the bed or chair and remove the transfer belt. Make the client comfortable. Leave the bed in its lowest position.

16. Wash your hands.

17. Document the procedure and your observations. How did the client feel or appear while walking? How far did the client walk? How much help did the client need?

4. List ways to make clients more comfortable

There are several things that promote the client's comfort and safety in and around the bed:

- Having plenty of pillows available to provide support in the various positions
- Using positioning devices, such as backrests, bed cradles or foot cradles, footboards, and handrolls

- Giving back rubs for comfort and relaxation
- Changing positions frequently (at least every two hours) and as directed in the care plan
- Maintaining the client's body alignment

Back rubs help relax tired muscles, relieve pain, and increase circulation. Back rubs are often given after baths. The care plan will contain instructions for when to give back rubs and for how long. After giving a back rub, the HHA should note any changes in a client's skin.

Giving a back rub

Equipment: cotton blanket or towel, lotion

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe working level, usually waist high. Lower the head of the bed. If the bed is movable, lock bed wheels.
5. Position the client so he is lying on his side (lateral position) or his stomach (prone position). Many elderly people find that lying on their stomachs is uncomfortable. If so, have the client lie on his side. Cover the client with a cotton blanket, then fold back the bed covers. Expose the client's back to the top of the buttocks. Back rubs can also be given with the client sitting up.
6. Warm the lotion bottle in warm water for five minutes. Run your hands under warm water to warm them. Pour the lotion on your hands. Rub them together to spread it. Always put the lotion on your hands rather than directly on the client's skin. Warn the client that the lotion may still feel cool.
7. Place your hands on each side of the upper part of the buttocks. Use the full palms of your hands. Make long, smooth upward strokes with both hands. Move along each side of the spine, up to the shoulders (Figs. 12-32 and 12-33). Circle your hands outward. Move back along the outer edges of the back. At the buttocks, make another circle and move your hands back up to the shoulders. Without taking your hands off the client's skin, repeat this motion for three to five minutes.

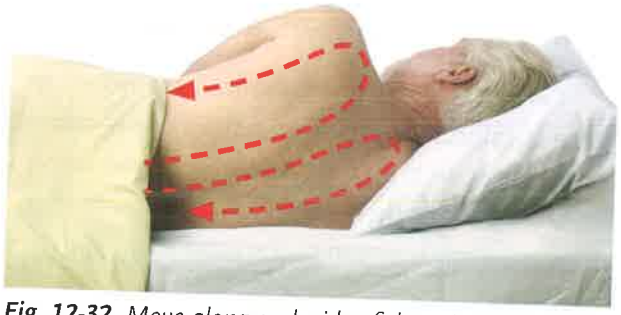

Fig. 12-32. *Move along each side of the spine, up to the shoulders.*

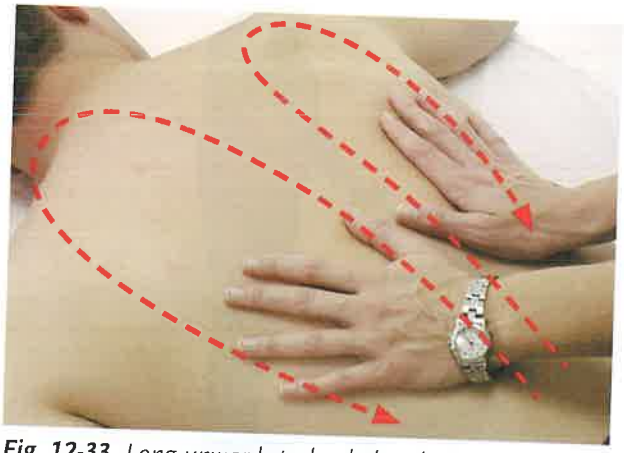

Fig. 12-33. *Long upward strokes help release muscle tension.*

8. Knead with the first two fingers and thumb of each hand. Place them at the base of the spine. Move upward together along each side of the spine, applying gentle downward pressure with the fingers and thumbs. Follow the same direction as with the long, smooth strokes, circling at shoulders and buttocks.
9. Gently massage bony areas (spine, shoulder blades, hip bones) with circular motions of your fingertips. Gentle massage stimulates

circulation and helps prevent skin damage. However, if any of these areas are pale, white, or red, massage around them rather than on them. The redness indicates that the skin is already irritated and fragile.

10. Let your client know when you are almost through. Finish with some long smooth strokes, like the ones you used at the beginning of the massage.
11. Dry the back if extra lotion remains on it.
12. Remove the cotton blanket or towel.
13. Assist the client with getting dressed.
14. Help the client into a comfortable position. If you raised an adjustable bed, return it to its lowest position.
15. Store the lotion and put dirty linens in the hamper.
16. Wash your hands.
17. Document the procedure and your observations. Report any changes in the client's skin to your supervisor. Did the client appear comfortable during the back rub? Did you observe any discolored areas or broken skin?

Many positioning devices are available to make clients more comfortable. Some can be inexpensively made in the client's home. Check with your supervisor on the use of positioning devices for each client.

Guidelines: Positioning Devices

- Backrests provide support and comfort for the back. They can be made of pillows, cardboard or wood covered by pillows, or special wedge-shaped foam pillows.
- Bed cradles or foot cradles are used to keep the bed covers from resting on clients' legs and feet. Sometimes simply the pressure of a sheet draped over the toes can eventually lead to pressure injuries. A cardboard box can be used as a bed cradle by placing the client's feet inside the box underneath the covers (Fig. 12-34). The box should be at least **two inches above** the toes.

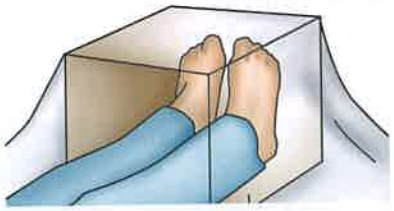

Fig. 12-34. *An illustration of a homemade bed cradle.*

- Bed tables are often used to keep food or frequently used items close to the client while he is in bed. They are available commercially. You can also make one by cutting openings in each of the longer sides of a sturdy cardboard box (Fig. 12-35).

Fig. 12-35. *A bed table made out of a cardboard box.*

- Draw sheets may be placed under clients to help move clients who are unable to assist with turning in bed, lifting, or moving up in bed. Draw sheets also help prevent skin damage that can be caused by shearing. A regular bed sheet folded in half can be used as a draw sheet.
- Footboards are padded boards placed against the client's feet to keep them properly aligned. They help prevent foot drop. **Foot drop** is a weakness of muscles in the feet and ankles that causes difficulty with the ability to flex the ankles and walk normally. Foot splints may also be used to help prevent foot drop. Footboards are also used to keep bed covers off the feet. Rolled blankets or pillows can also be used as footboards.

G Handrolls are cloth-covered or rubber items that keep the hand and/or fingers in a normal, natural position (Fig. 12-36). A rolled washcloth, gauze bandage, or a rubber ball placed inside the palm may be used to keep the hand in a natural position. Handrolls can help prevent finger, hand, or wrist contractures.

Fig. 12-36. *Handrolls keep the fingers and hand in a natural position, helping to prevent contractures.* (PHOTOS COURTESY OF NORTH COAST MEDICAL, INC., WWW.NCMEDICAL.COM, 800-821-9319)

G An **orthotic device**, or **orthosis**, is a device applied externally that helps support and align a limb and improve its functioning (Fig. 12-37). It may be prescribed by a doctor to keep a client's joints in the correct position. Orthoses also help prevent or correct deformities. Splints are a type of orthotic device. Splints and the skin area around them should be cleaned at least once daily and as needed.

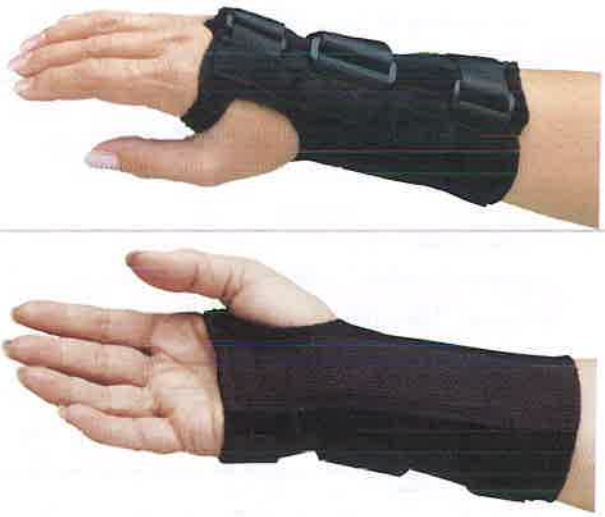

Fig. 12-37. *This is one type of orthotic splint.* (PHOTOS COURTESY OF NORTH COAST MEDICAL, INC., WWW.NCMEDICAL.COM, 800-821-9319)

G Trochanter rolls are rolled towels or blankets used to keep the client's hips and legs from turning outward.

G Abduction pillows/wedges/splints/pads or hip wedges keep hips in the proper position after hip surgery. Pillows between the legs from knees to ankles, while in the lateral position, can help keep the spine, hips, and knees in the proper position.

Observing and Reporting: Physical Comfort and Safety

An HHA's observations about clients' physical comfort and safety can be very helpful to the care team. Report the following:

O/R How well the client tolerates positioning, transferring, and ambulating

O/R Any signs of skin breakdown (pale, white, red, purple, or dark areas, rashes, or broken skin)

O/R Changes that could be made in the home environment to improve comfort or safety

O/R Any change in the client's ability

Chapter Review

1. What is positioning?
2. How often should bedbound clients be repositioned?
3. In which position is a client lying on his side?
4. In which position is a client lying on his stomach?
5. In which position is a client lying flat on his back?
6. In which position is a client lying on his left side with the lower arm behind the back and the upper knee flexed and raised toward the chest?

7. In which position is a client in a semisitting position (45 to 60 degrees) with the head and shoulders elevated?
8. What is a draw sheet?
9. What is shearing?
10. When is logrolling necessary?
11. How does dangling benefit a client?
12. Describe how a transfer belt is applied.
13. If a client has a weaker side, which side should move first in a transfer?
14. Before assisting a client into or out of a wheelchair, what should an HHA do?
15. List four guidelines for using a mechanical lift.
16. Define *ambulation.*
17. Describe what an HHA should do if a client has fallen.
18. How many feet does a quad cane have?
19. Which side should an HHA stand near when a client is using assistive equipment?
20. List four comfort and safety measures for a client who is in bed.
21. List five types of positioning devices that can make clients more comfortable.

13 Personal Care Skills

1. Describe the home health aide's role in assisting clients with personal care

Personal care is different from other tasks that HHAs may perform for clients, such as cleaning, shopping, or preparing meals. The term *personal* refers to tasks that are concerned with the person's body, appearance, and hygiene, and suggests privacy may be important. **Hygiene** (*HIGH-jeen*) is the term used to describe practices to keep bodies clean and healthy. Bathing and brushing teeth are two examples. **Grooming** refers to practices like caring for fingernails and hair, shaving, and applying makeup. Hygiene and grooming activities, as well as dressing, eating, drinking, transferring, and elimination, are called **activities of daily living** (**ADLs**).

Some people who are recovering from an illness or an accident may not have the energy to care for themselves. They may also need help with personal care due to any of the following:

- A person has a long-term, chronic condition
- A person is frail because of advanced age
- A person is permanently disabled
- A person is dying

These clients may need assistance with their personal care, or they may need home health aides to provide it for them entirely. HHAs may provide or help with any or all of this personal care: bathing, **perineal** (*payr-i-NEE-al*) **care** (care of the genital and anal area), elimination, mouth care, shampooing and combing the hair, nail care, shaving, dressing, eating, drinking, walking, transferring, and changing bed linens. Each of the required tasks will be specified in the care plan.

Some clients may never be able to care for themselves, while other clients will regain strength and be able to perform their own personal care. An important part of a home health aide's job is to help clients be as independent as possible. This means teaching clients with disabilities to care for themselves and encouraging other clients to perform self-care as soon as they are able. Promoting independence is an important part of care.

All people have routines for personal care and activities of daily living. They also have preferences for how they are done. These routines remain important even when people are elderly, sick, or disabled. HHAs should be aware of clients' individual preferences concerning their personal care (Fig. 13-1). Clients may prefer certain soaps or skin care products. They may choose to bathe in the morning or at night. It is important for HHAs to ask clients about their routines and preferences, which is part of providing person-centered care.

Many people have been doing personal care tasks for themselves their entire lives. They may feel uncomfortable about having anyone, especially a person they do not know well, do or help them do these tasks. Some clients may not like

to be touched by someone else. It may be stressful for some people to have help with personal care, and HHAs should be sensitive to this.

Fig. 13-1. *Asking a client which outfit she would like to wear promotes independence and shows respect.*

Before beginning any task, the HHA should explain to the client exactly what she will be doing. Explaining care to a client is not only a legal right, but it may also help lessen anxiety. The HHA should ask if she would like to use the bathroom or bedpan first. She should also provide privacy and let the client make as many decisions as possible about when, where, and how a procedure will be done. This promotes independence and is part of providing person-centered care. During the procedure, if the client appears tired, the HHA should stop and take a short break. The client should never be rushed. After care, the HHA should always ask if the client would like anything else.

Personal care provides an opportunity for the HHA to observe a client's skin, mental state, mobility, flexibility, comfort level, and ability to perform ADLs. For example, as she bathes a client, the HHA can observe the skin for color, texture, temperature, and whether it is dry or moist. Is it pale, yellow, ashen, or flushed? Are there blotches or a rash? Is there redness around bony areas? Is the skin dry and flaky?

Personal care offers the chance for the HHA to talk with clients. Communication is especially important during personal care. Some clients will talk about symptoms they are experiencing during personal care. They may say that they have been itching or that their skin feels dry. They may complain of numbness and tingling in a certain part of the body. The HHA should keep a small notepad in a pocket to note exactly how the client describes these symptoms. These comments should be reported to the supervisor and documented immediately after the procedure.

During personal care, the HHA can also observe the client's mental and emotional state. Is the client depressed or confused? Can the client concentrate on the activity or hold a conversation? Is the client short of breath? Does the client tremble or shake? Is the client having trouble using certain muscles or joints? The focus should be on changes from the client's normal state. Is there a change in behavior, level of activity, skin color, movement, or anything else? HHAs are in the best position to observe, report, and document any small change in clients. No matter what care task is assigned, performing it is only half the job.

Noticing and Reporting Change

Licensed nurses once performed much of the care HHAs are learning to give. Nurses have completed years of education to notice signs of illnesses and health problems. Because an HHA will be performing these care tasks, nurses lose an opportunity to discover early signs of illness or disease. An HHA's role is to make certain that small changes in a client do not go unnoticed. Noticing and reporting change is one of the most important parts of the job!

After a procedure is completed, the HHA should check the client's room. Is it a comfortable temperature? Is it well ventilated, but free from drafts? Can the client easily signal for help? Does the room have adequate lighting? Are there electrical cords or other objects in the walkways? Is the room cluttered and/or unsafe?

Communication and Personal Care

An HHA's feelings about providing personal care can influence how clients communicate with her. If an HHA is uncomfortable doing certain tasks, her body language may make this discomfort obvious.

Clients may not want to communicate changes or concerns if they think an HHA is uncomfortable or anxious. Recognizing her own feelings can help the HHA start to accept them.

Knowing a client's physical condition before visiting her for the first time may help an HHA feel more prepared. It is important for the HHA to talk to her supervisor and discuss any questions or concerns she has about a client's condition.

Being professional while assisting clients with personal care tasks may help put them at ease. Ideal relationships with clients are based on acceptance and respect, as well as helping them be as independent as possible. An HHA can build these kinds of relationships by doing the following:

- Listening
- Being empathetic
- Being patient
- Promoting privacy
- Encouraging independence
- Giving praise for accomplishments
- Involving clients in the care provided
- Giving person-centered care

2. Explain guidelines for assisting with bathing

Bathing promotes health and well-being. It removes perspiration, dirt, oil, and dead skin cells that collect on the skin. It helps to prevent skin irritation and body odor. Bathing can also be relaxing. The bed bath is an excellent time for moving arms and legs and increasing circulation.

Guidelines: Bathing

- Only give a client a tub bath if it is assigned. Many agencies have rules against helping clients into the bathtub. These rules are for the client's safety, as well as the home health aide's. Follow your agency's policies.
- Many people prefer a daily bath or shower, but this is not really necessary. The face, hands, **axillae** (*AK-sil-eye*, or underarms), and **perineum** (genital and anal area) should be washed every day. A complete bath or shower can be taken every other day or even less frequently. Older skin produces less perspiration and oil. Elderly people whose skin is dry and fragile should bathe only once or twice a week. Be gentle with the skin when bathing older clients.
- Before bathing, make sure the room is warm enough. Remove any loose rugs that do not have slip-resistant, rubber backings.
- Gather supplies before giving a bath. Never leave an elderly person or young child alone in the bathtub.
- Never use bath oils or gels. They make the tub slippery and can cause a fall.
- Before bathing, make sure the water temperature is safe and comfortable. Test the water temperature against the inside of your wrist to make sure it is not too hot. Then have the client test the water temperature. The client is best able to choose a comfortable water temperature.
- Wear gloves while bathing a client and change your gloves before performing perineal care.
- Be familiar with available safety and assistive devices. Assistive devices, such as a transfer belt or lift, tub chair, and safety bars, can make bathing easier and safer. An occupational therapist may teach you and the client transfer techniques for getting safely in and out of the bathtub.

A **shower chair** (Fig. 13-2) is a sturdy chair designed to be placed in a bathtub or shower. It is water- and slip-resistant. If a client is unable to get into a tub or is too weak to stand in a shower, the chair or bench enables him to bathe in the tub rather than in bed. Safety or grab bars are often installed in and near the tub and toilet to give the client something to hold while changing position.

You will not find the same equipment in each client's home. Become familiar with the tools you have to work with. Learn how to use them before trying to assist the client. Report any need for equipment or equipment repair to your supervisor.

Fig. 13-2. *A shower chair must be locked before transferring a client into it.* (PHOTO COURTESY OF NOVA MEDICAL PRODUCTS, WWW.NOVAJOY.COM)

G Make sure all soap is removed from the skin before completing the bath.

Helping client transfer to the bathtub

You may have to adapt this procedure to work with your clients' varying strength levels.

Equipment: chair, transfer belt, towel or robe to wear under transfer belt, slide board (if appropriate), tub or shower chair, bath supplies (as listed in next procedure)

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Help the client to the bathroom.
4. Provide privacy for the client.
5. Seat the client in a chair facing the bathtub and centered between the grab bars. If using a wheelchair, lock the brakes and remove the footrests (Fig. 13-3).

Fig. 13-3. *Lock the wheelchair before beginning to transfer a client.*

6. Ask the client to place one leg at a time over the sides of the tub.
7. Have the client hold on to the grab bars or the edge of the tub to bring himself to a sitting position on the edge of the tub (Fig. 13-4). A slide board may also be used to help the client move from the chair to the tub.

Fig. 13-4. *Have the client hold on to the grab bars while moving him into the tub. Keep your back straight and your knees slightly bent while assisting with the move.*

8. Help the client lower himself into the tub or onto the tub chair (bath bench) while holding on to the edge of the tub or grab bars. If necessary, have him wear a transfer belt. If using a transfer belt to get in and out of the tub, the client will need to wear a shirt or robe while transferring, so the belt is not placed directly against his skin. When he is in the tub, place supplies within reach (Fig. 13-5).

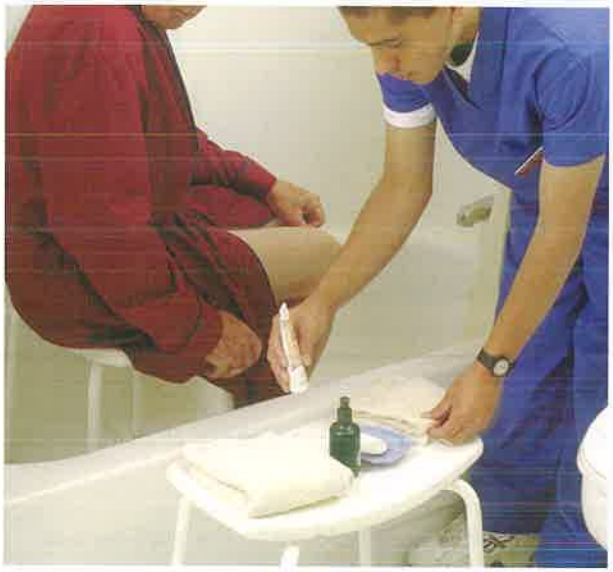

Fig. 13-5. *Keep bathing supplies close to the client during the shower or bath.*

9. Reverse this procedure to help the client out of the tub when the bath is over. If the client has trouble getting out of the tub, help him to his hands and knees. From that position, he can use the grab bar or the edge of the tub to help pull himself up. You can also help by putting the transfer belt back on the client (over a robe).
10. Wash your hands.
11. Document the procedure and your observations.

Clients who can get out of bed to take a shower or bath will need different assistance and supervision. The care plan will include necessary instructions.

Helping the ambulatory client take a shower or tub bath

Equipment: 2 bath towels, washcloth, soap or other cleanser, shampoo, rubber bath mat, tub or shower chair (if appropriate), table for bath supplies and bell (for clients who bathe without assistance), nonskid bath rug, deodorant, lotion and other toiletries, clean clothes or a robe, nonskid shoes or slippers, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Clean the tub or shower if necessary. Place the rubber mat on the tub or shower floor. Set up the tub or shower chair. Place the nonskid bath rug on the floor next to the tub or shower.
4. Provide privacy for the client.
5. Fill the tub halfway with warm water or adjust the shower water temperature. Turn on cold water first, then add hot water. This helps reduce the risk of burns. Test the water temperature against the inside of your wrist to see if it is comfortable. Water temperature should be no higher than 105°F. Have the client test the water temperature to see if it is comfortable. Adjust if necessary.
6. Put on gloves.
7. Ask the client to undress and assist as needed. Help client transfer to the tub or step into the shower.
8. If the care plan allows you to leave the client to bathe alone, place the bathing supplies on a small table within the client's reach. Place a bell or other signal on the table (Fig. 13-6). Tell the client to signal when you are needed. Ask the client not to add more hot or warm water and not to remain in the tub more than 20 minutes. Do not lock the bathroom door.

Check on your client every five minutes. If the client is weak or confused, remain in the bathroom. Otherwise, you can make the client's bed while he is in the tub.

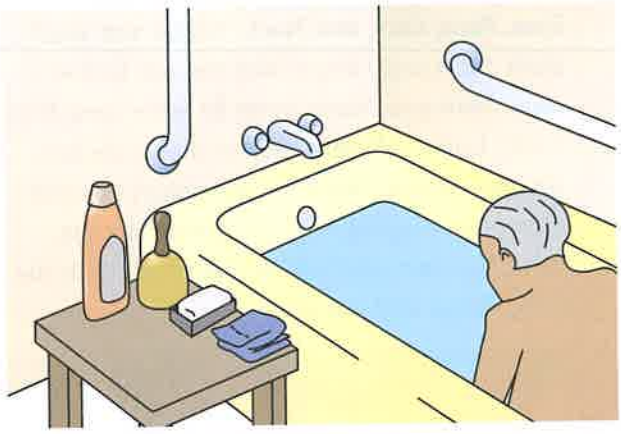

Fig. 13-6. *A bell or other signal provides a way for the client to communicate that he needs you.*

9. For a shower, stay with the client and assist with washing hard-to-reach areas. Observe for signs of fatigue.
10. If the client needs more assistance in the bath or shower, help him wash himself. Always wash from clean areas to dirty areas so you do not spread dirt into areas that have already been washed. Make sure all soap is rinsed off so the client's skin does not become dry or irritated.
11. Assist the client with shampooing hair if necessary (see procedure later in chapter). Make sure all shampoo is rinsed out of hair.
12. When the bath or shower is finished, help the client get out of the tub. Wrap him in a towel. Have the client sit in a chair or on the toilet seat, and provide him with another towel for drying himself (Fig. 13-7). Offer assistance in drying hard-to-reach places. The client may need help applying deodorant or lotion. If necessary, help the client get dressed.
13. If your client is tired after the bath or shower, help him back to bed. Other personal care, such as mouth care, can be done later or while the client is in bed.

Fig. 13-7. *Give the client any needed assistance when drying herself.*

14. Clean the tub and place soiled laundry (towels, washcloths, dirty clothes) in the laundry hamper.
15. Remove and discard your gloves.
16. Wash your hands.
17. Store supplies.
18. Document the procedure and your observations. Did you observe any redness or whiteness on the skin? Was there any broken skin? How did the client tolerate bathing or showering? Has there been a change in the client's abilities since the last bath or shower? Talk with your supervisor if the client makes a request that is not included in the care plan.

Giving a complete bed bath

Equipment: soft cotton blanket or large towel, bath basin, soap, 2–4 washcloths, 2–4 towels, clean gown or clothes, 2 pairs of gloves, lotion, deodorant, brush or comb, orangewood stick

When bathing, move the client's body gently and naturally. Avoid force and overextension of limbs and joints.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

3. Provide privacy for the client. Be sure the room is at a comfortable temperature and there are no drafts.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Ask client to remove his eyeglasses and jewelry and put them in a safe place. Offer a bedpan or urinal for use before the bath (see procedures later in this chapter).
6. Place a soft cotton blanket or large towel over the client, and ask him to hold on to it as you remove or fold back the top bedding to the foot of the bed (Fig. 13-8). Remove top clothing, while keeping the client covered with the blanket (or top sheet). Place clothing in the hamper.

Fig. 13-8. *Cover the client with a cotton blanket before removing the top bedding.*

7. Fill the basin with warm water. Test water temperature against the inside of your wrist. Water temperature should be no higher than 105°F. Have the client test the water temperature to see if it is comfortable. Adjust if necessary. The water will cool quickly. During the bath, change the water when it becomes too cool, soapy, or dirty.
8. Put on gloves.
9. Ask the client to participate in washing. Help him do this whenever needed.
10. Uncover only one part of the body at a time. Place a towel under the body part being washed.
11. Wash, rinse, and dry one part of the body at a time. Start at the head, work down, and complete the front first. When washing, use a clean area of the washcloth for each stroke.

    Eyes, Face, Ears, and Neck: With a wet washcloth (no soap), begin with the eye farther away from you. Wash inner to outer area (Fig. 13-9). Use a different area of the washcloth for each stroke. Wash the face from the middle outward using firm but gentle strokes. Wash the ears and behind the ears. Wash the neck. Rinse and pat dry.

Fig. 13-9. *First wash the far eye from the inner to outer area, using a different area of the washcloth for each stroke.*

Arms and Axillae: Begin with the arm farther away from you. Remove one arm from under the towel. With a soapy washcloth, wash the upper arm and the underarm. Use long strokes from the shoulder down to the wrist (Fig. 13-10). Rinse and pat dry. Repeat for the other arm.

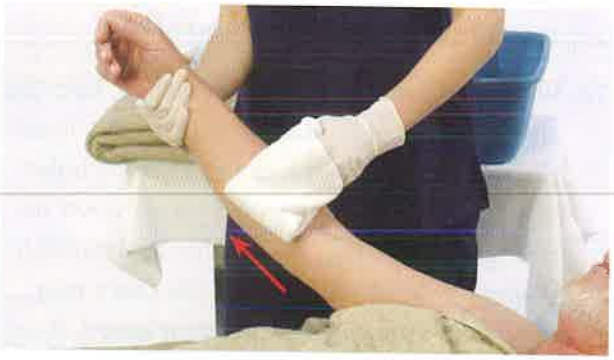

Fig. 13-10. *Support the wrist while washing the shoulder, arm, underarm, and elbow.*

Hands: Wash the far hand, including the fingers and fingernails. Clean under the nails with an orangewood stick (or a nail brush if

available). Rinse and pat dry. Make sure to dry between the fingers. Give nail care (see procedure later in this chapter). Repeat for the other hand. Put lotion on the client's elbows and hands.

Chest: Place the towel across the client's chest. Pull the blanket down to the waist. Lift the towel only enough to wash the chest, rinse it, and pat dry. For a female client, wash, rinse, and dry breasts and under breasts. Check the skin in this area for signs of irritation.

Abdomen: Keep the towel across the chest. Fold the blanket down so that it still covers the genital area. Wash the abdomen, rinse, and pat dry. If the client has an **ostomy** (*AH-stoh-mee*), or opening in the abdomen for getting rid of body wastes, provide skin care around the opening. (Chapter 14 includes more information about ostomies.) Cover with the towel. Pull the cotton blanket up to the client's chin and remove the towel.

Legs and Feet: Expose the far leg and place a towel under it. Wash the thigh, using long, downward strokes. Rinse and pat dry. Do the same from the knee to the ankle (Fig. 13-11).

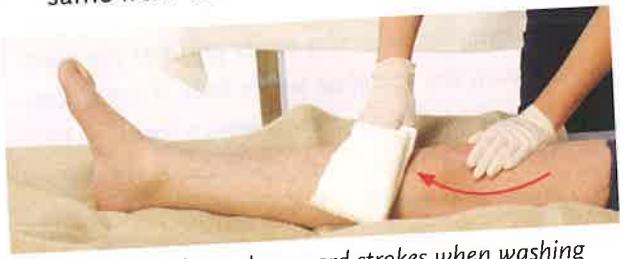

Fig. 13-11. *Use long, downward strokes when washing the legs.*

Place another towel under the far foot. Move the basin to the towel. Place the foot into the basin. Wash the foot and between the toes (Fig. 13-12). Rinse the foot and pat dry, making sure area between toes is dry. Give nail care (see procedure later in this chapter) if it has been assigned. Never clip a client's toenails. Apply lotion to the foot if ordered, especially to the heels. Do not apply lotion between the toes. Remove excess lotion (if any) with a towel. Repeat the steps for the other leg and foot.

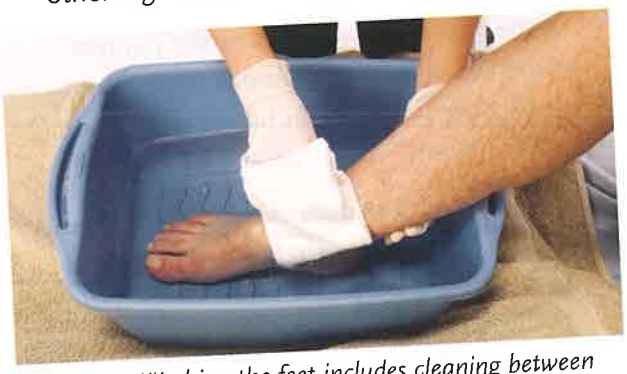

Fig. 13-12. *Washing the feet includes cleaning between the toes.*

Back: Help the client to move to the center of the bed. If the bed has rails, raise the far rail for safety. Help the client to turn onto his side, toward the raised side rail. Return to the working side of the bed. His back should be facing you. Fold the cotton blanket away from the back. Place a towel lengthwise next to the back. Wash the neck and back with long, downward strokes (Fig. 13-13). Rinse and pat dry. Apply lotion if ordered.

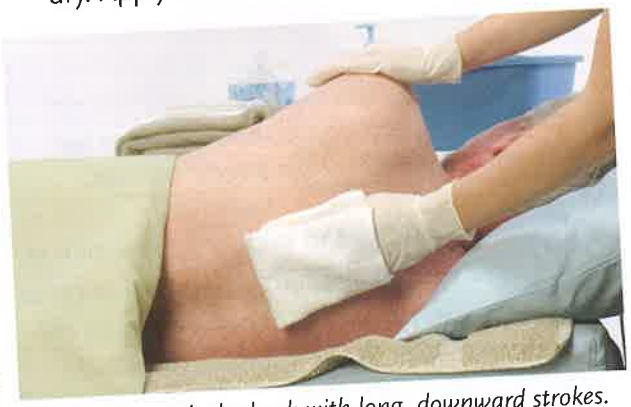

Fig. 13-13. *Wash the back with long, downward strokes.*

12. Place the towel under the buttocks and upper thighs. Help the client turn onto his back. If the client is able to wash his perineal area, place a basin of clean, warm water, a washcloth, and a towel within reach. Hand items to the client as needed. If the client wants you to leave the room, remove and discard your gloves. Wash your hands. Leave the bed rails up (if used). Return bed to its lowest

position. Leave a call signal and the supplies within reach. If the client has a urinary catheter in place, remind him not to pull it.

13. If the client is unable to provide perineal care, you will do so. Remove and discard your gloves. Wash your hands and put on clean gloves. Provide privacy at all times.

14. **Perineal area and buttocks**: Change the bath water. Place a towel under the perineal area, including the buttocks. Wash, rinse, and dry the perineal area, working from front to back (clean to dirty). Expose the perineal area only.

    For a female client: Using water and a small amount of soap, wash the perineum from front to back, using single strokes (Fig. 13-14). Do not wash from the back to the front, as this may cause infection. Use a clean area of the washcloth or a clean washcloth for each stroke.

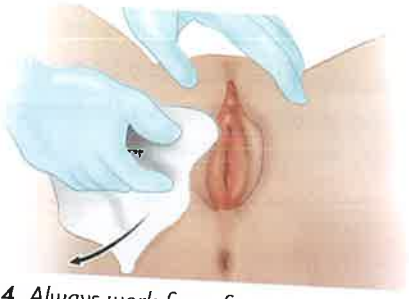

Fig. 13-14. *Always work from front to back when performing perineal care. This helps prevent infection.*

    Working from front to back, wipe one side of the labia majora, the outside folds of perineal skin that protect the urinary meatus and the vaginal opening. Then wipe the other side, using a clean part of the washcloth. With your thumb and forefinger, gently separate the labia majora. Wipe from front to back on one side with a clean washcloth, using a single stroke. Using a clean area of the washcloth, wipe from front to back on the other side. Using another clean area of the washcloth, wipe from front to back down the center. Clean the perineum (area between vagina and anus) last with a front-to-back motion. Rinse the area thoroughly in the same way. Make sure all soap is removed. Dry entire perineal area moving from front to back, using a blotting motion with the towel.

    Ask the client to turn on her side. Using a clean washcloth, wash and rinse buttocks and anal area. Work from front to back. Clean the anal area without contaminating the perineal area. With a clean, dry towel or washcloth, dry buttocks and anal area.

    For a male client: If the client is uncircumcised, pull back the foreskin first. Gently push skin toward the base of the penis. Hold the penis by the shaft and wash in a circular motion from the tip down to the base. Use a clean area of washcloth or clean washcloth for each stroke (Fig. 13-15).

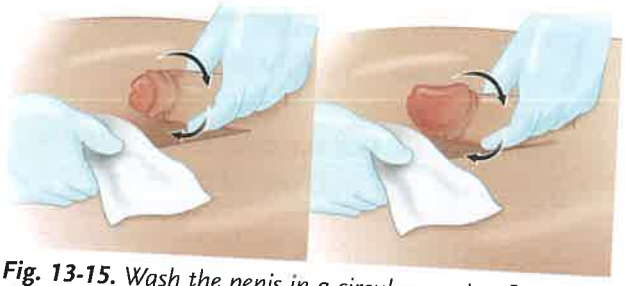

Fig. 13-15. *Wash the penis in a circular motion from the tip down to the base (an uncircumcised penis is shown on the left and a circumcised penis is shown on the right).*

    Thoroughly rinse the penis and pat dry with a clean, dry towel or washcloth. If the client is uncircumcised, gently return foreskin to normal position. Then wash the scrotum and groin. The **groin** is the area from the pubis (area around the penis and scrotum) to the upper thighs. Rinse thoroughly and pat dry. Ask the client to turn on his side. Using a clean washcloth, wash and rinse buttocks and anal area. Work from front to back. Clean the anal area without contaminating the perineal area. With a clean, dry towel or washcloth, dry buttocks and anal area.

15. Cover the client with the cotton blanket.

16. Place soiled washcloths and towels in the hamper or laundry basket. Empty dirty bath

water into the toilet. Rinse the basin and discard rinse water in the toilet. Flush the toilet. Dry the bath basin.

17. Remove and discard your gloves.

18. Wash your hands.

19. If time permits, a bed bath is a good time to give the client a back rub if he wants one (Chapter 12 explains how to give a back rub).

20. Provide the client with deodorant. Place a towel over the pillow and brush or comb the client's hair (see procedure later in this chapter). Help the client put on clean clothing and get into a comfortable position with proper body alignment. If you raised an adjustable bed, return it to its lowest position.

21. If the client uses a signaling device, place it within reach. Take the bath supplies away, and store everything. (If you need to change bed linens, don clean gloves first. Place used bed linens in the hamper or laundry basket.)

22. Wash your hands.

23. Document the procedure and your observations. Did you observe any redness, whiteness, or purple areas on the skin? Was there any broken skin? How did the client tolerate bathing? Did the client tell you about any symptoms? Has there been a change in the client's abilities since the last bath or shower?

Hair care is an important part of cleanliness. Shampooing the hair removes dirt, bacteria, oils, and other materials from the hair. Clients who can get out of bed may have their hair shampooed in the sink, tub, or shower. For clients who cannot get out of bed, shampoo basins can be used (Fig. 13-16). The basin fits under the client's head and neck and has a spout or hose that drains the water. An agency should be able to provide this equipment. A homemade trough can be constructed by placing a plastic garbage bag around a rolled towel. There are also special types of shampoo that do not require the use of water (Fig. 13-17). The manufacturer's instructions should be followed when using these types of shampoo. Gloves should be worn if a client has open sores on her scalp.

Fig. 13-16. *A shampoo basin can be used to shampoo hair while the person is in bed.* (PHOTO COURTESY OF NORTH COAST MEDICAL, INC., WWW.NCMEDICAL.COM, 800-821-9319)

Fig. 13-17. *This is one type of shampoo that does not require water.* (PHOTO COURTESY OF DOVE, WWW.DOVE.COM, 212-704-8172)

Shampooing hair

Equipment: shampoo, hair conditioner (if requested), 2 bath towels, washcloth, pitcher or handheld shower or sink attachment, plastic cup, waterproof pad (for washing hair in bed), cotton blanket (for washing hair in bed), shampoo basin (for washing hair in bed), chair (for washing hair in sink), large garbage bag or plastic sheet (for washing hair in sink), comb and brush, hair dryer

1. Wash your hands.

2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

3. Provide privacy for the client. Be sure the room is a comfortable temperature and there are no drafts.

4. Test water temperature against the inside of your wrist. Water temperature should be no higher than 105°F. Have the client check the water temperature. Adjust if necessary.

5. Position the client and wet the client's hair.

a. **For washing hair in the sink**, seat the client in a chair covered with a garbage bag or plastic sheet. Use a pillow under the plastic to support the head and neck. Have the client lean her head back toward the sink. Give the client a folded washcloth to hold over her forehead or eyes. Wet hair using a plastic cup, pitcher, or a handheld sink attachment (Fig. 13-18).

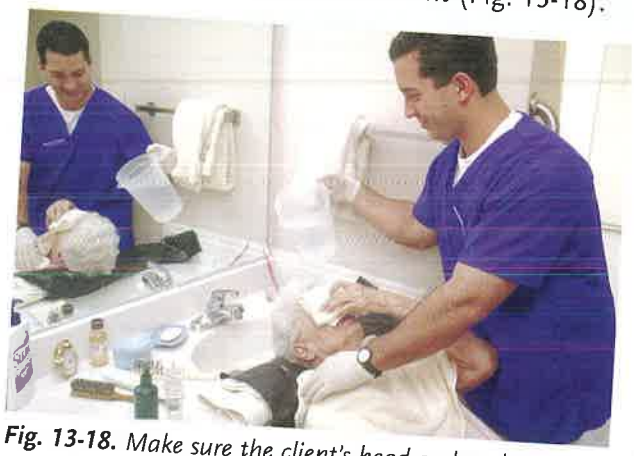

Fig. 13-18. *Make sure the client's head and neck are supported and her eyes are covered when washing hair in the sink.*

b. **For washing hair in the tub**, have the client tilt her head back. Give the client a folded washcloth to hold over her forehead or eyes. Wet hair using a plastic cup, pitcher, or handheld shower attachment.

c. **For washing hair in the shower**, have the client turn so her back is toward the showerhead. Ask the client to tilt her head backward. Direct the flow of water over the hair to wet it.

d. **For washing hair in bed**, arrange the supplies within reach on a nearby table. Remove all pillows and place the client in a flat position. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels. Place a waterproof pad beneath the client's head and shoulders. Cover the client with the cotton blanket and fold back the top sheet and regular blankets. Place the basin under the client's head. Place one towel across the client's shoulders. Protect the client's eyes with a dry washcloth. Using the pitcher or attachment, pour enough water on the client's hair to make it thoroughly wet.

6. Apply a small amount of shampoo to your hands and rub them together. Using both hands, massage the shampoo into a lather in the client's hair. With your fingertips (not fingernails), massage the scalp in a circular motion, from front to back (Fig. 13-19). Do not scratch the scalp.

Fig. 13-19. *Use your fingertips, not your fingernails, to work shampoo into a lather. Be gentle so that you do not scratch the scalp.*

7. Rinse the hair until the water runs clear. Use conditioner if the client wants it. Rinse as directed on the container. Be sure to rinse the hair thoroughly to prevent the client's scalp from getting dry and itchy.

8. Wrap the client's hair in a clean towel. If shampooing at the sink, return the client to an upright position. If shampooing in the bath or shower, help the client get out of the tub or shower. If shampooing in bed, remove the basin. Dry the client's face and neck with a washcloth or towel.

9. Remove the hair towel and gently rub scalp and hair with the towel. Comb or brush hair (see procedure later in the chapter).
10. If client wishes, dry hair with a hair dryer on the low setting. Style hair as the client prefers.
11. Wash and store equipment. Put soiled towels and washcloth in the hamper or laundry basket. If you raised an adjustable bed, return it to its lowest position.
12. Wash your hands.
13. Document the procedure and your observations. How did the client tolerate having her hair washed? Was the client able to help? Have the client's abilities changed since the last time her hair was washed?

3. Describe guidelines for assisting with grooming

Grooming affects the way people feel about themselves and how they appear to others. When assisting clients with grooming, HHAs should always let clients do all they can for themselves. Clients should make as many choices as possible. Some clients may have particular ways of grooming themselves. They may have routines. The HHA should work with the client to establish a routine that includes everything in the care plan and also satisfies the client. The supervisor can address any questions or problems.

Some clients may be embarrassed, depressed, or anxious because they need help with grooming tasks that they have performed for themselves all their lives. Being professional and respectful while assisting clients with grooming can help clients maintain self-respect and promote person-centered care.

Nail Care

Fingernails can harbor bacteria. It is important to keep hands and nails clean to help prevent infection. Nail care should be given when nails are dirty or have jagged edges and whenever it has been assigned. Some agencies do not allow home health aides to cut a client's fingernails or toenails. For some clients, poor circulation can lead to infection if skin is accidentally cut while caring for nails. For a client who has compromised circulation due to a disease such as diabetes, an infection can lead to a severe wound or even amputation. If directed to provide nail care, the HHA should know exactly what care she needs to provide.

Providing fingernail care ▶

Equipment: orangewood stick, emery board, small basin or bowl, soap, 2 washcloths, 2 towels, lotion, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If client is in bed and bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Remove any rings. If necessary, remove nail polish with a cotton ball soaked in nail polish remover.
6. Fill the basin halfway with warm water. Test water temperature against the inside of your wrist to ensure it is safe. Water temperature should be no higher than 105°F. Have the client check the water temperature. Adjust if necessary. Place the basin at a comfortable level for the client.
7. Put on gloves.
8. Soak the client's hands and nails in the basin of water. Soak all 10 fingertips for 5 to 10 minutes.
9. Remove hands from the water. Wash hands with a soapy washcloth. Rinse. Pat hands dry

with a towel, including between the fingers. Remove the hand basin.

10. Place the client's hands on the towel. Gently clean under each fingernail with the orangewood stick (Fig. 13-20).

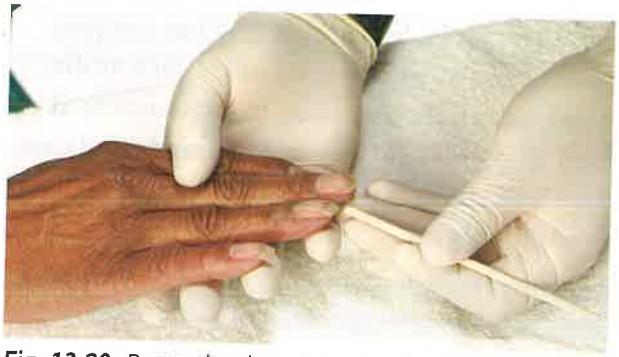

Fig. 13-20. *Be gentle when removing dirt from under the nails with an orangewood stick.*

11. Wipe the orangewood stick on the towel after cleaning under each nail. Wash the client's hands again. With a clean, dry towel or washcloth, dry them thoroughly, especially between the fingers.

12. Shape fingernails with an emery board or nail file, moving in one direction only (not back and forth). File in a curve. Finish with nails smooth and free of rough edges.

13. Apply lotion from fingertips to wrists. Remove excess, if any, with a towel or washcloth. Replace rings.

14. Discard the water, and rinse and dry the basin. Place the towels in the laundry hamper and store supplies. If you raised an adjustable bed, return it to its lowest position.

15. Remove and discard your gloves.

16. Wash your hands.

17. Document procedure and any observations.

Adding denture tablets to the basin for fingernail care or foot care may be listed in the client's care plan. Denture tablets are sometimes used to help whiten nails. The HHA should follow the care plan and his supervisor's instructions.

Foot Care

Careful foot care is extremely important; it should be a part of daily care of clients. For clients with diabetes, which causes poor circulation, a small sore on the foot can grow into a much larger wound that may take months to heal or may not heal at all. It can result in amputation. Long, thickened toenails contribute to pressure injuries and problems with balance, which contribute to falls. Falls can lead to hospitalization and further complications. Even if another person gives a client foot care, the HHA should still observe the client's feet for these signs of problems or illness on a regular basis.

Observing and Reporting: Foot Care

Report any of the following to your supervisor:

- O/R Dry, flaking skin
- O/R Nonintact or broken skin
- O/R Discoloration of the feet, such as reddened, gray, white, or black areas
- O/R Blisters
- O/R Bruises
- O/R Blood or drainage
- O/R Long, ragged, or thickened toenails
- O/R Ingrown nails
- O/R Swelling
- O/R Soft, fragile, or reddened heels
- O/R Differences in temperature of the feet

Providing foot care

Equipment: basin, bath mat, 2 towels, 2 washcloths, lotion, soap, clean socks, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.

4. If client is in bed, and the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Fill the basin halfway with warm water. Test the water temperature against the inside of your wrist to ensure it is safe. Water temperature should be no higher than 105°F. Have the client check the water temperature. Adjust if necessary.
6. Place the basin on a bath mat or bath towel on the floor (if the client is sitting in a chair) or on a towel at the foot of the bed (if the client is in bed). Make sure the basin is in a comfortable position for the client. Support the foot and ankle throughout the procedure.
7. Put on gloves.
8. Remove the client's socks. Completely submerge the client's feet in water. Soak the feet for 10 to 20 minutes. Add warm water to the basin as necessary.
9. Put soap on a wet washcloth. Remove one foot from the water. Wash the entire foot, including between the toes and around the nail beds (Fig. 13-21).

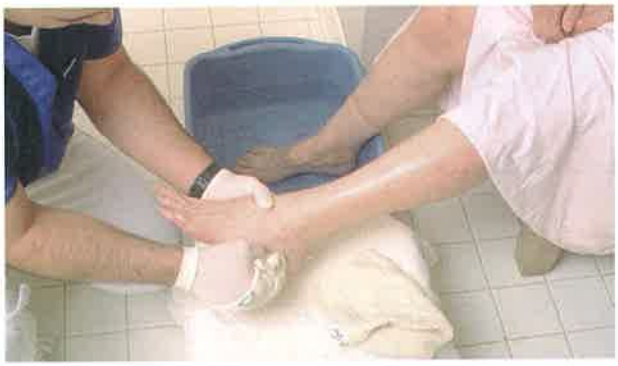

Fig. 13-21. *While supporting the foot and ankle, wash the entire foot with a soapy washcloth.*

10. Rinse the entire foot, including between the toes.
11. With a clean, dry towel or washcloth, pat the entire foot dry, including between the toes.
12. Repeat steps 9 through 11 for the other foot.
13. Put lotion in one hand and warm the lotion by rubbing your hands together. Massage lotion into entire foot (top and bottom), except between the toes, removing excess, if any, with a towel.
14. Help the client to put on clean socks.
15. Discard the water, and rinse and dry the basin. Place the towels in the laundry hamper and store supplies. If you raised an adjustable bed, return it to its lowest position.
16. Remove and discard your gloves.
17. Wash your hands.
18. Document procedure and any observations. Was there any redness, whiteness, or broken or discolored skin or nails? Were there any differences in temperature of the feet?

Shaving

The HHA should make sure the client wants her to shave him or help him shave before beginning. Personal preferences for shaving must be respected. HHAs must wear gloves when shaving clients due to risk of exposure to blood. Different types of razors include the following:

- A safety razor has a sharp blade, which comes with a special safety casing to help prevent cuts. This type of razor requires shaving cream or soap.
- A disposable razor requires shaving cream or soap. The HHA should not attempt to recap a disposable razor. It is discarded in a biohazard container for sharps after use.
- An electric razor is the safest and easiest type of razor to use. It does not require soap or shaving cream. Some clients who take blood thinners (anticoagulant medication that helps prevent clots from forming in the blood) may be told to use an electric razor to avoid nicks

and cuts. An electric razor should not be used near water or any water source or when oxygen is in use.

Shaving a client

Equipment: razor, basin filled halfway with warm water (if using a safety or disposable razor), shaving cream or soap (if using a safety or disposable razor), 2 towels, washcloth, mirror, aftershave lotion, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Place the equipment on a table within reach of the client if he will shave himself. If the client is in bed, raise the head of the bed, use a backrest, or use pillows to have him in an upright sitting position. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels. If the client wears dentures, be sure they are in place. Place the towel across the client's chest, under his chin.
5. Put on gloves.

Shaving using a safety or disposable razor:

6. If using a safety or disposable razor, use a blade that is sharp. A dull blade can irritate the skin. Soften the beard with a warm, wet washcloth on the face for a few minutes before shaving. Lather the face with shaving cream or soap and warm water. Warm water and lather make shaving more comfortable.
7. Hold skin taut. Shave in the direction of hair growth. Shave the beard in short, downward, and even strokes on the face and upward strokes on the neck (Fig. 13-22). Rinse the blade often in the basin to keep it clean and wet.

Fig. 13-22. *Holding the skin taut, shave in downward strokes on the face and upward strokes on the neck.*

8. When you have finished, wash and rinse the client's face with a warm, wet washcloth. If he is able, let him use the washcloth himself. Use a towel to dry his face. Offer a mirror to the client.

Shaving using an electric razor:

6. Use a small brush to clean the razor. Do not use an electric razor near any water source or when oxygen is in use.
7. Turn on the razor and hold skin taut. Shave with smooth, even movements (Fig. 13-23). If using a foil shaver, shave the beard with a back-and-forth motion in the direction of beard growth. If using a three-head shaver, shave beard in a circular motion. Shave the chin and under the chin.

Fig. 13-23. *Shave, or have the client shave, with smooth, even movements.*

8. When you have finished, offer a mirror to the client.

Final steps:

9. If the client wants aftershave lotion, moisten your palms with the lotion and pat it onto the client's face.
10. Remove the towel. Put the towel and washcloth in the hamper or laundry basket. If you raised an adjustable bed, return it to its lowest position.
11. Clean the equipment and store it. Follow agency policy for a safety razor. For a disposable razor, dispose of it in a biohazard container for sharps (if available). For an electric razor, clean the head of the razor. Remove whiskers, recap the shaving head, and return the razor to the case.
12. Remove and discard your gloves. Wash your hands.
13. Document the procedure and any observations.

Hair Care

Because hair thins as people age, pieces of hair can be accidentally pulled out of the head while combing or brushing it. HHAs must handle clients' hair very gently.

Combing or brushing hair

Equipment: comb, brush, towel, mirror, hair care items requested by the client

Use hair care products that the client prefers for his or her type of hair.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the client is in bed, raise the head of the bed, use a backrest, or use pillows to have her in an upright sitting position. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels. If the client is ambulatory, provide a chair.
5. Place the towel under the client's head or around the shoulders.
6. Remove any hair pins, hair ties, or clips.
7. If the hair is tangled, work on the tangles first. Remove tangles by dividing hair into small sections. Hold the lock of hair just above the tangle so you do not pull at the scalp, and gently comb or brush through the tangle. If the client agrees, use a small amount of detangler or leave-in conditioner.
8. After tangles are removed, brush two-inch sections of hair at a time (Fig. 13-24).

Fig. 13-24. *Gently brush hair after tangles are removed.*

9. Neatly style hair in the way the client prefers (Fig. 13-25). Each client may prefer different styles and different hair products. Avoid childish hairstyles. Offer a mirror to the client.

Fig. 13-25. *Assist the client in styling her hair as she prefers.*

10. Remove the towel and shake excess hair in the wastebasket. Place the soiled towel in the hamper. Store supplies. Clean hair from the brush/comb. If you raised an adjustable bed, return it to its lowest position.
11. Wash your hands.
12. Document the procedure and any observations.

Pediculosis is the medical term for an infestation of lice. Lice are tiny parasites that bite into the skin and suck blood to live and grow. Three types of lice are head lice, body lice, and crab or pubic lice. Head lice are usually found on the scalp. Lice are usually difficult to see. Symptoms include itching, bite marks on the scalp, skin sores, and matted, bad-smelling hair and scalp. Lice eggs may be visible on the hair, behind the ears, and on the neck. They are small and round and may be brown or white. Lice droppings look like a fine black powder. They may be seen on sheets or pillows. If an HHA notices any of these symptoms, she should tell her supervisor immediately. Lice can spread very quickly. Special creams, shampoos, lotions, sprays, or special combs may be used to treat lice. People who have lice can spread it to others. To help prevent the spread of lice, a client's combs, brushes, clothes, wigs, and hats should not be shared with anyone else.

Dressing and Undressing

Dressing and undressing clients is an important part of daily care. When helping with dressing, the HHA should know what limitations the client has. Clients may have one side of the body that is weaker than the other side due to stroke or injury. This side is called the weaker, **affected**, or **involved side**. The HHA should not refer to the weaker side as the "bad side" or talk about the "bad" leg or arm. When dressing clients, the HHA should begin with the weaker side of the body to reduce the risk of injury. The weaker arm is placed through a sleeve first (Fig. 13-26). When a leg is weak, it is easier if the client sits down to pull the pants over both legs.

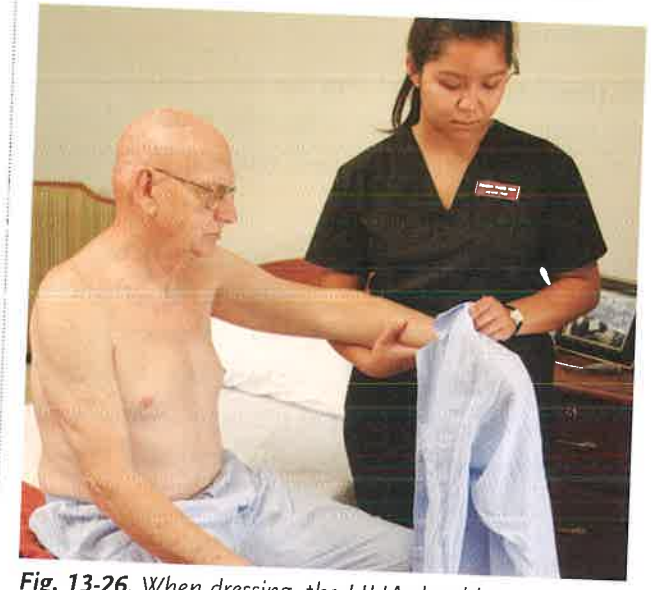

Fig. 13-26. When dressing, the HHA should start with the affected (weaker) side first.

Guidelines: Dressing and Undressing

- As with all care, ask about and follow the client's preferences. This is part of promoting person-centered care. Person-centered care is the client's legal right and your responsibility.
- Let the client choose clothing for the day. However, check to see if it is clean, appropriate for the weather, and in good condition.
- Encourage the client to dress in regular clothes rather than nightclothes. Wearing regular daytime clothing encourages more activity and out-of-bed time. Clothing with elastic waistbands and clothing that is a larger size than normal are easier to put on. Be sure the elastic waistband of underpants, slips, stockings, tights, pants, or skirt fits comfortably at the waist.
- The client should do as much to dress or undress himself as possible. It may take longer, but it helps maintain independence and regain self-care skills. Ask where your assistance is needed.

- Several types of assistive devices for dressing are available to help clients maintain independence in dressing themselves (Fig. 13-27). An occupational therapist may teach clients to perform ADLs using assistive equipment.

Fig. 13-27. *Special dressing aids promote independence by helping clients dress themselves.* (PHOTO COURTESY OF NORTH COAST MEDICAL, INC., WWW.NCMEDICAL.COM, 800-821-9319)

- Provide privacy. If the client has just had a bath, cover him with the bath blanket and put on undergarments first. Never expose more than what is needed.
- When putting on socks or stockings, roll or fold them down so they can be slipped over the toes and foot, then unrolled up into place. Make certain toes, heels, and seams of socks or stockings are in the right place.
- For a female client, make sure bra cups fit over the breasts. A front-fastening bra is easier for clients to work by themselves. A bra that fastens in back can be put around the waist and fastened first. After fastening, rotate the bra around and move it up, putting arms through the straps last. This can be done in reverse for undressing.
- For clients who have weakness or paralysis on one side, place the weaker arm or leg through the garment first, then the stronger arm or leg. When undressing, do the opposite—start with the stronger, or unaffected, side.

Dressing a client

Equipment: cotton blanket, clean clothes of client's choice, nonskid shoes

When putting on all items, move the client's body gently and naturally. Avoid force and overextension of limbs and joints.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the client is in bed, raise the head of the bed, use a backrest, or use pillows to have her in an upright sitting position. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Ask the client what she would like to wear. Dress her in the outfit she chooses.
6. Place a cotton blanket over the client and ask her to hold onto it as you remove or fold back the top bedding to the foot of the bed. Remove the gown or top. Keep the client covered with the blanket; do not completely expose the client. Take clothes off the stronger side first when undressing. Then remove from the weaker side. Place the gown or top in the hamper or laundry basket. Move the blanket down to cover the lower body.
7. Help the client put on the top. If the top goes over the head, slide the top over the head first. Then place the weaker arm through the sleeve before placing the garment on the stronger arm. Help the client lean forward and smooth the top down. If the top fastens in the front, slide your hand through one sleeve and grasp the client's hand on the

weaker side, pulling it through. Help the client lean forward and arrange the top across the back. Pull the second sleeve onto the stronger side as you did with the first one. Fasten the top.

8. Remove the cotton blanket and place it in the hamper or basket. Help the client put on a skirt or pants. Put the weaker leg through the skirt or pants first. Then place the stronger leg through the skirt or pants. Have the client raise her buttocks or turn her from side to side to pull the pants over her buttocks up to the waist. Fasten the pants or skirt if needed and make sure the clothing is comfortable.
9. Roll one sock over the weaker foot. Make sure the heel of the sock is over the heel of the foot. Make sure there are no twists or wrinkles in the sock after it is on. Repeat for the other foot.
10. Place the bed at the lowest position. Have the client sit up on the side of the bed with his legs hanging over the side (dangle).
11. Starting with the weaker foot, help put on nonskid footwear. Fasten the shoe securely and then put on the other shoe and fasten it.
12. Finish with the client dressed appropriately. Make sure clothing is right-side-out and zippers and buttons are fastened.
13. Make sure worn clothing is in the hamper or laundry basket. Keep the bed in its lowest position.
14. Wash your hands.
15. Document the procedure and any observations.

4. Identify guidelines for oral care

Oral care, or care of the mouth, teeth, and gums, is performed at least twice each day to clean the mouth. Oral care should be done after breakfast and after the last meal or snack of the day. It may also be done before a client eats. Oral care includes brushing teeth, tongue, and gums; flossing teeth with dental floss; caring for lips; and caring for dentures. **Dental floss** is a special kind of string used to clean between teeth. When providing oral care, the HHA should wear gloves and follow Standard Precautions. Accurate observing of the client's mouth by the HHA is important.

Observing and Reporting: Oral Care

- O/R Irritation
- O/R Raised areas
- O/R Coated or swollen tongue
- O/R Ulcers, such as canker sores or small, painful, white sores
- O/R Flaky, white spots
- O/R Dry, cracked, bleeding, or chapped lips
- O/R Loose, chipped, broken, or decayed teeth
- O/R Swollen, irritated, bleeding, or whitish gums
- O/R Breath that smells bad or fruity
- O/R Client reports of mouth pain

Providing oral care

Equipment: toothbrush, toothpaste, emesis basin, cup of water, towel or washcloth, lip moisturizer, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the client is in bed, raise the head of the bed, use a backrest, or use pillows to place him in an upright sitting position. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.

5. Put on gloves.
6. Place a towel or washcloth across the client's chest.
7. Remove any dental bridgework or ask your client to do so. (A procedure later in this chapter explains how to remove dentures.)
8. Wet the toothbrush and put a small amount of toothpaste on it.
9. Clean the entire mouth, including the tongue and all surfaces of the teeth and the gumline, using gentle strokes. First brush inner, outer, and chewing surfaces of the upper teeth, then do the same with the lower teeth. Use short strokes. Brush back and forth. Brush the tongue.
10. Give the client the cup of water to use to rinse the mouth. Place the emesis basin under the client's chin, with the inward curve under the chin. Have the client spit water into the basin (Fig. 13-28). Wipe his mouth and remove the towel.

Fig. 13-28. *Rinsing and spitting removes food particles and toothpaste.*

11. Replace any dental bridgework. (A procedure later in this chapter explains how to reinsert dentures.) Apply moisturizer to the lips if the client desires.
12. Rinse the toothbrush and place in the proper container. Discard the water, and rinse and dry the basin. Place the towels in the laundry hamper and store supplies. If you raised an adjustable bed, return it to its lowest position.
13. Remove and discard your gloves.
14. Wash your hands.
15. Document the procedure and any observations. Did you observe any mouth ulcers or other broken skin? What was the condition of the mucous membrane? Report any problems with teeth, mouth, tongue, and lips to your supervisor. This includes odor, cracking, sores, bleeding, and any discoloration.

Oral care must be given frequently to clients who are unconscious. Even though a person who is unconscious cannot eat, breathing through the mouth causes saliva to dry in the mouth. A lack of fluid intake can also cause the mouth to become dry. Regular oral care helps keep the mouth clean and moist.

With unconscious clients, HHAs must use as little liquid as possible when giving mouth care. Because the person's swallowing reflex is weak, he is at risk for aspiration. **Aspiration** is the inhalation of food, fluid, or foreign material into the lungs. Aspiration can cause pneumonia or death. Turning unconscious clients on their sides before giving oral care can also help prevent aspiration. For these clients, only swabs soaked in tiny amounts of fluid should be used to clean the mouth.

Providing oral care for the unconscious client

Equipment: sponge swabs, tongue depressor, emesis basin or small bowl, towel, cup of cool water, cleaning solution (as ordered in the care plan), lip moisturizer, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible. Even clients

who are unconscious may be able to hear you. Always speak to them as you would to any client.

3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Put on gloves.
6. Turn the client onto his side. Place a towel under his cheek and chin. Place emesis basin or bowl next to the cheek and chin so that excess fluid flows into the basin.
7. Hold the mouth open with the tongue depressor. (You can also use gentle pressure on the chin to open the mouth. Follow agency policy.)
8. Dip the sponge swab in the cleaning solution. Squeeze excess solution to prevent aspiration. Wipe inner, outer, and chewing surfaces of the upper and lower teeth, gums, tongue, and inside surfaces of the mouth. Remove debris with the swab. Change the swab often. Repeat this until the mouth is clean.
9. Rinse with a clean swab dipped in water. Squeeze the swab first to remove excess water.
10. Remove the towel and basin. Pat lips or face dry if needed. Apply lip moisturizer.
11. Discard the water, and rinse and dry the basin. Dispose of the towel in the laundry hamper and store supplies. If you raised an adjustable bed, return it to its lowest position.
12. Remove and discard your gloves.
13. Wash your hands.
14. Document the procedure and your observations. Did you observe any mouth ulcers or other broken skin? What was the condition of the mucous membrane? Report any problems with teeth, mouth, tongue, and lips to your supervisor. This includes odor, cracking, sores, bleeding, and any discoloration.

Flossing the teeth removes plaque and tartar buildup around the gumline and between the teeth. Teeth may be flossed immediately after or before they are brushed, according to the client's preference.

Flossing teeth

Equipment: dental floss, cup of water, emesis basin, towel, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the client is in bed, raise the head of the bed, use a backrest, or use pillows to have him in an upright sitting position. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Put on gloves.
6. Wrap the ends of the floss securely around each index finger (Fig. 13-29).

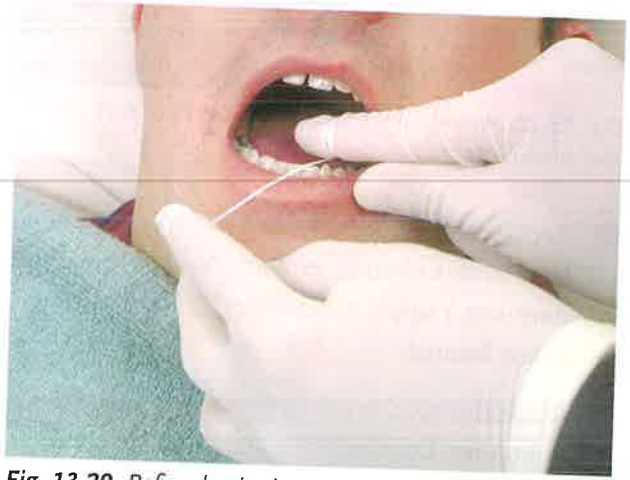

Fig. 13-29. *Before beginning, wrap floss securely around each index finger.*

7. Starting with the back teeth, place the floss between teeth. Move it down the surface of the tooth using a gentle sawing motion (Fig. 13-30).

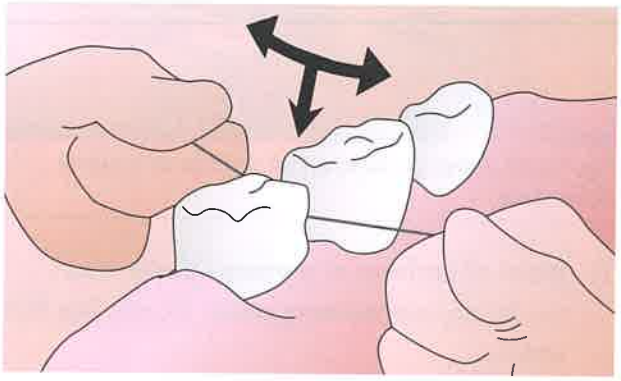

Fig. 13-30. *Floss teeth gently. Being gentle protects the gums.*

Continue to the gumline. At the gumline, curve the floss. Slip it gently into the space between the gum and tooth, then go back up, scraping that side of the tooth (Fig. 13-31). Repeat this on the side of the other tooth.

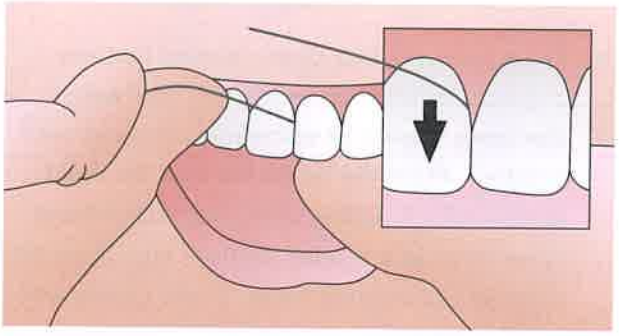

Fig. 13-31. *Floss gently in the space between the gum and tooth. This removes food and prevents tooth decay.*

8. After every two teeth, unwind the floss from your fingers and move it so you are using a clean area. Floss all teeth.
9. Occasionally offer water so that the client can rinse debris from the mouth into the basin.
10. Offer the client a towel when finished flossing all teeth.
11. Discard the floss. Discard the water and rinse and dry the basin. Dispose of the towel in the laundry hamper and store supplies. If you raised an adjustable bed, return it to its lowest position.
12. Remove and discard your gloves.
13. Wash your hands.
14. Document procedure and observations. Report any problems with teeth, mouth, tongue, and lips to your supervisor. This includes odor, cracking, sores, bleeding, and any discoloration.

Floss picks are sometimes used in place of standard dental floss. A floss pick is a small tool that is made of plastic and has a curved end that contains a piece of dental floss (Fig. 13-32). The HHA should follow his agency's policies and procedures if using a floss pick to floss a client's teeth.

Fig. 13-32. *This is a type of disposable floss pick.*

Dentures are artificial teeth. They are expensive, so they must be handled carefully to avoid breaking or chipping them. If a client's dentures break, she cannot eat. The HHA should notify his supervisor if a client's dentures do not fit properly, are chipped, or are missing.

The HHA must wear gloves when handling and cleaning dentures. Dentures and denture brushes should not be placed on contaminated surfaces. Once dentures are cleaned, they should either be returned to the client or stored in denture solution or in clean, moderate/cool water (not hot water) so that they do not dry out and warp. Dentures may crack if left uncovered.

Cleaning and storing dentures

Equipment: denture brush or toothbrush, denture cleanser or tablet, denture cup for storage, 2 towels, basin or sink, gauze squares, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Line the sink or a basin with one or two towels and partially fill the sink with water. The towel and water will prevent the dentures from breaking if they slip from your hands and fall into the sink.
6. Ask the client to remove the dentures and place them in the denture cup. If the client is unable to remove them, remove them for her. Remove the lower denture first. The lower denture is easier to remove because it floats on the gumline of the lower jaw. Grasp the lower denture with a gauze square (for a good grip) and remove it. Place it in a denture cup filled with moderate/cool water.
7. The upper denture is sealed by suction. Firmly grasp the upper denture with a gauze square and give a slight downward pull to break the suction. Turn it at an angle to take it out of the mouth. Place it in a denture cup filled with moderate/cool water.
8. Take the denture cup to the sink or basin. Rinse the dentures in clean, moderate/cool running water before brushing them. Do not use hot water. Hot water may warp or damage dentures.
9. Apply denture cleanser to the toothbrush.
10. Brush dentures on all surfaces (Fig. 13-33). These include the inner, outer, and chewing surfaces of dentures, as well as the groove that will touch gum surfaces.

Fig. 13-33. *Brush dentures on all surfaces to properly clean them.*

11. Rinse all surfaces of dentures under clean, moderate/cool running water. Do not use hot water.
12. Rinse the denture cup and lid before placing clean dentures in the cup.
13. Your client may prefer to clean the dentures with a soaking solution. Read the directions on the bottle and prepare the solution. Soak the dentures for the amount of time indicated. Rinse the dentures before placing them in the denture cup.
14. Place dentures in a clean, labeled denture cup with solution or moderate/cool water. Dentures should be completely covered with solution. Place the lid on the cup. To avoid accidentally throwing dentures away, always store them in a labeled denture cup when the client is not wearing them. Some clients will want to wear their dentures all of the time. They will only remove them for cleaning. If the client wants to continue wearing dentures, return them to her. Do not place them in the denture cup.
15. Rinse the toothbrush and place in the proper container. Clean, dry, and return the equipment to proper storage. Drain the sink and put towels in laundry hamper.
16. Remove and discard your gloves.
17. Wash your hands.
18. Document procedure and any observations.

Reinserting dentures

Equipment: denture cup with dentures, denture cream or adhesive, towel, gloves

Ask if the client needs your assistance in inserting dentures.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Position client as you would for brushing teeth (help her into an upright position).
5. Put on gloves.
6. Apply denture cream or adhesive to the dentures if needed.
7. Ask the client to open her mouth. Insert the upper denture into the mouth by turning it at an angle. Straighten it and press it onto the upper gumline firmly and evenly (Fig. 13-34).

Fig. 13-34. *Press the upper denture onto the upper gumline firmly and evenly.*

8. Insert the lower denture onto the gumline of the lower jaw and press firmly.
9. Offer the client the towel.
10. Rinse and store the denture cup. Place the towel in the laundry hamper and store supplies.
11. Remove and discard your gloves.
12. Wash your hands.
13. Document the procedure and any observations.

A dental implant is a metal post, usually titanium, that replaces a tooth or several teeth. The implant is placed surgically, and fuses with bone over time, normally within a few months. It looks like a natural tooth (or teeth) and is very stable. After dental implant surgery, careful oral care must be performed to remove food and keep plaque from forming around the implant. Brushing and flossing regularly are key, as is careful observation of the mouth.

5. Explain care guidelines for prosthetic devices

A **prosthesis** (*pros-THEE-sis*) is a device that replaces a body part that is missing or deformed because of an accident, injury, illness, or birth defect. It is used to improve a person's ability to function and/or to improve appearance. Examples of prostheses include the following:

- Artificial limbs, such as artificial hands, arms, feet, and legs, are made to resemble the body part that they are replacing (Fig. 13-35). Many advances have been made and continue to be made in the field of prosthetic limbs. Today's artificial limbs are usually made of strong and lightweight plastics and other materials, such as carbon fiber. Most artificial limbs are attached by belts, cuffs, or suction. Direct bone attachment is a newer method of attaching the limb to the body.

Fig. 13-35. *A type of prosthetic arm.* (MOTION CONTROL UTAH ARM. PHOTO BY KEVIN TWOMEY.)

- An artificial breast is made of a lightweight, soft, spongy material. It usually fits into a regular bra or in the pocket of a special bra, called a mastectomy bra.
- A hearing aid is a small device placed in the ear to amplify sound for persons with hearing loss. Many elderly clients have hearing aids.
- An artificial eye, or ocular prosthetic, replaces an eye that has been lost to disease or injury. It is usually made of plastic. It is held in place by suction. An ocular prosthetic does not provide vision; it can, however, improve appearance.
- Dentures are artificial teeth. They may be necessary when a tooth or teeth have been damaged, lost, or must be removed. Many elderly clients have dentures. Learning Objective 4 of this chapter contains more information on denture care.

Guidelines: Prosthetic Devices

G Because prostheses are specially fitted, expensive pieces of equipment (some cost tens of thousands of dollars), only care for them as assigned. Handle them carefully. Follow the care plan. Know exactly how to care for the equipment before you begin. If you have any questions, call your supervisor.

G A therapist or nurse will demonstrate application of a prosthesis. Follow instructions to apply and remove the prosthesis. Follow the manufacturer's care directions.

G Respect a client's decision not to wear a prosthetic limb. Some clients may find the limb uncomfortable and only wish to wear it for special occasions.

G Keep the prosthesis and the skin under it dry and clean. The socket of the prosthesis must be cleaned at least daily. Follow the care plan.

G If ordered, apply a stump sock before putting on the prosthesis.

G Observe the skin on the stump. Watch for signs of skin breakdown caused by pressure and abrasion. Report any redness or open areas.

G Never try to fix a prosthesis. Report any problems to your supervisor.

G Do not show negative feelings about a client's stump during care.

G Many different types of hearing aids exist (Fig. 13-36). Always follow manufacturer's directions for cleaning and handling the hearing aid. In general, the hearing aid needs to be cleaned daily. Wipe it with a special cleaning solution and a soft cloth. Do not put the hearing aid in water. Handle it carefully; do not drop it. Always keep it in the same safe place, such as its case, when it is not being worn. Turn it off when it is not in use. Remove it before bathing, showering, or shampooing hair. Some hearing aids have rechargeable batteries. Some need to be recharged nightly. Follow instructions in the care plan. Replace batteries as needed. The correct size of battery must be used, and it needs to be firmly in place.

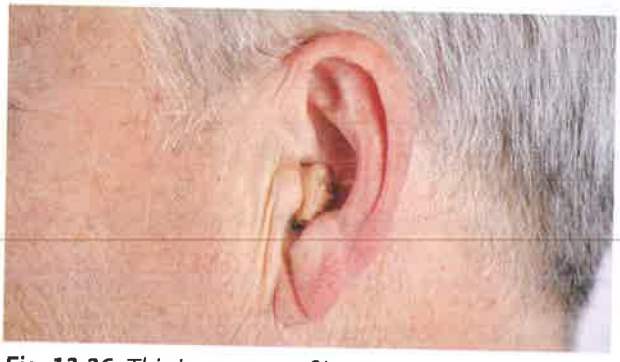

Fig. 13-36. *This is one type of hearing aid.*

G If instructed to care for an artificial eye, review the care plan with your supervisor. Always wash your hands and don gloves before handling an artificial eye. Provide

privacy for the client. Put on gloves before beginning care. Artificial eyes are held in place by suction. Some artificial eyes do not require frequent removal. Others need daily removal and cleaning.

- If the artificial eye is removed, wash the eye with solution and rinse in warm water. Never clean or soak the eye in rubbing alcohol. It will crack the plastic and destroy it.
- When the eye is removed, wash the eye socket with warm water or saline. Use a clean gauze square to clean it. Clean the eyelid with a clean cotton ball. Wipe gently from inner corner (canthus) outward.
- If the artificial eye is to be removed and not reinserted, line an eye cup or basin with a soft cloth or a piece of 4x4 gauze. This prevents scratches and damage. Fill with water or saline solution. Place the eye in the container and close the container.
- To reinsert the eye, moisten it and place it far under the upper eyelid. Pull down on the lower eyelid and the eye should slide into place.

6. Explain guidelines for assisting with elimination

Clients who are unable to get out of bed to use the toilet may be given a standard bedpan, a fracture pan, or a urinal. A **fracture pan** is a bedpan that is flatter than a regular bedpan. It is used for clients who cannot assist with raising their hips onto a regular bedpan (Fig. 13-37). Women will generally use a **bedpan** for urination and bowel movements. Men will generally use a **urinal** for urination and a bedpan for bowel movements (Fig. 13-38).

The best position for women to have normal urination is sitting. For men, the best position is standing. The supine (lying on the back) position should be avoided if possible because in this position a person cannot put pressure on the bladder and must work against gravity. The best position for bowel elimination is squatting and leaning forward. If the client cannot get out of bed, the HHA can raise the head of the bed for bowel elimination. That way the client does not have to work against gravity.

Fig. 13-37. *In the top photo, a standard bedpan is on the left side, and a fracture pan is on the right. In the bottom photo, a bariatric standard bedpan is in back, and a bariatric fracture pan is in front. Bariatric bedpans can be used for people who are overweight or obese.* (BOTTOM PHOTO © MEDLINE INDUSTRIES, INC. 2020)

Fig. 13-38. *A urinal.* (PHOTO COURTESY OF NOVA MEDICAL PRODUCTS, WWW.NOVAJOY.COM)

A client may ask for the bedpan, or the HHA may need to ask if the client needs it at regular times listed on the assignment sheet. Because clients may be embarrassed about needing help with bodily functions, the HHA should always be professional and provide as much privacy as possible when giving assistance.

Assisting a client with use of a bedpan

Equipment: bedpan, bedpan cover (towel), disposable bed protector, cotton blanket, toilet paper, disposable wipes, 2 towels, supplies for perineal care, plastic bag, 2 pairs of gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client by closing doors and shades and using a bath blanket.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed has rails, raise the far rail for safety. Before placing the bedpan, lower the head of the bed. If the bed is movable, lock the bed wheels.
5. Put on gloves.
6. Warm the outside of the bedpan with warm water in the bathroom and cover it when you bring it to the client. If a stool or urine sample is not needed, place a few sheets of toilet paper in the bedpan to make cleanup easier.
7. Cover the client with the cotton blanket and ask him to hold it while you pull down the top covers underneath. Do not expose more of client than you have to. Keep the client covered from the chest down except when placing or removing the bedpan.
8. Place the bed protector under the client's buttocks and hips. To do this, have the client turn toward the raised side rail. If the client cannot do this, you must turn him (see Chapter 12). Be sure the client cannot roll off the bed. Place the bed protector on the empty side of the bed, on the area where the client will lie on his back. The side of the protector nearest the client should be fanfolded (folded several times into pleats) and tucked under the client (Fig. 13-39).

Fig. 13-39. *Fanfold the protective pad near the client's back.*

Ask the client to turn onto his back, or turn him as you did before. Unfold the rest of the bed protector so it completely covers the area under and around the client's buttocks and hips.

9. Keeping him covered, ask the client to remove his undergarments or help him do so.
10. Place the bedpan near his hips in the correct position. A **standard bedpan** should be positioned with the wider end aligned with the client's buttocks. A **fracture pan** should be positioned with the handle toward the foot of bed.
11. If client is able, ask him to raise his hips by pushing with his feet and hands at the count of three (Fig. 13-40). Slide the bedpan under his hips.

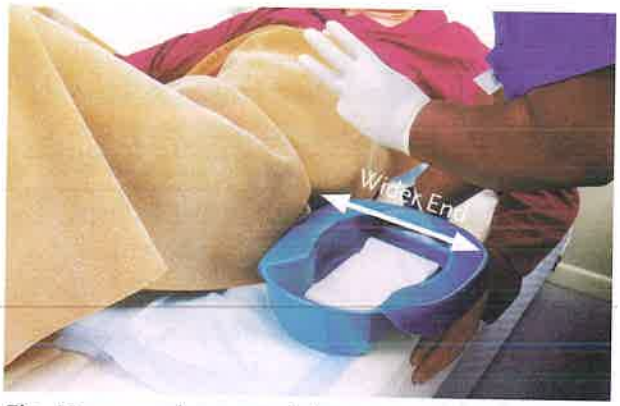

Fig. 13-40. *On the count of three, slide the bedpan under the client's hips. The wider end of the bedpan should be aligned with the client's buttocks.*

If the client cannot assist with getting on the bedpan, keep the bed flat and turn the client away from you toward the raised side rail.

Place the protective pad on the area where the client will lie on his back. Place the bedpan firmly against the client's buttocks (Fig. 13-41). Holding the bedpan securely, gently roll the client back onto the bedpan. Keep the bedpan centered underneath.

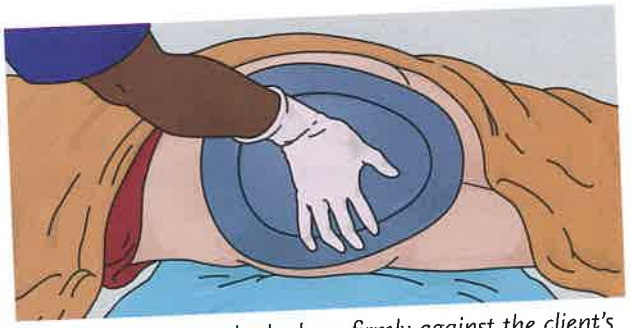

Fig. 13-41. *Placing the bedpan firmly against the client's buttocks, gently roll him back onto the bedpan.*

12. Remove and discard your gloves. Wash your hands.
13. Raise the head of the bed. Prop the client into a semisitting position using pillows. If the bed has rails, leave them both up. Return the bed to its lowest position.
14. Make sure the blanket is still covering the client. Place toilet paper, disposable wipes, and a bell or other way to call you within the client's reach. Ask the client to clean his hands with a wipe when finished if he is able. Tell him you will return when called. Leave the room and close the door.
15. When called by the client, return and wash your hands. Put on clean gloves.
16. Raise the bed to a safe level, and lower the head of the bed. Make sure the client is still covered. Lower the side rail (if present) on the near/working side.
17. Remove the bedpan carefully and cover it with a towel.
18. Give perineal care if help is needed (see procedure earlier in the chapter). Wipe from front to back. Dry the perineal area with a towel. Remove bed protector and place it in the plastic bag. Help the client put on undergarment. Cover the client and remove the cotton blanket.
19. Place the toilet paper and disposable wipes in the plastic bag and discard the bag. Place the cotton blanket and towel in a hamper.
20. If you raised an adjustable bed, return it to its lowest position. Leave side rails in ordered position.
21. Take the bedpan to the bathroom. Note color, odor, and consistency of contents. Empty the contents carefully into the toilet unless a specimen is needed or urine is being measured for intake/output monitoring (Chapter 14). If you notice anything unusual about the stool or urine (for example, the presence of blood), do not discard it. You will need to notify your supervisor.
22. Turn the faucet on with a paper towel. Rinse the bedpan with cold water first and empty it into the toilet. Flush the toilet. Then clean the bedpan with hot, soapy water and store.
23. Remove and discard your gloves.
24. Wash your hands.
25. Document the time of the elimination, the contents, and any observations.

Assisting a male client with a urinal

Equipment: urinal, disposable bed protector, disposable wipes, plastic bag, 2 pairs of gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client by closing doors and shades and keeping client covered.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed has rails, raise the far rail for safety. If the bed is movable, lock the bed wheels.

5. Put on gloves.
6. Warm the outside of the urinal with warm water in the bathroom.
7. Place the bed protector under the client's buttocks and hips, as in earlier procedure.
8. Hand the urinal to the client. If the client is not able to do this himself, place the urinal between his legs and position the penis inside the urinal (Fig. 13-42). Replace covers.

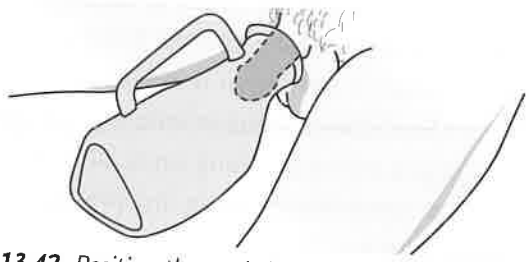

Fig. 13-42. *Position the penis inside the urinal if the client cannot do it himself.*

9. Remove and discard your gloves. Wash your hands.
10. Raise the head of the bed. If the bed has rails, leave them both up. Return the bed to its lowest position. Place disposable wipes and a bell or other way to call you within the client's reach. Ask the client to clean his hands with a wipe when finished if he is able. Tell him you will return when called. Leave the room and close the door.
11. When called by the client, return and wash your hands. Put on clean gloves.
12. Raise the bed to a safe level. Lower the side rail (if present) on the near/working side. Remove bed protector and place it in the plastic bag. Put the disposable wipes in the plastic bag and discard the bag.
13. Remove the urinal or have him hand it to you. Take the urinal to the bathroom. Note color, odor, and qualities (for example, cloudiness) of contents before flushing. Empty contents into toilet unless a specimen is needed or urine is being measured for intake/output monitoring (Chapter 14).
14. Turn the faucet on with a paper towel. Rinse the urinal with cold water and empty it into the toilet. Flush the toilet. Store the urinal.
15. Remove and discard your gloves.
16. Wash your hands.
17. Return the bed to its lowest position. Leave side rails in ordered position.
18. Document the time, the amount of urine (if monitoring intake and output), and any other observations.

Some clients are able to get out of bed but may still need help walking to the bathroom and using the toilet. Others who are able to get out of bed but cannot walk to the bathroom may use a portable commode (also called a *bedside commode* [*BSC*]). A **portable commode** is a chair with a toilet seat and a removable container underneath (Fig. 13-43). The removable container must be cleaned after each use. Toilets can be fitted with raised seats to make it easier for clients to get up and down.

Fig. 13-43. *The top photo shows a regular portable commode. The bottom photo shows a bariatric portable commode (used for people who are overweight or obese).* (PHOTOS COURTESY OF NOVA MEDICAL PRODUCTS, WWW.NOVAJOY.COM)

Handrails can also be installed next to the toilet (Fig. 13-44). The HHA should report if these assistive devices are needed but are not present. The HHA should offer to help clients get to the bathroom or commode regularly. This can avoid accidents and embarrassment.

Fig. 13-44. *Handrails can be installed next to toilets to promote safety. The HHA should report if these assistive devices are needed.*

Helping a client use a portable commode or toilet

Equipment: portable commode with basin, toilet paper, disposable wipes, towel, supplies for perineal care, plastic bag, 3 pairs of gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client by closing doors and shades and using a bath blanket.
4. Lock the commode wheels. If the bed is movable, adjust the bed to its lowest position. Lock the bed wheels. Make sure client is wearing nonskid shoes and that the laces are tied. Help the client out of bed and to the portable commode or bathroom.
5. Put on gloves.
6. If needed, help the client remove clothing and sit comfortably on the toilet seat. Put toilet paper and wipes within reach. Ask the client to clean his hands with a wipe when finished if he is able.
7. Remove and discard your gloves. Wash your hands.
8. Provide privacy. Give the client a bell or another way to call you. Leave the room and close the door, but do not lock it. Do not go too far away in case you are needed soon.
9. When called by the client, return and wash your hands. Put on clean gloves. Provide perineal care if help is needed. Remember to wipe from front to back. Dry the perineal area with a towel. Help the client put on undergarment. Put disposable wipes in a plastic bag and discard the bag. Place the towel in a hamper.
10. Remove and discard your gloves. Wash your hands.
11. Help the client back to bed.
12. Put on clean gloves.
13. When using a portable commode, remove waste container. Note color, odor, and consistency of contents. Empty it into the toilet unless a specimen is needed or the client's urine is being measured for intake/output monitoring (Chapter 14).
14. Turn the faucet on with a paper towel. Rinse the container with cold water first and empty it into the toilet. Flush the toilet. Then clean the container with hot, soapy water and put it back in its place.
15. Remove gloves and discard.
16. Wash your hands.
17. Document the procedure and any observations.

7. Describe how to dispose of body wastes

Urine and feces are considered infectious wastes. Home health aides must always wear

gloves when handling bedpans, urinals, or basins that contain wastes, including dirty bath water. HHAs should be careful not to spill or splash wastes, and wastes should be discarded in the toilet. Containers used for elimination should cleaned and stored immediately after use. Then the HHA should remove and discard her gloves and wash her hands. A clean pair of gloves should be donned if she is not finished with client care.

Washcloths used to wash perineal areas must be washed in hot water. Washing them separately is safest. The HHA should always wear gloves when handling these washcloths. Disposable wipes may or may not be flushable; the instructions on the package should include this information. If they are not flushable, they should be disposed in a waste container lined with a plastic bag. To prevent odors, the HHA should remove and replace the plastic bag frequently.

Chapter Review

1. List five reasons that a client may need help with personal care.
2. Give two examples of how to promote dignity and independence while giving personal care.
3. What are five observations about a client that an HHA can make during personal care?
4. Why is it unnecessary for older clients to have a complete bath or shower every day?
5. Why should clients, as well as HHAs, test the water temperature before bathing?
6. Why should an HHA wipe from front to back when giving perineal care?
7. Explain why HHAs must be especially careful while giving nail care to clients who have diabetes.
8. Why should an HHA wear gloves while shaving clients?
9. If a client has an affected side due to a stroke or an injury, how should the HHA refer to that side?
10. When dressing a client with a weak side, which arm is usually placed through the sleeve first—the weaker or stronger arm?
11. What does oral care consist of?
12. How can HHAs help prevent aspiration during oral care of unconscious clients?
13. Why should hot water not be used on dentures?
14. What is a prosthesis?
15. Why is it important to care for prostheses carefully?
16. In general, how should a hearing aid be cleaned?
17. Why should alcohol not be used on artificial eyes?
18. How should a standard bedpan be positioned? How should a fracture pan be positioned?
19. Where should body wastes, such as urine and feces, be discarded?

14 Core Healthcare Skills

1. Explain the importance of monitoring vital signs

Home health aides monitor, document, and report clients' **vital signs**. Vital signs are important. They show how well the vital organs of the body, such as the heart and lungs, are working. They consist of the following:

- Measuring the body temperature
- Counting the pulse rate
- Counting the rate of respirations
- Measuring the blood pressure

Watching for changes in vital signs is very important. Changes can indicate a client's condition is worsening. An HHA should always notify the supervisor in these situations:

- The client has a fever (temperature is above average for the client or outside the normal range)
- The client has a respiratory or pulse rate that is too rapid or too slow
- The client's blood pressure changes
- The client's pain is worse or is not relieved by pain management

Ranges for Adult Vital Signs

Temp. Site	Fahrenheit	Celsius
Mouth (oral)	97.6°–99.6°	36.4°–37.6°
Rectum (rectal)	98.6°–100.6°	37.0°–38.1°
Armpit (axillary)	96.6°–98.6°	35.9°–37.0°
Ear (tympanic)	96.6°–99.7°	35.9°–37.6°
Temporal Artery (forehead)	97.2°–100.1°	36.2°–37.8°

Normal Pulse Rate: 60–100 beats per minute
Normal Respiratory Rate: 12–20 respirations per minute

Blood Pressure		
Normal	Systolic Diastolic	90–119 mm Hg *and* 60–79 mm Hg
Low (hypotensive)	Systolic Diastolic	Below 90 mm Hg *or* Below 60 mm Hg
Elevated	Systolic Diastolic	120–129 mm Hg *and* Less than 80 mm Hg
Stage 1 hypertension	Systolic Diastolic	130–139 mm Hg *or* 80–89 mm Hg
Stage 2 hypertension	Systolic Diastolic	At or over 140 mm Hg *or* At or over 90 mm Hg
Hypertensive crisis	Systolic Diastolic	Over 180 mm Hg *and/or* Over 120 mm Hg

Temperature

Body temperature is normally very close to 98.6°F (Fahrenheit) or 37°C (Celsius). Body temperature reflects a balance between the heat created by the body and the heat lost to the environment. Many factors affect body temperature: age, illness, stress, environment, exercise, and the circadian rhythm can all cause changes in body temperature. The **circadian rhythm** is the 24-hour day-night cycle. Average temperature readings change throughout the day. People tend to have lower temperatures in the morning.

Increases in body temperature may indicate an infection or disease.

There are different sites for measuring the body's temperature: the mouth (oral), the rectum (rectal), the armpit (axillary), the ear (tympanic), and the temporal artery (the artery just under the skin of the forehead). The different sites require different thermometers. Common types of thermometers include the following:

- Digital
- Electronic
- Tympanic
- Temporal artery
- Mercury-free

A digital thermometer can be used to measure an oral, rectal, or axillary temperature. This thermometer displays the results digitally in 2 to 60 seconds (Fig. 14-1). The thermometer will beep or flash when the temperature has registered. A digital thermometer is battery-operated and requires battery replacement periodically. This thermometer may require a disposable plastic sheath to cover the probe to help prevent infection. The sheath is used once and is then discarded.

Fig. 14-1. *A digital thermometer.*

An electronic thermometer can be used to measure an oral, rectal, or axillary temperature (Fig. 14-2). This thermometer registers the temperature digitally in 2 to 60 seconds. The thermometer flashes or makes a sound when the temperature is displayed. An electronic thermometer is battery operated and is stored in a wall unit for recharging when it is not in use. A probe cover is applied before use and is only used once before being discarded.

Fig. 14-2. *An electronic thermometer.* (PHOTO COURTESY OF WELCH ALLYN, WWW.WELCHALLYN.COM, 800-535-6663)

A tympanic thermometer is used to measure the temperature reading in the ear (Fig. 14-3). This thermometer registers the temperature in seconds. However, this thermometer may require more practice to be able to use it accurately.

Fig. 14-3. *A tympanic thermometer.*

A temporal artery thermometer determines the temperature reading by measuring the heat from the skin over the temporal artery, the artery under the skin of the forehead. This is done by a gentle stroke or scan across the forehead, and the reading is registered in about three seconds (Fig. 14-4). A temporal artery thermometer is noninvasive, which means that it does not need to be inserted into the body.

Fig. 14-4. *A temporal artery thermometer.* (PHOTO COURTESY OF EXERGEN CORPORATION, WWW.EXERGEN.COM, 800-422-3006)

A mercury-free thermometer can be used to measure an oral, rectal, or axillary temperature. Thermometers are usually color-coded to distinguish between an oral thermometer and a rectal thermometer. Oral thermometers are usually green or blue. Rectal thermometers are usually red (Fig. 14-5).

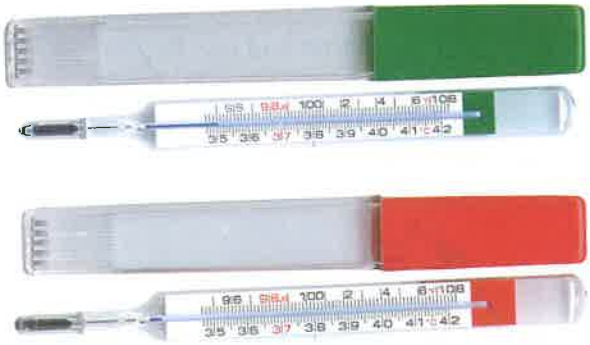

Fig. 14-5. *A mercury-free oral thermometer and a mercury-free rectal thermometer. Oral thermometers are usually green or blue; rectal thermometers are usually red.*
(PHOTOS COURTESY OF RG MEDICAL DIAGNOSTICS OF WIXOM, MI, RGMD.COM)

Numbers on the thermometer allow the temperature to be read after it registers. Most thermometers show the temperature in degrees Fahrenheit (F). Each long line represents one degree and each short line represents two-tenths of a degree. Some thermometers show the temperature in degrees Celsius (C), with the long lines representing one degree and the short lines representing one-tenth of a degree. Small arrows or highlighted numbers show the normal temperature: 98.6°F and 37°C (Fig. 14-6).

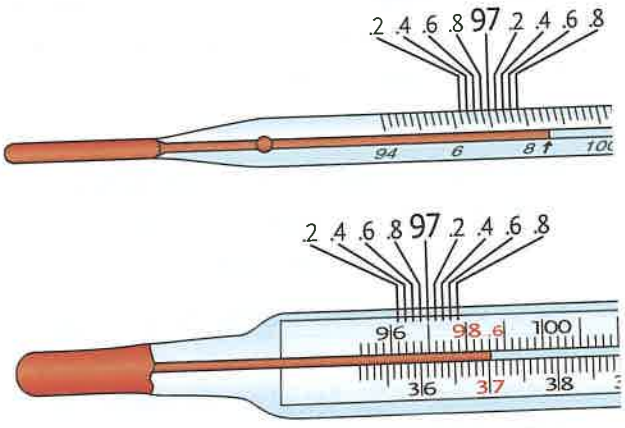

Fig. 14-6. *This shows a normal temperature reading: 98.6°F and 37°C.*

Environmentally Friendly Care

Mercury Glass Thermometers

Using mercury glass or glass bulb thermometers to measure oral, rectal, or axillary temperatures is no longer common because mercury is a dangerous, toxic substance. Many states have passed laws banning the sale of mercury thermometers.

Mercury glass thermometers may still be used in the home, however, so it is beneficial to know a little bit about them. Mercury glass thermometers have a stem and a bulb. The stem has a column for the mercury to go up and down; the bulb stores the mercury. The bulb is available in either a long, slim shape or a blunt, rounded shape. Mercury is silver in color. If a thermometer's bulb is any color other than silver, it is not a mercury thermometer.

It is very important that a thermometer that has the long, slim bulb never be used to take a rectal or axillary temperature. This is because the slender bulb could break in the client's rectum or armpit, causing injuries and exposing the client to mercury. Thermometers with long, slim bulbs should only be used to take oral temperatures.

Thermometers with blunt, rounded bulbs can be used to take rectal and axillary temperatures. The blunt bulbs can also be used for oral temperatures. However, a thermometer with a blunt bulb that has been used to take a rectal temperature should never be used to take an oral temperature.

To clean a mercury glass thermometer, the HHA can wipe it with alcohol wipes from clean to dirty (stem to bulb). Hot water should never be used on a mercury thermometer, because hot water can heat the mercury and break the thermometer.

If a mercury glass thermometer must be used, the HHA should use it carefully. If the thermometer breaks, the HHA must never touch the mercury or broken glass. There are specific procedures that must be followed to dispose of mercury safely. The HHA should know her agency's policies and procedures regarding the safe disposal of mercury. If a client still uses a mercury glass thermometer, the HHA should check with the supervisor about replacing it.

There is a range of normal temperatures. Some people's temperatures normally run low. Others in good health will run slightly higher temperatures. Normal temperature readings also vary according to the method used to take the temperature. A rectal temperature is considered to be the most accurate. However, measuring a rectal temperature on an uncooperative person,

such as a client with dementia, can be dangerous. An axillary temperature is considered the least accurate.

A home health aide should not measure an oral temperature on a person who:

- Is unconscious
- Has recently had facial or oral surgery
- Is younger than 5 years old
- Is confused or disoriented
- Is heavily sedated
- Is likely to have a seizure
- Is coughing
- Is using oxygen
- Has facial paralysis
- Has a nasogastric tube (a feeding tube that is inserted through the nose and goes into the stomach)
- Has sores, redness, swelling, or pain in the mouth
- Has an injury to the face or neck

Measuring and recording an oral temperature

Equipment: clean digital, electronic, or mercury-free thermometer, gloves, disposable sheath/cover for thermometer, tissues, pen and paper

Do not take an oral temperature if the client has smoked, eaten food or drunk fluids, chewed gum, or exercised in the last 10 to 20 minutes.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. **Digital thermometer**: Put on the disposable sheath. Turn on the thermometer and wait until the ready sign appears.

   Electronic thermometer: Remove the probe from the base unit. Put on the probe cover.

   Mercury-free thermometer: Hold the thermometer by the stem. Before inserting it in the client's mouth, shake the thermometer down to below the lowest number (at least below 96°F or 35°C). To shake the thermometer down, hold it at the end opposite the bulb with the thumb and two fingers. With a snapping motion of the wrist, shake the thermometer (Fig. 14-7). Stand away from furniture and walls while doing so.

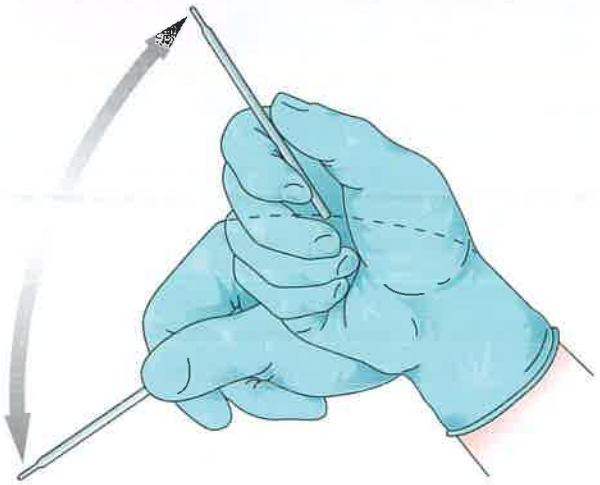

Fig. 14-7. Shake thermometer down to below the lowest number before inserting it into a client's mouth.

6. **Digital thermometer**: Insert the end of the thermometer into the client's mouth, under the tongue and to one side.

   Electronic thermometer: Insert the end of the thermometer into the client's mouth, under the tongue and to one side.

   Mercury-free thermometer: Put on a disposable sheath if available. Insert the bulb end of the thermometer into the client's mouth, under the tongue and to one side.
7. **For all thermometers**: Tell the client to hold the thermometer in her mouth with her lips closed (Fig. 14-8). Assist as necessary. The client should breathe through her nose. Ask the client not to bite down or talk.

Fig. 14-8. While the thermometer is in the client's mouth, she should keep her lips closed.

Digital thermometer: Hold in place until the thermometer blinks or beeps.

Electronic thermometer: Hold in place until you hear a tone or see a flashing or steady light.

Mercury-free thermometer: Hold in place for at least three minutes.

8. **Digital thermometer**: Remove the thermometer. Read the temperature on the display screen. Remember the temperature reading.

   Electronic thermometer: Read the temperature on the display screen. Remember the temperature reading. Remove the probe.

   Mercury-free thermometer: Remove the thermometer. Wipe it with a tissue from stem to bulb or remove the sheath. Discard the tissue or sheath. Hold the thermometer at eye level. Rotate until the line appears, rolling the thermometer between your thumb and forefinger. Read the temperature. Remember the temperature reading.

9. **Digital thermometer**: Using a tissue, remove and discard the sheath. Replace the thermometer in the case.

   Electronic thermometer: Press the eject button to discard the cover. Return the probe to the holder.

   Mercury-free thermometer: Clean the thermometer according to policy. Rinse with clean water and dry. Return it to the case.

10. Remove and discard your gloves.
11. Wash your hands.
12. Immediately record the temperature, date, time, and method used (oral).

Rectal temperatures may be necessary for clients who are unconscious, have missing teeth or dentures that do not fit properly, or have difficulty breathing through the nose. Rectal thermometers should be lubricated and inserted 1/2 to 1 inch for adults. The home health aide must always explain what she will do before starting this procedure. The HHA needs the client's cooperation to take a rectal temperature. She should ask the client to hold still and reassure him that the procedure will only take a few minutes. It is important to hold onto the thermometer at all times while the thermometer is in the rectum.

Measuring and recording a rectal temperature

Equipment: clean digital, electronic, or mercury-free rectal thermometer, lubricant, gloves, tissue, disposable sheath/cover, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible. Remind the client that the procedure will take only a few minutes.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe working level, usually waist high. If the bed is movable, lock the bed wheels.
5. Assist the client to a left-lying (Sims') position (Fig. 14-9). An infant can be placed on

his back or stomach for measuring rectal temperature.

Fig. 14-9. *The client must be in the left-lying (Sims') position.*

6. Fold back the linens to expose only the rectal area.
7. Put on gloves.
8. **Digital thermometer**: Put on the disposable sheath. Turn on the thermometer and wait until the ready sign appears.

   Electronic thermometer: Remove the probe from the base unit. Put on the probe cover.

   Mercury-free thermometer: Hold the thermometer by the stem. Shake the thermometer down to below the lowest number. Put on the disposable sheath.
9. Apply a small amount of lubricant to tip of the bulb or probe cover.
10. Separate the buttocks. Gently insert thermometer into rectum 1/2 to 1 inch. Stop if you meet resistance. Do not force the thermometer into the rectum (Fig. 14-10).

Fig. 14-10. *Gently insert a lubricated rectal thermometer 1/2 to 1 inch into the rectum. Do not force it into the rectum.*

11. Replace the sheet over the buttocks while holding on to the thermometer at all times.
12. **Digital thermometer**: Hold in place until the thermometer blinks or beeps.

    Electronic thermometer: Hold in place until you hear a tone or see a flashing or steady light.

    Mercury-free thermometer: Hold in place for at least three minutes.
13. Gently remove the thermometer. Wipe it with a tissue from stem to bulb or remove the sheath. Discard the tissue or sheath.
14. Read the thermometer at eye level as you would for an oral temperature. Remember the temperature reading.
15. **Digital thermometer**: Clean the thermometer according to policy and replace it in the case.

    Electronic thermometer: Press the eject button to discard the cover. Return the probe to the holder.

    Mercury-free thermometer: Clean the thermometer according to policy. Rinse with clean water and dry. Return it to the case.
16. Remove and discard your gloves.
17. Wash your hands.
18. Assist the client to a safe and comfortable position. If you raised an adjustable bed, return it to its lowest position.
19. Immediately record the temperature, date, time, and method used (rectal).

Tympanic thermometers can be used to take a fast temperature reading. The HHA should tell the client that she will be taking his temperature by placing a thermometer in the ear canal. She should reassure the client that the procedure is painless. The short tip of the thermometer will only go into the ear 1/4 to 1/2 inch.

Measuring and recording a tympanic temperature

Equipment: tympanic thermometer, gloves, disposable probe sheath/cover (if used), pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Put a disposable sheath over the earpiece of the thermometer.
6. Position the client's head so that the ear is in front of you. Straighten the ear canal by gently pulling up and back on the outside edge of the ear for an adult (Fig. 14-11). Pull straight back for infants and children. Insert the covered probe into the ear canal and press the button.

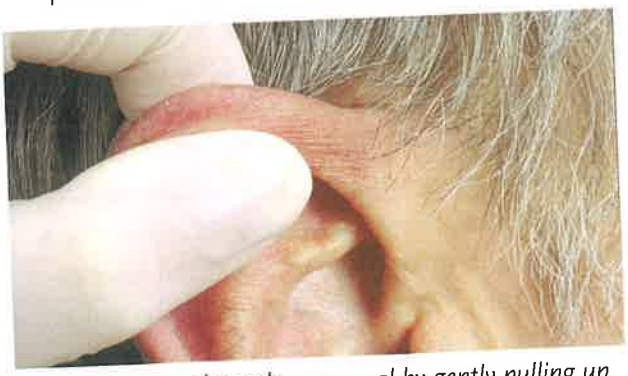

Fig. 14-11. *Straighten the ear canal by gently pulling up and back on the outside edge of the ear.*

7. Hold the thermometer in place until the thermometer blinks or beeps.
8. Read temperature. Remember the temperature reading.
9. Discard the sheath. Return the thermometer to storage or to the battery charger if thermometer is rechargeable.
10. Remove and discard your gloves.
11. Wash your hands.
12. Immediately record the temperature, date, time, and method used (tympanic).

Axillary temperatures are not as accurate as temperatures measured at other sites. However, they can be safer if a client is confused, disoriented, uncooperative, or has dementia. The axillary area must be clean and dry before measuring the temperature.

Measuring and recording an axillary temperature

Equipment: clean digital, electronic, or mercury-free thermometer, gloves, tissues, disposable sheath/cover, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe working level, usually waist high. If the bed is movable, lock the bed wheels.
5. Put on gloves.
6. Remove the client's arm from the sleeve of the gown or top to allow skin contact with the end of the thermometer. Wipe the axillary area with tissues before placing the thermometer.
7. **Digital thermometer**: Put on the disposable sheath. Turn on the thermometer and wait until the ready sign appears.

   Electronic thermometer: Remove the probe from the base unit. Put on the probe cover.

   Mercury-free thermometer: Hold the thermometer by the stem. Shake the thermometer down to below the lowest number. Put on the disposable sheath.

8. Position the thermometer (bulb end for mercury-free) in the center of the armpit. Fold the client's arm over his chest.

9. **Digital thermometer**: Hold in place until the thermometer blinks or beeps.

   Electronic thermometer: Hold in place until you hear a tone or see a flashing or steady light.

   Mercury-free thermometer: Hold in place, with the arm close against the side, for 8 to 10 minutes (Fig. 14-12).

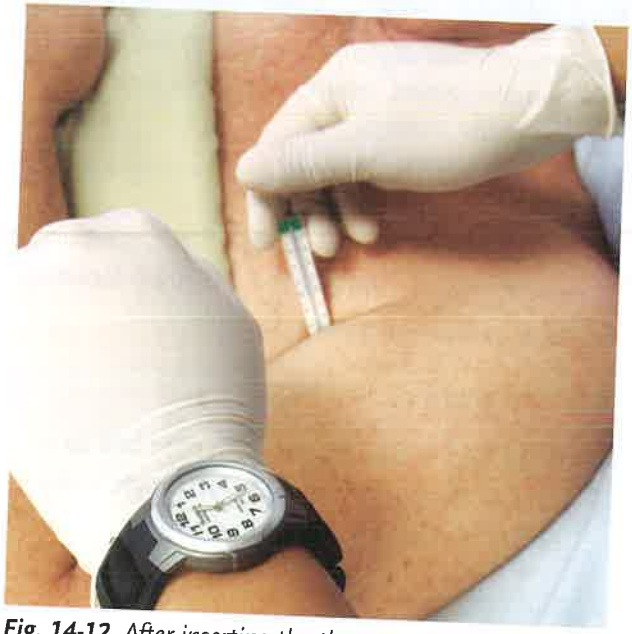

Fig. 14-12. *After inserting the thermometer, fold the client's arm over his chest and hold it in place for 8 to 10 minutes.*

10. **Digital thermometer**: Remove the thermometer. Read the temperature on the display screen. Remember the temperature reading.

    Electronic thermometer: Read the temperature on the display screen. Remember the temperature reading. Remove the probe.

    Mercury-free thermometer: Remove the thermometer. Wipe it with a tissue from stem to bulb or remove the sheath. Discard the tissue or sheath. Read the thermometer at eye level as you would for an oral temperature. Remember the temperature reading.

11. **Digital thermometer**: Using a tissue, remove and discard the sheath. Replace the thermometer in the case.

    Electronic thermometer: Press the eject button to discard the cover. Return the probe to the holder.

    Mercury-free thermometer: Clean the thermometer according to policy. Rinse with clean water and dry. Return it to the case.

12. If you raised an adjustable bed, return it to its lowest position.

13. Remove and discard your gloves.

14. Wash your hands.

15. Immediately record the temperature, date, time, and method used (axillary).

Pulse

The pulse is the number of heartbeats per minute. The beat that is felt at certain pulse points in the body represents the wave of blood moving through an artery as a result of the heart pumping. The most common site for monitoring the pulse rate is on the inside of the wrist, where the radial artery runs just beneath the skin. This is called the **radial pulse**. The procedure for counting this pulse rate is located later in this chapter. The **brachial pulse** is the pulse inside the elbow, about 1 to 1 1/2 inches above the elbow. The radial and brachial pulses are involved in measuring blood pressure, which is explained later in this chapter. Common pulse sites are shown in Figure 14-13.

For adults, the normal pulse rate is 60 to 100 beats per minute. Small children have more rapid pulses, in the range of 100 to 120 beats per minute. A newborn baby's pulse may be as high as 120 to 140 beats per minute. Many things can affect pulse rate, including exercise, fear, anger, anxiety, heat, infection, illness, medications, and pain. A high or low rate does not necessarily indicate disease. However, sometimes the pulse

rate can signal that illness exists. For example, a rapid pulse may result from fever, infection, or heart failure. A slow or weak pulse may indicate infection.

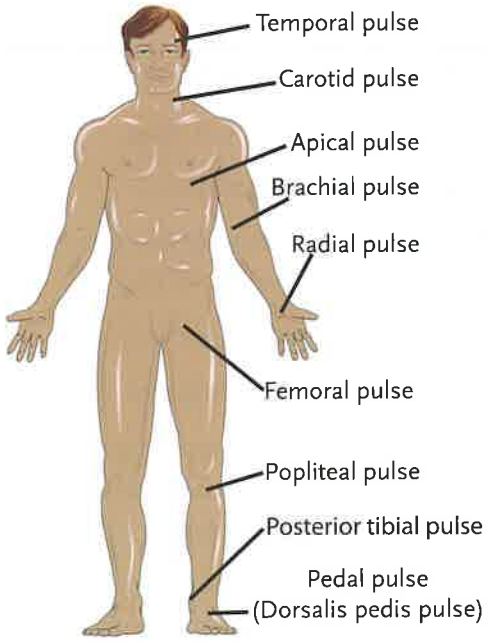

Fig. 14-13. *Common pulse sites.*

The **apical** (*AY-pi-kul*) **pulse** is heard by listening directly over the heart with a stethoscope. A **stethoscope** is an instrument designed to listen to sounds within the body, such as the heart beating or air moving through the lungs (Fig. 14-14). This is often the easiest method for measuring the pulse in infants and small children because their pulse points are harder to find.

Fig. 14-14. *The diaphragm (the larger side) of the stethoscope is used to hear a pulse and to measure blood pressure.*

The apical pulse is on the left side of the chest, just below the nipple. For adult clients, the apical pulse may be checked when the person has heart disease or takes medication that affects the heart. It may also be taken on clients who have a weak radial pulse or an irregular pulse.

Counting and recording apical pulse

Equipment: stethoscope, watch with second hand, alcohol wipes, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Before using the stethoscope, wipe the diaphragm and earpieces with alcohol wipes.
5. Fit the earpieces of the stethoscope snugly in your ears. Place the flat metal diaphragm on the left side of the chest, just below the nipple. Listen for the heartbeat.
6. Use the second hand of your watch. Count the heartbeats for one full minute (Fig. 14-15). Each "lub-dub" you hear is counted as one beat. A normal heartbeat is rhythmical. Leave the stethoscope in place while counting respirations.

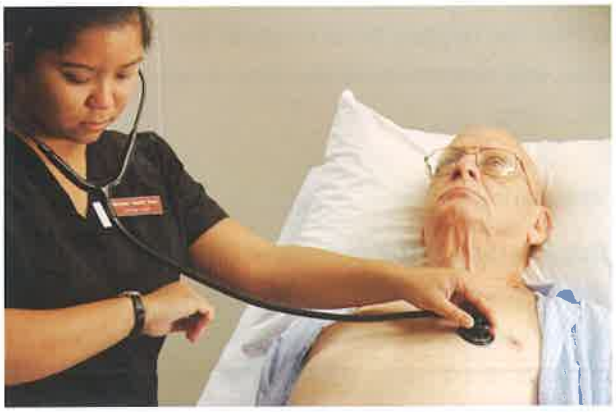

Fig. 14-15. *Count the heartbeats for one full minute to measure the apical pulse.*

7. Wash your hands.

8. Immediately record the pulse rate, date, time, and method used (apical). Note any irregularities in the rhythm.
9. Clean the earpieces and diaphragm of the stethoscope with alcohol wipes. Store the stethoscope.
10. Wash your hands.

In addition to other vital sign measurements, some HHAs may be asked to obtain a pulse oximeter reading. A pulse oximeter is a device that uses a light to determine the amount of oxygen in the blood. A pulse oximeter also measures a person's pulse rate (Fig. 14-16).

Fig. 14-16. *A pulse oximeter sensor is usually clipped on a person's finger to measure the amount of oxygen in the blood, as well as pulse rate.*

A pulse oximeter may be used when clients have had surgery, are on oxygen, are in intensive care, or have cardiac or respiratory problems. When asked to obtain this reading, the HHA should report the oxygen percentage to her supervisor, who will determine if the level is adequate for the client.

Respirations

Respiration is the process of inhaling air into the lungs, or **inspiration**, and exhaling air out of the lungs, or **expiration**. Each respiration consists of an inspiration and an expiration. The chest rises during inspiration and falls during expiration.

The normal respiration rate for adults ranges from 12 to 20 breaths per minute. Infants and children have a faster respiratory rate. Infants normally breathe at a rate of 30 to 40 respirations per minute.

Different types of respirations include the following:

- **Apnea**: the absence of breathing
- **Dyspnea**: difficulty breathing
- **Eupnea**: normal respirations
- **Orthopnea**: shortness of breath when lying down that is relieved by sitting up
- **Tachypnea**: rapid respirations
- **Bradypnea**: slow respirations
- **Cheyne-Stokes**: alternating periods of slow, irregular respirations and rapid, shallow respirations, along with periods of apnea

The respiratory rate is usually counted directly after counting the pulse rate because people tend to breathe more quickly if they know they are being observed. The home health aide should keep his fingers on the client's wrist or on the stethoscope over the heart. He should not make it obvious that he is observing the client's breathing and should not mention that he is counting respirations. If it is difficult to remember the pulse rate after counting the respiratory rate, the HHA can use a pencil and paper to jot down the pulse rate before counting respirations. Once the respiratory rate has been obtained, both the pulse and respiration rates should be documented on the visit notes.

Counting and recording radial pulse and counting and recording respirations ▶

Equipment: watch with a second hand, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.

4. Place the fingertips of your index finger and middle finger on the thumb side of the client's wrist to locate the radial pulse (Fig. 14-17). Do not use your thumb.

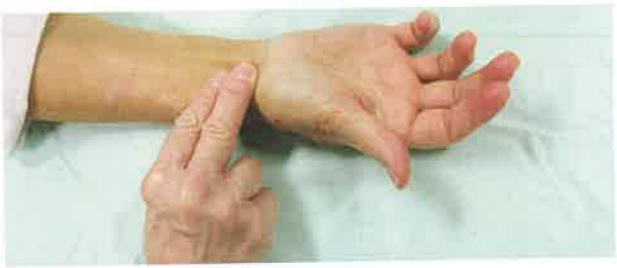

Fig. 14-17. *Count the radial pulse by placing the fingertips of your index finger and middle finger on the thumb side of the client's wrist.*

5. Count the beats for one full minute.

6. Keeping your fingertips on the client's wrist, count respirations for one full minute (Fig. 14-18). Observe for the pattern and character of the client's breathing. Normal breathing is smooth and quiet. If you see signs of difficult breathing, shallow breathing, or noisy breathing, such as wheezing, report it to your supervisor.

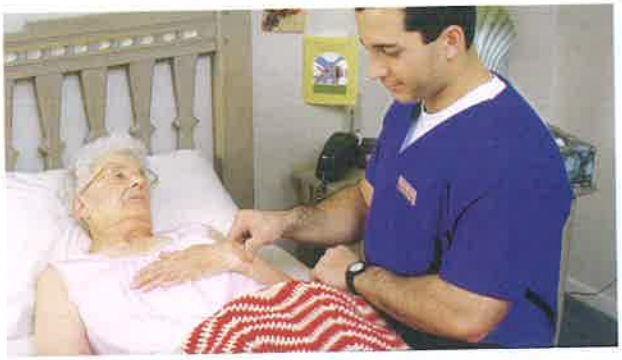

Fig. 14-18. *Count the respiratory rate directly after counting the radial pulse. Do not make it obvious that you are watching her breathing.*

7. Wash your hands.

8. Immediately record the pulse rate, date, time, and method used (radial). Notify your supervisor if the pulse is less than 60 beats per minute, over 100 beats per minute, or if the rhythm is irregular. Record the respiratory rate and the pattern or character of breathing.

Blood Pressure

Blood pressure is an important indicator of a person's health. The measurement shows how well the heart is working. Blood pressure is measured in millimeters of mercury (mm Hg) and is recorded as a fraction—for example, 120/80. There are two parts of blood pressure: the systolic (*sis-TOL-ik*) measurement and the diastolic (*DYE-a-stol-ik*) measurement.

In the **systolic** phase, which is the top number of the blood pressure reading, the heart is at work, contracting and pushing the blood from the left ventricle of the heart. The reading shows the pressure on the walls of the arteries as blood is pumped through the body. The normal range for systolic blood pressure is below 120 mm Hg.

The second measurement reflects the **diastolic** phase, which is the bottom number of the reading. This phase is when the heart relaxes. The diastolic measurement is always lower than the systolic measurement. It shows the pressure in the arteries when the heart is at rest. The normal range for adults is below 80 mm Hg.

When blood pressure is consistently high, it may be categorized as elevated, stage 1 hypertensive, stage 2 hypertensive, or hypertensive crisis. People with high blood pressure (**hypertension**) (*high-per-TEN-shun*) have elevated systolic and/or diastolic blood pressures. The ranges for the different categories of hypertension are listed in the orange box on page 237.

When blood pressure is low (below 90 mm Hg or below 60 mm Hg), it is called **hypotension** (*high-poh-TEN-shun*). A loss of blood or slowed blood flow can cause hypotension, which can be life-threatening if it is not corrected.

Blood pressure is affected by many factors, including aging, exercise, stress, pain, medications, illness, obesity, alcohol intake, tobacco products, and the volume of blood in circulation.

Blood pressure is measured with either a manual or electronic **sphygmomanometer**

(*sfig-moh-ma-NOM-e-ter*). An aneroid sphygmomanometer is a type of manual sphygmomanometer (Fig. 14-19). This sphygmomanometer consists of a cuff, a bulb, and a pressure gauge. Inside the cuff is an inflatable balloon that expands when air is pumped into the cuff. Two pieces of tubing are connected to the cuff. One leads to a rubber bulb that pumps air into the cuff. A pressure control button allows a person to control the release of air from the cuff after it is inflated. The other piece of tubing is connected to a pressure gauge with numbers that shows the blood pressure. Manual sphygmomanometers require the use of a stethoscope to determine the blood pressure reading.

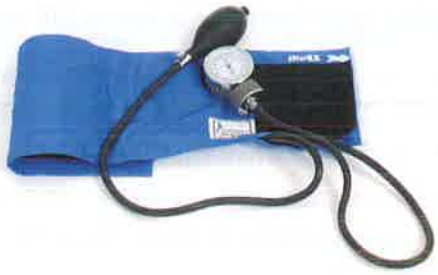

Fig. 14-19. *A type of aneroid sphygmomanometer.*

With an electronic sphygmomanometer, the systolic and diastolic pressure readings are displayed digitally. In addition to blood pressure, an electronic sphygmomanometer may also measure other vital signs, such as pulse, respiratory rate, and temperature, as well as checking blood oxygen levels (Fig. 14-20). The cuff usually inflates and deflates automatically, and the use of a stethoscope is not required with electronic sphygmomanometers.

When measuring blood pressure, the first sound heard is the systolic pressure (top number). When the sound changes to a soft muffled thump or disappears, this is the diastolic pressure (bottom number).

Blood pressure should not be measured on an arm that has an IV, a dialysis shunt, or any medical equipment. A side that has a cast, recent trauma, paralysis from a stroke, burn(s), or breast surgery (mastectomy) should be avoided.

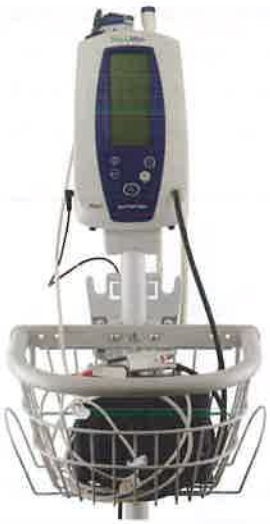

Fig. 14-20. *This type of electronic sphygmomanometer measures blood pressure, as well as other vital signs.*

It is important to use a cuff that is the correct size when measuring blood pressure. Available cuff sizes for adults include small adult, adult, large adult, and thigh. There are also sizes available for infants and children.

Measuring and recording blood pressure manually ▶

Equipment: sphygmomanometer, stethoscope, alcohol wipes, pen and paper

Do not check blood pressure if the client has smoked, eaten food, drunk alcohol or fluids containing caffeine, or exercised in the last 30 minutes.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Before using the stethoscope, wipe the diaphragm and earpieces with alcohol wipes.
5. Ask the client to roll up his sleeve so that his upper arm is exposed. Do not measure blood pressure over clothing.
6. Position the client's arm with his palm up. The arm should be level with the heart.

7. With the valve open, squeeze the cuff to make sure it is completely deflated.
8. Place the blood pressure cuff snugly on the client's upper arm. The center of the cuff with sensor/arrow is placed over the brachial artery (1–1½ inches above the elbow, toward the inside of the elbow) (Fig. 14-21).

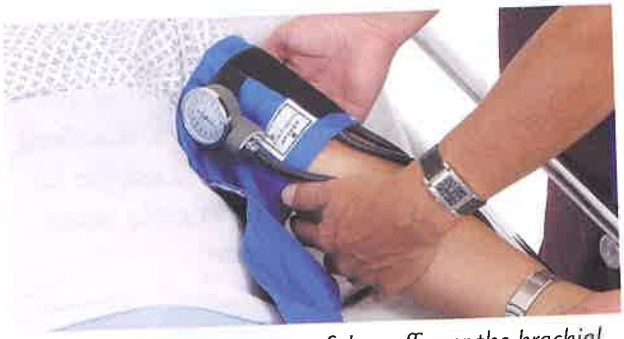

Fig. 14-21. *Place the center of the cuff over the brachial artery.*

9. Ask the client to remain still and quiet during the measurement.
10. Locate the brachial pulse with your fingertips.
11. Place the earpieces of the stethoscope in your ears.
12. Place the diaphragm of the stethoscope over the brachial artery.
13. Close the valve (clockwise) until it stops. Do not overtighten it (Fig. 14-22).

Fig. 14-22. *Close the valve by turning it clockwise until it stops. Do not overtighten it.*

14. Inflate the cuff to between 160 mm Hg and 180 mm Hg. If a beat is heard immediately upon cuff deflation, completely deflate the cuff. Reinflate the cuff to no more than 200 mm Hg.
15. Open the valve slightly with your thumb and index finger. Deflate the cuff slowly.
16. Watch the gauge and listen for the sound of the pulse.
17. Remember the reading at which the first pulse sound is heard. This is the systolic pressure.
18. Continue listening for a change or muffling of pulse sound. The point of a change or the point at which the sound disappears is the diastolic pressure. Remember this reading.
19. Open the valve to deflate the cuff completely. Remove the cuff.
20. Wash your hands.
21. Immediately record both the systolic and diastolic pressures. Record the numbers like a fraction, with the systolic reading on top and the diastolic reading on the bottom (for example: 110/70). Note which arm was used. Use RA for right arm and LA for left arm. (You may need to note the client's position when blood pressure is measured, i.e., lying down, sitting, or standing.)
22. Wipe the diaphragm and earpieces of the stethoscope with alcohol wipes. Store equipment.
23. Wash your hands.

Measuring and recording blood pressure electronically

Equipment: electronic blood pressure machine, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

3. Provide privacy for the client.
4. Ask the client to roll up his sleeve so that his upper arm is exposed. Do not measure blood pressure over clothing.
5. Position the client's arm with his palm up. The arm should be level with the heart.
6. Make sure the cuff is completely deflated. Place the blood pressure cuff snugly on the client's upper arm. The center of the cuff with sensor/arrow is placed over the brachial artery (1–1½ inches above the elbow, toward the inside of the elbow).
7. Ask the client to remain still and quiet during the measurement.
8. Turn on the blood pressure machine and press the start button.
9. When the measurement is complete, the reading will be displayed on the screen and the machine may beep. The cuff should deflate.
10. Remove the cuff.
11. Wash your hands.
12. Immediately record both the systolic and diastolic pressures that are displayed on the screen. Note which arm was used.
13. Store equipment.
14. Wash your hands.

Pain

Although pain is not considered a vital sign, it is very important to monitor and manage. Pain is uncomfortable and it can greatly affect a client's quality of life and ability to perform self-care. It can quickly drain energy and hope. Pain is a subjective experience (something reported by a person) and vital signs are objective measurements (information collected by using the senses). Pain is also a personal experience, which means it is different for each person.

Because home health aides spend the most time with clients, they play a significant role in pain monitoring, management, and prevention. Care plans are made and adjusted based on HHAs' reports.

Pain is not a normal part of aging. Sustained pain may lead to withdrawal, depression, and isolation. HHAs must treat clients' complaints of pain seriously (Fig. 14-23). They should listen to what clients are saying about the way they feel. They should take action to help them. If a client complains of pain, the HHA should ask the following questions and then immediately report the information to the supervisor:

Fig. 14-23. *The home health aide should believe clients when they say they are in pain and take quick action to help them. Being in pain is unpleasant. The HHA should be empathetic and responsive.*

- Where is the pain?
- When did the pain start?
- How long does the pain last? How often does it occur?
- How severe is the pain? To help assess this, the HHA can ask the client to rate the pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain the client can imagine.
- Can you describe the pain? For example, is it a dull, aching, sharp, piercing, or stabbing pain? The HHA should use the client's words when reporting to the supervisor.
- What makes the pain better? What makes the pain worse?

- Do you remember what you were doing when the pain started?

Clients may have concerns about their pain. These concerns may make them hesitant to report their pain. Barriers to managing pain include the following:

- Fear of addiction to pain medication
- Feeling that pain is a normal part of aging
- Worrying about constipation and fatigue from pain medication
- Feeling that caregivers are too busy to deal with their pain
- Feeling that too much pain medication will cause death

HHAs should be patient and caring when helping clients in pain. If clients are worried about the effects of pain medication or have questions about it, the HHA should tell the supervisor. Some people do not feel comfortable saying that they are in pain. A person's culture affects how she responds to pain. In some cultures, there is a belief that it is best not to react to pain, while in other cultures, people are encouraged to express pain freely. Body language or other messages that a client may be in pain are important for the HHA to observe.

Observing and Reporting: Pain

O/R Increased pulse, respirations, blood pressure
O/R Sweating
O/R Nausea
O/R Vomiting
O/R Tightening the jaw
O/R Squeezing eyes shut
O/R Holding or guarding a body part
O/R Clenching fists
O/R Frowning
O/R Grinding teeth
O/R Increased restlessness
O/R Agitation or tension
O/R Change in behavior
O/R Crying
O/R Sighing
O/R Groaning
O/R Breathing heavily
O/R Rocking
O/R Pacing
O/R Repetitive movements
O/R Difficulty moving or walking

Guidelines: Measures to Reduce Pain

G Report complaints of pain or unrelieved pain promptly to your supervisor. Be prepared to report the client's other vital signs when calling your supervisor.
G Gently position the body in proper alignment. Use pillows for support. Assist in frequent changes of position if the client desires it.
G Give back rubs.
G Ask if the client would like to take a warm bath or shower.
G Assist the client to the bathroom or commode or offer the bedpan or urinal.
G Encourage slow, deep breathing.
G Provide a calm and quiet environment. Use soft music to distract the client.
G If a client is taking pain medication, remind him when it is time to take it (Chapter 15).
G Be patient, caring, gentle, empathetic, and responsive to clients who are in pain.

Weight and Height

Measuring a client's weight and height are part of a home health aide's regular care. Height is checked less frequently than weight. Weight

changes can be signs of illness. They can also affect the medication doses a client needs. For these reasons, the HHA must report any weight loss or gain, no matter how small.

Weight will be measured using pounds or kilograms. A pound is a unit of weight equal to 16 ounces. Kilograms are units of metric measurement. A kilogram is a unit of mass equal to 1000 grams; one kilogram equals 2.2 pounds.

Clients who are unable to get out of bed can be weighed using a chair scale. If this equipment is needed, the agency will provide it. Clients who are ambulatory can be weighed on a bathroom scale or a standing scale. The HHA should keep the following in mind when weighing a client:

- Always explain what she will do before beginning any procedure. She will need the client's cooperation to measure weight properly.
- Provide for privacy, as some people are sensitive about their weight.
- Always weigh at the same time of day, with client wearing the same amount of clothing. Have the client void, or empty her bladder, before she is weighed.
- Scales for home use may differ in accuracy and consistency. To see how accurate a home scale is, she can test it by weighing an object with a known weight. Because scales can differ, using the same scale each time to weigh the client will help identify weight gain or loss that must be reported.

Measuring and recording weight of an ambulatory client

Equipment: bathroom scale or standing scale, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If using a bathroom scale, set the scale on a hard surface (not on carpet) in a place the client can get to easily.
5. Make sure the client is wearing nonskid shoes that are fastened before walking to the scale.
6. Start with the scale balanced at zero before weighing the client (Fig. 14-24).

Fig. 14-24. *The scale must be balanced at zero before beginning to obtain a client's weight. On the top is a digital scale and on the bottom is a standing scale.* (PHOTO COURTESY OF DETECTO, WWW.DETECTO.COM, 800-641-2008)

7. Help the client step onto the center of the scale as needed, facing the scale. Be sure she is not holding, touching, or leaning against anything. This interferes with weight measurement. However, do not force the client to let go if she is holding on to something. If you are unable to obtain a weight, notify your supervisor.
8. Determine the client's weight.

   Using a bathroom scale: Read the weight on the display screen or when the dial has stopped moving.

   Using a standing scale: Balance the scale by making the balance bar level. Move the small and large weight indicators until the bar balances. Read the two numbers shown (on the small and large weight indicators) when the bar is balanced. Add these two numbers together. This is the client's weight (Fig. 14-25).

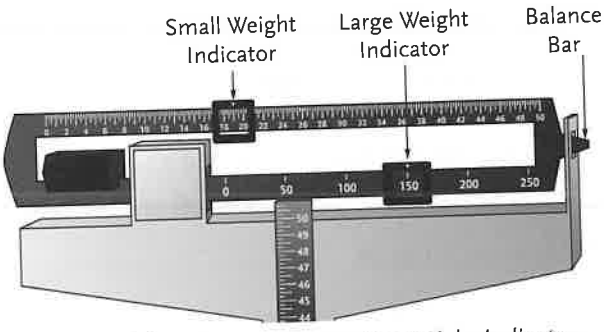

Fig. 14-25. *Move the small and large weight indicators until the bar balances. The weight shown in the illustration is 169 pounds.*

9. Help the client to safely step off the scale before recording weight. Help her back into a comfortable position.
10. Wash your hands.
11. Immediately record the client's weight in pounds (lb) or kilograms (kg), depending on policy. Report any changes in client's weight to your supervisor.
12. Store the scale if it was moved.
13. Wash your hands.

Measuring and recording height of a client

Some clients will be unable to get out of bed. If so, height can be measured using a tape measure (Fig. 14-26).

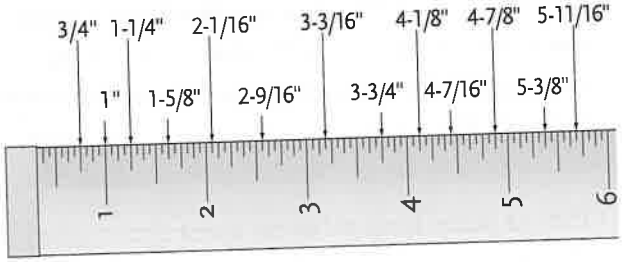

Fig. 14-26. *An illustration of a tape measure with markings.*

Equipment: tape measure, pencil, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Position the client lying straight in bed, flat on his back with his arms and legs at his sides. Be sure the bed sheet is smooth underneath the client.
5. Make a small pencil mark on the sheet at the top of the head.
6. Make another mark at the client's heel.
7. With the tape measure, measure the distance between the marks.
8. Wash your hands.
9. Immediately record the height.
10. Store equipment.
11. Wash your hands.

For clients who can get out of bed, you will measure height while they stand against a wall.

Equipment: tape measure, pencil, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Have the client stand with his back to the wall, with his arms at his sides and without shoes. A hard floor is better than carpet.
5. Make a pencil mark on the wall at the top of the client's head.
6. To determine the client's height, ask the client to step away. Use the tape measure to measure the distance between the pencil mark and the floor.
7. Wash your hands.
8. Immediately record the height.
9. Store equipment.
10. Wash your hands.

For clients who can get out of bed, you can also measure height using a standing scale.

Equipment: standing scale, pen and paper

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Make sure the client is wearing nonskid shoes that are fastened before walking to the scale.
5. Help the client to step onto the scale, facing away from the scale.
6. Ask the client to stand straight if possible. Help as needed.
7. Pull up the measuring rod from back of the scale and gently lower the rod until it rests flat on the client's head (Fig. 14-27).

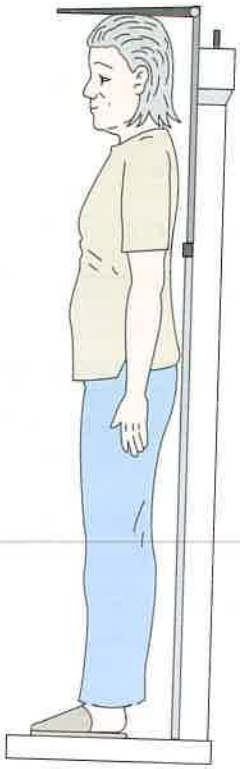

Fig. 14-27. *To determine height on a standing scale, gently lower the measuring rod until it rests flat on the client's head.*

8. Determine the client's height.
9. Assist the client in stepping off the scale before recording height. Make sure that the measuring rod does not hit the client on the head while helping the client off of the scale.
10. Wash your hands.
11. Immediately record the height.

2. List three types of specimens that may be collected from a client

Home health aides may be asked to collect a specimen from a client. A **specimen** is a sample that is used for analysis in order to try to make a diagnosis. Different types of specimens are used for different tests.

There are factors to consider when collecting specimens. Body wastes and elimination needs are very private matters for most people. Having another person handle body wastes may make clients embarrassed and uncomfortable. The HHA should be sensitive to this, and be empathetic. She should think about how difficult this may be for the client. When collecting specimens, it is important that the HHA behave professionally. If she feels that this is an unpleasant task, she should not make it known. She should not make faces or frown or use words that let the client know she is uncomfortable. Remaining professional while collecting specimens can help put clients at ease. A supervisor may have more ideas on how to make clients more comfortable.

Different states have different rules about what home health aides are allowed to do. Each HHA should understand her state's guidelines before performing any procedures.

Sputum Specimens

Sputum (*SPYOO-tum*) is thick mucus coughed up from the lungs. It is not the same as saliva, which comes from the mouth. People with colds

or respiratory illnesses may cough up large amounts of sputum. Sputum specimens may help diagnose respiratory problems or illness, or evaluate the effects of medication.

Early morning is the best time to collect sputum. The client should cough up the sputum and spit it directly into the specimen container. Because sputum may be infectious, the HHA should not let the client cough on him. Standing behind the client during the collection process may prevent sputum from coming into contact with the HHA. Proper personal protective equipment (PPE) must be worn when collecting sputum. The required PPE are gloves and a special mask. It is important that the HHA's hands and the specimen container are clean before beginning this procedure.

The seal must be intact on specimen containers before they are used. This helps avoid specimen contamination. All specimens must be labeled with the client's first and last name, date of birth, address, and the date and time the specimen was collected.

Collecting a sputum specimen

Equipment: specimen container and lid, completed label (labeled with client's name, date of birth, address, date, and time), specimen bag, tissues, gloves, N95 or other required mask as indicated in the care plan

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on the mask and gloves.
5. Stand behind the client if the client can hold the specimen container by himself. Ask the client to cough deeply, so that sputum comes up from the lungs. To prevent the spread of infectious material, give the client tissues to cover his mouth while coughing. Ask the client to spit the sputum into the specimen container.
6. When you have obtained a good sample (about two tablespoons of sputum), cover the container tightly. Wipe any sputum off the outside of the container with tissues. Discard the tissues. Apply the label, place the container in a clean specimen bag (or plastic bag), and seal the bag.
7. Remove and discard your gloves and mask.
8. Wash your hands.
9. Document the procedure.

Stool Specimens

Stool (feces) specimens are collected so that the stool can be tested for blood, pathogens, and other things, such as worms or amoebas. If the client uses a bedpan or portable commode for elimination, that is where the HHA will collect the stool specimen. If the client uses the toilet, a special container (often called a **hat**) will be used. A hat fits into the toilet bowl to collect and measure stool and urine (Fig. 14-28). Hats must be cleaned after each use.

Fig. 14-28. *A "hat" is a container that is placed under the toilet seat to collect a specimen.*

The home health aide should ask the client to let her know when he is ready to have a bowel movement, and she should be ready to collect the specimen. The HHA should explain that urine or toilet paper should not be included in the sample because they can ruin the sample and create the need for a new specimen.

Collecting a stool specimen

Equipment: specimen container and lid, completed label (labeled with client's name, date of birth, address, date, and time), specimen bag, 2 tongue blades, 2 pairs of gloves, bedpan (if client cannot use a portable commode or toilet), hat for toilet (if client uses commode or toilet), plastic bag, toilet paper, disposable wipes, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. When the client is ready to move his bowels, ask him not to urinate at the same time and not to put toilet paper in with the sample. Provide a plastic bag to discard toilet paper separately.
6. Fit the hat to the toilet or commode, or provide the client with the bedpan.
7. Make sure the bed is in its lowest position. Place toilet paper, disposable wipes, and a bell or other way to call you within the client's reach. Ask the client to clean his hands with a wipe when finished if he is able.
8. Remove and discard your gloves. Wash your hands. Leave the room and close the door.
9. When called by the client, return and wash your hands. Put on clean gloves. Give perineal care if help is needed.
10. Using the two tongue blades, take about two tablespoons of stool and put it in the container. Without touching the inside of the container, cover it tightly. Apply the label, place the container in a clean specimen bag, and seal the bag.
11. Wrap the tongue blades in toilet paper and put them in plastic bag with the used toilet paper. Discard bag in the proper container.
12. Empty the bedpan or container into the toilet. Turn the faucet on with a paper towel. Rinse the bedpan or container with cold water first and empty it into the toilet. Flush the toilet. Then clean the bedpan or container with hot, soapy water and store. Store the equipment.
13. Store the specimen properly.
14. Remove and discard your gloves.
15. Wash your hands.
16. Document the procedure. Note amount and characteristics of stool.

Urine Specimens

Urine specimens may be categorized as routine, clean catch (midstream), or 24-hour. A **routine urine specimen** is collected anytime the client voids, or urinates. The client will void into a bedpan, urinal, commode, or hat. Some clients will be able to collect their own urine specimens. Others will need help. The HHA should be sure to explain exactly how the specimen must be collected (Fig. 14-29).

Fig. 14-29. *Specimens must always be labeled with the client's name, date of birth, address, and the date and time. A specimen may need to be placed into a clean specimen bag once it is collected.*

Collecting a routine urine specimen

Equipment: specimen container and lid, completed label (labeled with client's name, date of birth, address, date, and time), specimen bag, 2 pairs of gloves, bedpan or urinal (if client cannot use a portable commode or toilet), hat for toilet (if client uses portable commode or toilet), plastic bag, toilet paper, disposable wipes, paper towels, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Fit hat to toilet or commode, or provide the client with the bedpan. Ask the client to void into the hat, urinal, or bedpan. Ask the client not to put toilet paper in with the sample. Provide a plastic bag to discard toilet paper separately.
6. Make sure the bed is in its lowest position. Place toilet paper, disposable wipes, and a bell or other way to call you within the client's reach. Ask the client to clean his hands with a wipe when finished if he is able.
7. Remove and discard your gloves. Wash your hands. Leave the room and close the door.
8. When called, return and wash your hands. Put on clean gloves. Give perineal care if help is needed.
9. Take the bedpan, urinal, or hat to the bathroom.
10. Pour urine into the specimen container until the container is at least half full.
11. Cover the urine container with its lid. Do not touch the inside of the container. Wipe off the outside with a paper towel and discard the paper towel.
12. Apply the label, place the container in a clean specimen bag, and seal the bag.
13. Discard extra urine in the toilet. Turn the faucet on with a paper towel. Rinse the bedpan, urinal, or hat with cold water and empty it into the toilet. Flush the toilet. Store equipment.
14. Remove and discard your gloves.
15. Wash your hands.
16. Document the procedure. Note amount and characteristics of urine.

The **clean-catch specimen**, or midstream specimen (CCMS), does not include the first and last urine voided in the sample. The perineal area is cleaned and then the client urinates a small amount into the toilet to clear the urethra. The client then begins urinating again into a clean or sterile container, stopping before urination is complete. The container is removed, and the client finishes urinating into the toilet. This specimen is collected to detect bacteria in the urine.

Collecting a clean-catch (midstream) urine specimen

Equipment: specimen kit with container and lid, completed label (labeled with client's name, date of birth, address, date, and time), specimen bag, cleansing wipes, gloves, bedpan or urinal (if client cannot use a portable commode or toilet), plastic bag, toilet paper, disposable wipes, paper towels, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Open the specimen kit. Do not touch the inside of the container or the inside of the lid.

6. If client cannot clean his perineal area, you will do it. Use the cleansing wipes to do this. Be sure to use a clean area of the wipe or a clean wipe for each stroke. See bed bath procedure in Chapter 13 for a reminder on how to give perineal care.
7. Ask the client to urinate a small amount into the bedpan, urinal, or toilet, and to stop before urination is complete.
8. Place the container under the urine stream and have the client start urinating again until the container is at least half full. Ask the client to stop urinating and remove the container. Have the client finish urinating in bedpan, urinal, or toilet.
9. After urination, provide a plastic bag so that the client can discard the toilet paper. Give perineal care if help is needed. Ask the client to clean his hands with a wipe if he is able.
10. Cover the urine container with its lid. Do not touch the inside of container. Wipe off the outside with a paper towel and discard the paper towel.
11. Apply the label, place the container in a clean specimen bag, and seal the bag.
12. If using a bedpan or urinal, discard extra urine in the toilet. Turn the faucet on with a paper towel. Rinse the bedpan or urinal with cold water and empty it into the toilet. Flush the toilet. Store equipment.
13. Remove and discard your gloves.
14. Wash your hands.
15. Document the procedure. Note amount and characteristics of urine.

A **24-hour urine specimen** collects all the urine voided by a client in a 24-hour period. It is used to test for certain chemicals and hormones. Usually the collection begins at 7 a.m. and continues until 7 a.m. the next day. When beginning a 24-hour urine specimen collection, the client must void and discard the first urine so that the collection begins with an empty bladder. All urine must be collected and stored properly. If any is accidentally thrown away or improperly stored, the collection will need to be started over. Since the HHA will probably not be present during all 24 hours of the test, it is important for her to explain the collection fully to the client and family members.

Collecting a 24-hour urine specimen

Equipment: 24-hour specimen container with lid, completed label (labeled with client's name, date of birth, address, date, and time), bedpan or urinal (for clients confined to bed), hat for toilet (if client can use portable commode or toilet), bucket of ice (if the urine must be kept cold; a clearly marked container may also be able to be put in the refrigerator), funnel (if the container opening is small), gloves, toilet paper, disposable wipes, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. When beginning the collection, have the client completely empty his bladder. Discard the urine and note the exact time of this voiding. The collection will run until the same time the next day.
5. Wash your hands and put on gloves each time the client voids.
6. Ask the client not to put toilet paper in with the sample each time the client voids. Pour urine from the bedpan, urinal, or hat into the container, using the funnel as needed. Container may be stored at room temperature, on ice, or in the refrigerator. Follow the supervisor's instructions.

7. After each voiding, help as necessary with perineal care. Ask the client to clean his hands with a wipe after each voiding if he is able.
8. Be sure the client or family member understands that all urine is to be saved, even when you are gone. Demonstrate how to pour the urine into the container. Remind them to store the container properly (room temperature, in the bucket of ice, or in the refrigerator if ordered).
9. Clean equipment after each voiding.
10. Remove and discard your gloves.
11. Wash your hands.
12. Document the time of the last void before the 24-hour collection period began, and the last void of the 24-hour collection period.

Urine Straining

Urine straining is the process of pouring all urine through a fine filter to catch any particles that are present. Urine is strained to discover the presence of kidney stones that can develop in the urinary tract. These stones can be as small as grains of sand or as large as golf balls. If any stones are found, they are saved and then sent to a laboratory for examination. A routine urine specimen is collected first in order to strain urine. In the bathroom, the home health aide will pour it through a strainer or a 4x4-inch piece of gauze into a specimen container. Any stones that are present are wrapped in the filter and placed in the specimen container and then into a clean specimen bag to go to the laboratory.

3. Describe the importance of fluid balance and explain intake and output (I&O)

To maintain health, the body must take in a certain amount of fluid each day. Fluid comes in the form of liquids that a person drinks and is also found in semiliquid foods like gelatin, soup, ice cream, pudding, and yogurt. The fluid a person consumes is called **intake**, or **input**.

A general recommendation for daily fluid intake is 64 ounces (or eight 8-ounce glasses) for a healthy person. However, that is not necessarily a firm guideline for health. Some people may need more than 64 ounces, while others may need less. The amount needed depends on factors such as activity, heat, and overall health. If a person's intake is not in a healthy range, he can become dehydrated. Dehydration is a serious medical condition that requires immediate attention. More information on dehydration is in Chapter 22.

All fluid taken in each day cannot remain in the body. It must be eliminated as **output**. Output includes urine, feces (including diarrhea), and vomitus, as well as perspiration, moisture in the air that a person exhales, and wound drainage. If a person's intake exceeds his output, fluid builds up in body tissues. This fluid retention can cause medical problems and discomfort.

Fluid balance is maintaining equal input and output, or taking in and eliminating equal amounts of fluid. Most people do this naturally but some clients must have their intake and output, or I&O, monitored and documented due to illness or special diets. To monitor this, the HHA will need to measure and document all fluids and foods the client takes in by mouth, as well as all urine and vomitus produced. This information is recorded on an Intake and Output (I&O) sheet if provided by the agency, but it can also be done on regular paper (Fig. 14-30).

To measure these amounts, the HHA should use separate measuring containers for input and output; these containers should not be mixed up. Measuring cups can be used. If a client frequently drinks out of one type of cup, the HHA can measure the amount that cup holds. Masking tape placed on the outside of the cup can be used to mark different quantities. This makes it easier to keep track of input.

INTAKE-OUTPUT RECORD

Resident/Patient Name		Room No.
FLUID INTAKE	URINE	EMESIS or DRAINAGE
7:00 A.M. to 3:00 P.M.		
8-Hour Total		
3:00 P.M. to 11:00 P.M.		
8-Hour Total		
11:00 P.M. to 7 A.M.		
8-Hour Total		

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Fig. 14-30. *A sample intake and output (I&O) record.* (REPRINTED WITH PERMISSION OF BRIGGS HEALTHCARE®, BRIGGSHEALTHCARE.COM, 800-247-2343)

Fluids are usually measured in milliliters (mL). Milliliters are units of measurement in the metric system. One milliliter is 1/1000 of a liter. Ounces (oz) are converted to milliliters. One ounce equals 30 milliliters, so to convert ounces to milliliters, the number of ounces must be multiplied by 30. Graduates are containers that measure fluid in milliliters and may also measure in ounces (Fig. 14-31). Some common conversions are listed in the orange box.

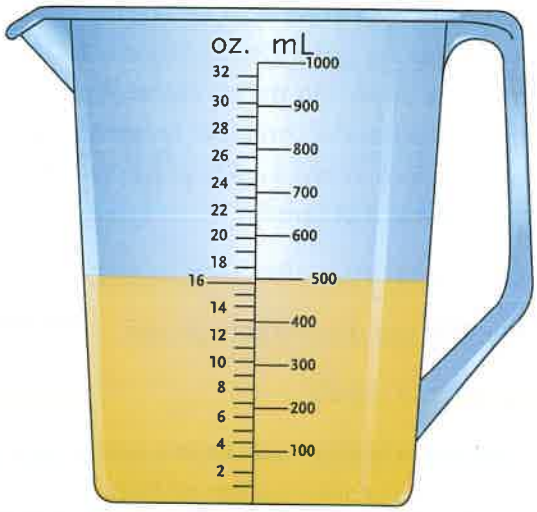


Fig. 14-31. *A graduate is a measuring container for measuring fluid volume.*

Conversions

One ounce equals 30 milliliters. To convert ounces to milliliters, the number of ounces must be multiplied by 30.

1 oz = 30 mL

2 oz = 60 mL

3 oz = 90 mL

4 oz = 120 mL

5 oz = 150 mL

6 oz = 180 mL

7 oz = 210 mL

8 oz = 240 mL

¼ cup = 2 oz = 60 mL

½ cup = 4 oz = 120 mL

1 cup = 8 oz = 240 mL

Before beginning, the HHA should explain to the client that she needs to keep track of his intake. The HHA should ask the client to let her know when he drinks something (if it is not something she served to him) and how much it was.

Measuring and recording intake and output

Equipment: I&O sheet, graduate (measuring container), pen and paper

Measure intake first.

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Using the graduate, measure the amount of fluid a client is served. Note the amount on paper, not in the visit notes. (If the amount is between measurement lines, you may need to round up to the nearest 25 mL. Follow policy.)
5. When client has finished a meal or snack, measure any leftover fluids. Note this amount on paper.
6. Subtract the leftover amount from the amount served. If you have measured in ounces, convert to milliliters (mL) by multiplying by 30.
7. Document the amount of fluid consumed (in mL) in the visit notes and/or in the input column of I&O record, as well as the time and the type of fluid consumed. Report anything unusual, such as the client refuses to drink, drinks very little, is nauseated, etc.
8. Wash your hands.

Measuring output is the other half of monitoring fluid balance.

Equipment: I&O sheet, graduate, paper towel, gloves, pen and paper

1. Wash your hands.
2. Put on gloves before handling a bedpan or urinal.
3. Pour the contents of the bedpan or urinal into the graduate. Do not spill or splash any of the urine.
4. Place the graduate on a flat surface. Measure the amount of urine at eye level. Keep the container level (Fig. 14-32). Note the amount on paper, converting to mL if necessary. (If the amount is between measurement lines, you may need to round up to the nearest 25 mL. Follow policy.)

Fig. 14-32. *Keep the container on a flat surface while measuring output.*

5. After measuring urine, empty the graduate into the toilet without splashing.
6. Turn the faucet on with a paper towel. Rinse the graduate with cold water and pour rinse water into the toilet.
7. Rinse the bedpan/urinal with cold water and pour rinse water into the toilet. Flush the toilet. Clean and store equipment.
8. Remove and discard your gloves.
9. Wash your hands before recording output.
10. Immediately document the time and amount of urine in the output column on the sheet. For example: 1545 hours, 200 mL urine.

    To measure vomitus, pour from the basin into the measuring container, then discard it in the toilet. If client vomits on the bed or floor, estimate the amount. Document **emesis** (*EM-e-sis*, or vomiting) and amount in the visit notes and/or in output column of the I&O sheet.

Emesis, or vomiting, must be documented. It may be a sign of illness or of a reaction to medication. Some clients, such as people with cancer who are undergoing chemotherapy, may vomit frequently as a result of treatment. Vomiting is unpleasant. The HHA should handle it calmly and provide comfort to the client.

Guidelines: Vomiting

- G Treat vomitus as you treat urine and other potentially infectious wastes. Follow Standard Precautions. Always wear gloves when handling it. Flush vomitus down the toilet. Clean spills thoroughly with a disinfecting solution of bleach and water.
- G Provide comfort to a client who has vomited. Stay calm and offer a basin if you think he may vomit again. Remove soiled sheets or clothing promptly. Provide a wet washcloth to wipe face, mouth, or hands. Offer a drink of water or oral care to clean the mouth.
- G Provide plenty of fluids to the client who has vomited. Water, diluted juices, or sports drinks may help prevent dehydration. Discontinue solid foods when vomiting occurs. Check with your supervisor for what you can serve. Clear liquids or a bland diet may be recommended.
- G Because you may not know when a client is going to vomit, you may not have time to explain what you will do and assemble supplies ahead of time. Talk to the client soothingly as you help him clean up. Tell him what you are doing to help him.

Observing, reporting, and documenting emesis

Equipment: emesis basin, 2 pairs of gloves, pen and paper or I&O sheet, supplies for oral care

1. Put on gloves.
2. Make sure the head is up or turned to one side. Place an emesis basin under the chin. Remove it when vomiting has stopped.
3. Remove soiled linens or clothes. Set aside for laundering. Replace with fresh linens or clothes.
4. If the client's I&O is being monitored, measure and note the amount of vomitus.
5. Flush vomit down the toilet unless vomit is red, has blood in it, or looks like wet coffee grounds. If these signs are observed, call your supervisor before disposing of the vomit. After discarding the vomit, wash, dry, and store the basin.
6. Remove and discard your gloves.
7. Wash your hands.
8. Put on clean gloves.
9. Provide comfort to client: wipe the face and mouth, position comfortably, and offer a drink of water or oral care (Fig. 14-33). Oral care helps get rid of the taste of vomit in the mouth.

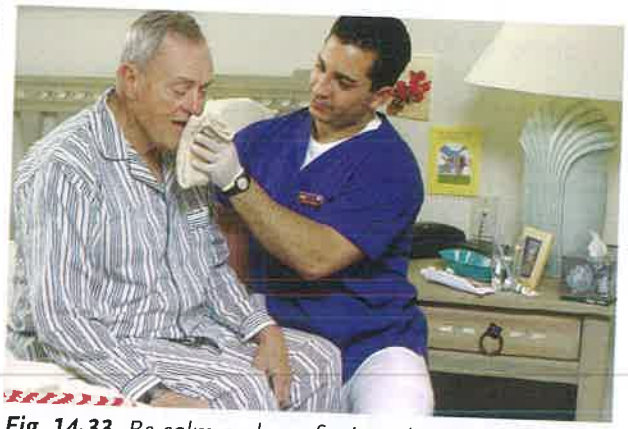


Fig. 14-33. *Be calm and comforting when helping a client who has vomited.*

10. Launder soiled linens and clothes promptly in hot water.
11. Remove and discard your gloves.
12. Wash your hands again.

13. Document time, amount, color, and consistency of vomitus.
14. Report to your supervisor immediately and get instructions for diet.

4. Describe the guidelines for catheter care

Some clients may have a urinary catheter. A **catheter** (*KATH-et-er*) is a thin tube inserted into the body that is used to drain or inject fluids. A **urinary catheter** is used to drain urine from the bladder. A **straight catheter** is a type of urinary catheter that is inserted to drain urine from the bladder and is removed after urine is drained. It does not remain inside the person. An **indwelling catheter** (also called a *Foley catheter*) remains inside the bladder for a period of time (Fig. 14-34). The urine drains into a bag.

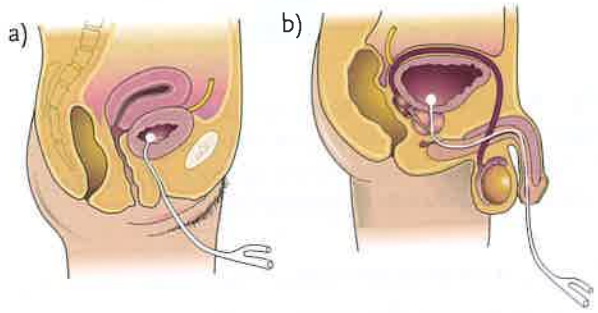


Fig. 14-34. *An illustration of a) an indwelling catheter (female) and b) an indwelling catheter (male).*

Another type of catheter that is used for males is an external catheter, or **condom catheter** (also called a *Texas catheter*). It has an attachment on the end that fits onto the penis and is fastened with special tape. Urine drains through the catheter into the tubing, then into the drainage bag. A smaller bag, called a leg bag, attaches to the leg and collects the urine. The condom catheter is changed daily or as needed. In some states, home health aides are allowed to change a condom catheter. However, in other states, nurses must perform this procedure.

Nurses or doctors insert urinary catheters. Home health aides do not insert, irrigate, or remove catheters. HHAs may be asked to give daily catheter care, clean the area around the urethral opening, and empty the drainage bag. The bag is emptied into a measuring container (a graduate).

Due to serious complications, such as infections, that can result from poor catheter care, it is very important that home health aides follow proper guidelines for urinary catheters.

Guidelines: Catheters

- **G** Thoroughly wash your hands before giving catheter care.
- **G** Keep the genital area clean to prevent infection. Because the catheter goes all the way into the bladder, bacteria can enter the bladder more easily. Daily care of the genital area (perineal care) is especially important.
- **G** Make sure the drainage bag always hangs lower than the hips or bladder. Urine must never flow from the bag or tubing back into the bladder. This can cause infection.
- **G** Keep the drainage bag off the floor. Make sure the catheter tubing does not touch the floor.
- **G** To help keep urine draining properly, keep the tubing as straight as possible. Make sure there are no kinks in the tubing and that the client is not sitting or lying on the tubing.

Observing and Reporting: Catheter Care

- **O/R** Blood in the urine or urine that looks unusual in any way
- **O/R** Catheter bag does not fill after several hours
- **O/R** Catheter bag fills suddenly
- **O/R** Catheter is not in place

- O/R Urine leaks from the catheter
- O/R Client reports pain or pressure
- O/R Odor is present

Providing catheter care

Equipment: bath blanket, disposable bed protector, bath basin with warm water, soap, 2–4 washcloths or disposable wipes, towel, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Lower the head of the bed. Position the client lying flat on her back.
6. Remove or fold back the top bedding, keeping the client covered with the bath blanket.
7. Test the water temperature against the inside of your wrist. Water temperature should be no higher than 105°F. Have the client check the temperature to see if it is comfortable. Adjust if necessary.
8. Put on gloves.
9. Ask the client to flex her knees and raise her buttocks off the bed by pushing against the mattress with her feet. Place a clean bed protector under her perineal area, including her buttocks.
10. Expose only the area necessary to clean the catheter. Avoid overexposing the client.
11. Place a towel under the catheter tubing before washing.
12. Wet a washcloth in the basin. Apply soap to a washcloth. Clean the area around the meatus. Use a clean area of the washcloth for each stroke.
13. Hold the catheter near the meatus. Avoid tugging the catheter throughout the procedure.
14. Clean at least four inches of the catheter nearest the meatus. Move in only one direction, away from the meatus (Fig. 14-35). Use a clean area of the washcloth for each stroke.

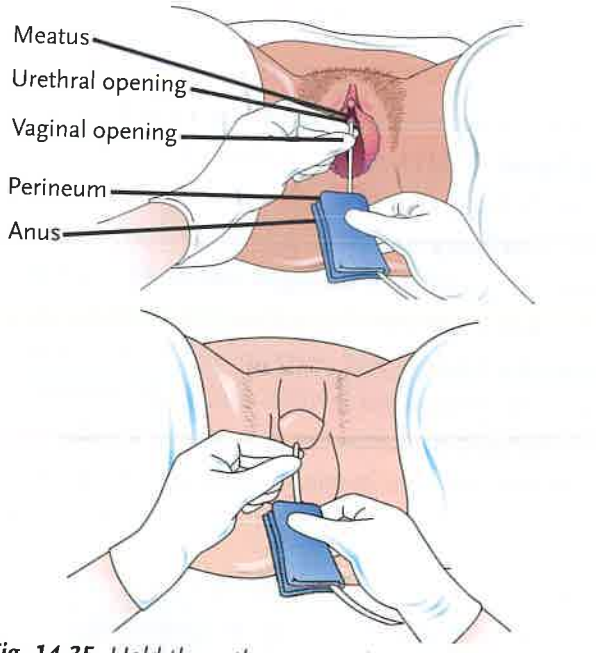


Fig. 14-35. *Hold the catheter near the meatus to avoid tugging the catheter. Moving in only one direction, away from the meatus, helps prevent infection. Use a clean area of the washcloth for each stroke.*

15. Dip a clean washcloth in the water. Rinse the area around the meatus, using a clean area of the washcloth for each stroke. With a clean, dry towel, dry the area around the meatus.
16. Dip a clean washcloth in the water. Rinse at least four inches of the catheter nearest the meatus. Move in only one direction, away from the meatus. Use a clean area of the washcloth for each stroke.
17. With a clean, dry towel, dry at least four inches of the catheter nearest the meatus. Move in only one direction, away from the meatus. Do not tug the catheter.
18. Remove the bed protector from under the client and discard. Remove the towel from under the catheter tubing and place it in the proper container.

19. Place linen and used washcloths in the proper containers. Empty the basin into the toilet and flush the toilet. Clean and store the basin.
20. Remove and discard your gloves.
21. Wash your hands.
22. Replace the top covers and remove the bath blanket and place it in the proper container.
23. If you raised an adjustable bed, return it to its lowest position.
24. Help the client dress. Arrange the covers. Check that the catheter tubing is free from kinks and twists and that it is securely taped to the leg.
25. Wash your hands again.
26. Document procedure and any observations.

Emptying the catheter drainage bag

Equipment: graduate (measuring container), alcohol wipes, paper towels, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Place a paper towel on the floor under the drainage bag. Place the graduate on the paper towel.
6. Open the clamp on the drainage bag so that urine flows out of the bag and into the graduate (Fig. 14-36). Do not let the spout or clamp touch the graduate.
7. When urine has drained out of the bag, close the clamp. Using alcohol wipes, clean the drain spout. Replace the drain spout in its holder on the bag.
8. Go into the bathroom. Place the graduate on a flat surface and measure at eye level. Note the amount and characteristics of urine. Empty urine into the toilet and flush the toilet.

Fig. 14-36. *Keep the spout and clamp from touching the graduate while draining urine.*

9. Clean and store the graduate. Discard paper towels.
10. Remove and discard your gloves.
11. Wash your hands.
12. Document procedure and amount of urine.

Changing a condom catheter

Equipment: condom catheter and collection bag, catheter tape, plastic bag, bath blanket, disposable bed protector, gloves, supplies for perineal care

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.

5. Lower the head of the bed. Position the client lying flat on his back.
6. Remove or fold back the top bedding, keeping the client covered with the bath blanket.
7. Put on gloves.
8. Place a clean bed protector under his perineal area, including his buttocks.
9. Adjust the bath blanket to only expose the genital area.
10. Gently remove the condom catheter. Place condom and tape in the plastic bag.
11. Assist as necessary with perineal care.
12. Move pubic hair away from the penis so it does not get rolled into the condom.
13. Hold penis firmly. Place the condom at the tip of the penis and roll toward the base of the penis. Leave space (at least one inch) between the drainage tip and glans of penis to prevent irritation. If client is not circumcised, be sure that the foreskin is in normal position.
14. Secure the condom to the penis with the special tape provided (Fig. 14-37). Apply the tape in a spiral manner. Never wrap tape all the way around the penis because it can impair circulation.

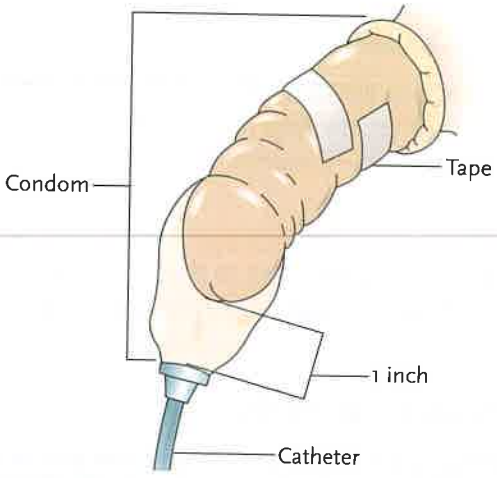


Fig. 14-37. *Gently secure the condom to the penis with provided tape, applying it in a spiral.*

15. Connect the catheter tip to the drainage tubing. Do not touch the tip to any object but the drainage tubing. Make sure the tubing is not twisted or kinked.
16. Check to see if collection bag is secured to the leg. Make sure the drain is closed.
17. Remove and discard the bed protector. Discard used supplies in the plastic bag. Place soiled clothing and linens in proper containers. Clean and store supplies.
18. Remove and discard your gloves.
19. Wash your hands.
20. Replace the top covers. Remove the bath blanket and place it in the proper container. Make sure the client is comfortable. If you raised an adjustable bed, return it to its lowest position.
21. Wash your hands again.
22. Document procedure and any observations.

5. Explain the benefits of warm and cold applications

Applying heat or cold to injured areas can have several positive effects. Heat relieves pain and muscular tension. It reduces swelling, elevates the temperature in the tissues, and increases blood flow. Increased blood flow brings more oxygen and nutrients to the tissues for healing.

Cold applications can help stop bleeding. They help prevent swelling, reduce pain, and bring down high fevers. Applying ice bags or cold compresses immediately after an injury can stop bleeding and prevent swelling.

Home health aides must be very careful when using these applications. They should know how long the application should be performed and should use the correct temperature as given in the care plan. When warm and cold applications

are applied for too long, the opposite effect of what is intended results. Clients receiving warm or cold applications should be checked often, especially those who have conditions that may make them unaware of possible injury.

Warm and cold applications may be dry or moist. Moisture strengthens the effect of heat and cold. This means that moist applications are more likely to cause injury. Paralysis, numbness, disorientation, confusion, dementia, and other conditions may cause a person to be unable to feel, notice, or understand damage that is occurring from a warm or cold application. For example, a client recovering from a stroke who has paralysis on one side may not be able to feel if a warm pack is burning his skin. A client with Alzheimer's disease may not understand that he is being burned and/or be able to communicate pain clearly.

Moist applications include the following:

- Compresses (warm or cold)
- Soaks (warm or cold)
- Tub baths (warm)
- Sponge baths (warm or cold)
- Sitz baths (warm)
- Ice packs (cold)

Dry applications include the following:

- Electric heating pads (warm)
- Disposable warm packs (warm)
- Ice bags (cold)
- Disposable cold packs (cold)

Home health aides may be allowed to prepare and apply warm water bottles, heating pads, warm compresses or soaks, ice packs, and cold compresses. If other methods are allowed, a supervisor will train the HHA. The HHA should only perform procedures that are assigned to him and that he is trained to do.

Observing and Reporting: Warm and Cold Applications

These signs indicate that the application may be causing tissue damage and should be reported:

- O/R Excessive redness
- O/R Pain
- O/R Blisters
- O/R Numbness

An electric heating pad may be ordered in the care plan. When using an electric heating pad, the HHA should follow these guidelines:

Guidelines: Electric Heating Pads

- G Check the skin frequently for redness or pain. Electric heating pads do not cool down. Having it just a little too hot can be very dangerous for the client.
- G Make sure any electric heating pad you use is in good shape. Do not use it if the cord is frayed or if wires are exposed.
- G Do not use a pin to fasten the pad. The pin could contact a wire inside the pad and cause a shock.
- G Do not allow the client to lie on top of an electric heating pad.
- G Do not allow the client to use an electric heating pad near a source of water.

A washcloth or a commercial warm compress may be used as a warm compress. There are different types of commercial compresses available (Fig. 14-38). If these are provided, the home health aide should follow the package directions and the care plan's instructions.

Fig. 14-38. *Disposable warm compresses are used only once and then discarded.* (PHOTO COURTESY OF ARIEL HARTMAN, MCKESSON MEDICAL-SURGICAL, MMS.MCKESSON.COM, 804-264-7702)

Applying warm compresses

Equipment: washcloth or compress, plastic wrap, towel, basin

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill basin one-half to two-thirds full with warm water. Test water temperature against the inside of your wrist to ensure it is safe. Water temperature should be no higher than 105°F. Have the client check the temperature to see if it is comfortable. Adjust if necessary.
5. Soak the washcloth in the water and wring it out. Immediately apply it to the area. Note the time. Quickly cover the washcloth with plastic wrap and the towel to keep it warm (Fig. 14-39).
6. Check the area every five minutes. Remove the compress if the area is red or numb or if the client complains of pain or discomfort. Change the compress if cooling occurs. Remove the compress after 20 minutes.

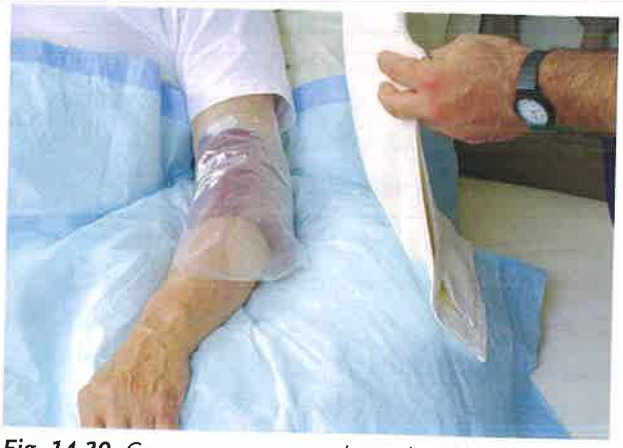


Fig. 14-39. *Cover compresses to keep them warm.*

7. Discard plastic wrap. Empty the basin in the toilet. Rinse the basin and pour rinse water in the toilet. Flush the toilet. Clean and store the basin and other supplies. Put laundry in the hamper.
8. Wash your hands.
9. Document the time, length, site of procedure, and any observations.

Administering warm soaks

Equipment: basin or bathtub (depending on the area to be soaked), bath blanket, towel, disposable absorbent pad

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill the basin or tub half full of warm water. Test the water temperature against the inside of your wrist to ensure it is safe. Water temperature should be no higher than 105°F. Have the client check the temperature to see if it is comfortable. Adjust if necessary.
5. Place the basin on a disposable absorbent pad (protective barrier), in a comfortable position for the client.

6. Immerse the body part in the basin or help the client into the tub. Pad the edge of the basin with a towel (Fig. 14-40). Use a bath blanket to cover the rest of the client, if needed, for extra warmth.

Fig. 14-40. *Pad the edge of the basin with a towel to make the client more comfortable.*

7. Check the water temperature every five minutes. Add hot water as needed to maintain the temperature. Never add water hotter than 105°F to avoid burns. To prevent burns, ask the client not to add hot water. Observe the area for redness. Discontinue the soak if the client complains of pain or discomfort.
8. Soak for 15–20 minutes or as ordered in the care plan.
9. Remove basin or help the client out of the tub. Use the towel to dry the client.
10. Drain the tub or empty the basin in the toilet. Rinse the basin and pour rinse water in the toilet. Flush the toilet. Clean and store the basin and other supplies. Put laundry in the hamper.
11. Wash your hands.
12. Document the time, length, and site of procedure. Report the client's response and any of your observations about the skin.

Using a hot water bottle

Equipment: hot water bottle, cloth cover or towel

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill the bottle half full with warm water (no higher than 105°F, or 98°F for infants and small children or older adults).
5. Press out excess air and seal the bottle.
6. Dry the bottle and check for leaks. Cover with a cloth cover or towel.
7. Apply the bottle to the area ordered. Check skin every five minutes for redness or pain. If redness or pain are present, add cold water to the bottle to reduce the temperature.
8. Remove the bottle after 20 minutes or as ordered in the care plan.
9. Empty the hot water bottle. Wash and store supplies.
10. Wash your hands.
11. Document the time, length, and site of procedure. Document the client's response and any of your observations about the skin.

Another type of heat application is a **sitz bath**, or a warm soak of the perineal area. Sitz baths clean perineal wounds and reduce inflammation and pain. Sitz baths cause circulation to be increased to the perineal area. Voiding may be stimulated by a sitz bath. Clients with perineal swelling (such as hemorrhoids) or perineal wounds (such as those that occur during childbirth) may be ordered to take sitz baths. Because the sitz bath causes increased blood flow to the pelvic area, blood flow to other parts of the body is decreased. Clients may feel weak, faint, or dizzy after taking a sitz bath. Home health aides must always wear gloves when helping with a sitz bath.

A disposable sitz bath fits on the toilet seat and is attached to a rubber bag containing warm water (Fig. 14-41).

Fig. 14-41. *A disposable sitz bath.* (PHOTO COURTESY OF NOVA MEDICAL PRODUCTS, WWW.NOVAJOY.COM)

Assisting with a sitz bath

Equipment: disposable sitz bath, towels, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Put on gloves.
5. Fill the sitz bath two-thirds full with warm water. Place the sitz bath on the toilet seat. Check the water temperature. Normally water temperature should be no higher than 105°F.
6. Help the client undress and sit on the sitz bath. A valve on the tubing connected to the bag allows the client or you to refill the water in the sitz bath with warm water.
7. You may be required to stay with the client for safety reasons. If you leave the room, check on the client every five minutes to make sure she is not dizzy or weak. Stay with a client who seems unsteady.
8. Help the client off of the sitz bath after 20 minutes. Provide towels and help with dressing if needed.
9. Clean and store supplies. Discard disposable supplies as indicated in the care plan. Put laundry in hamper.
10. Remove and discard your gloves.
11. Wash your hands.
12. Document the procedure, including the time and length of procedure, the client's response, and the water temperature.

There are different types of commercial packs available, which may be used instead of traditional ice packs. If these are provided, the HHA should follow the package directions and the care plan's instructions. Some cold packs are disposable, while others are cleaned and reused.

Applying ice packs

Equipment: cold pack or sealable plastic bag and crushed ice, towel to cover pack or bag

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Fill the plastic bag or ice pack one-half to two-thirds full with crushed ice. Seal the bag. Remove excess air. Cover bag or ice pack with towel (Fig. 14-42).

Fig. 14-42. *Seal the bag filled with ice and cover it with a towel.*

5. Apply the bag or pack to the area as ordered. Note the time. Use another towel to cover the bag if it is too cold.

6. Check the area after five minutes for blisters, or pale, white, or gray skin. Stop treatment if the client complains of numbness or pain.
7. Remove the bag or pack after 20 minutes or as ordered in the care plan.
8. Return the ice bag or pack to the freezer. Put laundry in the hamper.
9. Wash your hands.
10. Document the time, length, and site of procedure. Report the client's response and any of your observations about the skin.

A washcloth dipped in cold water may be used as a cold compress; disposable or reusable compresses are also available (Fig. 14-43). Home health aides should follow instructions on the package.

Fig. 14-43. *Disposable cold compresses are used only once and then discarded.* (PHOTO COURTESY OF ARIEL HARTMAN, MCKESSON MEDICAL-SURGICAL, MMS.MCKESSON.COM, 804-264-7702)

Applying cold compresses

Equipment: basin filled with water and ice, 2 washcloths, disposable bed protector, towels

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. Place the bed protector under the area to be treated. Rinse a washcloth in the basin and wring it out. Cover the area to be treated with a towel. Apply the cold washcloth to the area as directed (Fig. 14-44). Change washcloths often to keep the area cold.

Fig. 14-44. *Wring out the washcloth before applying it to the area to be treated.*

5. Check the area after five minutes for blisters, or pale, white, or gray skin. Stop treatment if the client complains of numbness or pain.
6. Remove compress after 20 minutes or as ordered in the care plan. Give the client towels as needed to dry the area.
7. Empty, clean, and store the basin. Put laundry in the hamper.
8. Wash your hands.
9. Document the time, length, and site of procedure. Report the client's response and any observations about the skin.

6. Explain how to apply nonsterile dressings

Sterile dressings cover new, open, or draining wounds. A nurse changes these dressings. Nonsterile dressings are applied to dry, closed wounds that have less chance of infection. Home health aides may change nonsterile dressings.

Changing a dry dressing using nonsterile technique

Equipment: package of 4"x4" gauze dressings, adhesive tape, scissors, 2 pairs of gloves, plastic bag

1. Wash your hands.

2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. With scissors, cut pieces of tape long enough to secure the dressing. Hang the tape on the edge of a table within reach. Open the gauze package without touching the gauze. Place the opened package on a flat surface.
5. Put on gloves.
6. Remove soiled dressing by gently peeling the tape toward the wound. Lift the dressing off the wound. Do not drag it over the wound. Observe the dressing for odor or drainage. Notice the color and size of the wound. Discard used dressing in the plastic bag.
7. Remove your gloves and discard them in the plastic bag. Wash your hands.
8. Put on clean gloves. Touching only the outer edges of new four-inch gauze, remove it from the package. Apply it to the wound. Tape gauze in place. Secure it firmly (Fig. 14-45).

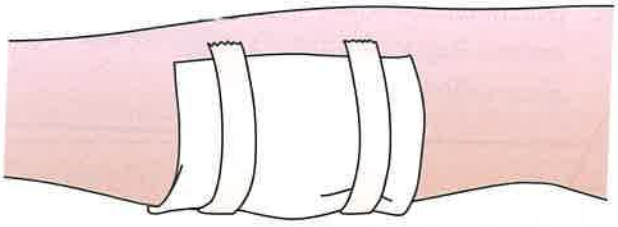


Fig. 14-45. *Tape gauze in place to secure the dressing. Do not completely cover all areas of the dressing with tape.*

9. Discard supplies.
10. Remove and discard your gloves.
11. Wash your hands.
12. Document the procedure and your observations.

More information on dressings can be found in the Appendix at the back of this textbook.

7. Describe the purpose of elastic stockings and how to apply them

For some cases of poor circulation to legs and feet, elastic stockings are ordered. These special stockings help prevent swelling and blood clots. They promote blood circulation. Elastic stockings are also known as *antiembolic* or *compression stockings* or *TED hose*. They are referred to as antiembolic because they help prevent embolisms. An embolism is an obstruction of a blood vessel, usually by a blood clot. The embolism can travel from where it was formed to another part of the body, blocking blood flow. It can cause serious damage and even death.

Elastic stockings may either be knee-high or thigh-high. They need to be put on in the morning, before the client gets out of bed. Legs are at their smallest size then. The stockings are usually removed in the evening.

Putting elastic stockings on a client

Equipment: elastic stockings

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. The client should be in the supine position (on her back) in bed. With the client lying down, remove her socks, shoes, or slippers, and expose one leg. Expose no more than one leg at a time.
5. Take one stocking and turn it inside out at least to the heel area (Fig. 14-46).

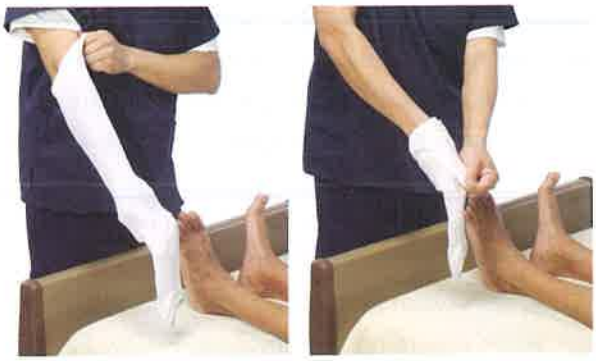


Fig. 14-46. *Turning the stocking inside out allows the stocking to roll on gently.*

6. Gently place the foot of the stocking over toes, foot, and heel (Fig. 14-47). Make sure the heel is in the right place (the heel of the foot should be in the heel of the stocking).

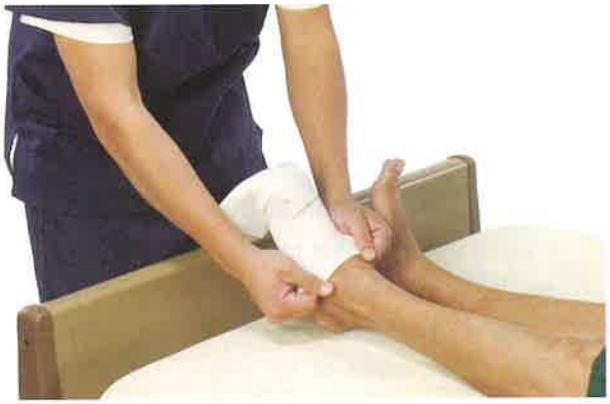


Fig. 14-47. *Place the foot of the stocking over the toes, foot, and heel. Promote the client's comfort and safety. Avoid force and overextension of joints.*

7. Gently pull the top of stocking over foot, heel, and leg.
8. Make sure that there are no twists and wrinkles in the stocking after it is on the leg. It must fit smoothly (Fig. 14-48). Make sure the heel of the stocking is over the heel of the foot. If the stocking has an opening in the toe area, make sure the opening is either over or under the toe area, depending upon the manufacturer's instructions. Adjust if needed.
9. Repeat steps 5 through 8 for the other leg.
10. Wash your hands.

Fig. 14-48. *Make stocking smooth. Twists or wrinkles cause the stocking to be too tight, which reduces circulation.*

11. Document the procedure and your observations. How did the skin appear? Were there any changes in color or temperature? Were there any sores or swelling on the legs? If the client complains of pain, numbness, or tingling, remove the stockings and contact your supervisor.

Elastic stockings should be removed at least once a day, as directed in the care plan. After removing them, bathe the skin underneath, dry the skin, and reapply them. Observe the skin for changes in color, temperature, and swelling or sores. Report any changes to your supervisor.

8. Define *ostomy* and list care guidelines

An **ostomy** (*OS-toh-mee*) is the surgical creation of an opening from an area inside the body to the outside. The terms *colostomy* (*koh-LOS-toh-mee*) and *ileostomy* (*il-ee-OS-toh-mee*) refer to the surgical removal of a portion of the intestines. In a client with one of these ostomies, the end of the intestine is brought out of the body through an artificial opening in the abdomen. This opening is called a **stoma** (*STOH-ma*). Stool, or feces, is eliminated through the ostomy rather than through the anus. An ostomy may be necessary due to bowel disease, such as diverticulitis, Crohn's disease, or colon cancer. It may be temporary or permanent.

The terms *colostomy* and *ileostomy* indicate what section of the intestine was removed and the type of stool that will be eliminated. A **colostomy** is a surgically created opening into the large intestine to allow stool to be expelled. With a colostomy, stool will generally be semisolid. An **ileostomy** is a surgically created opening into the end of the small intestine to allow stool to be expelled. Stool will be liquid and may be irritating to the client's skin.

Clients who have had an ostomy wear a disposable pouching system that fits over the stoma to collect the feces (Fig. 14-49). The pouching system is attached to the skin by adhesive, and a belt may also be used to secure it.

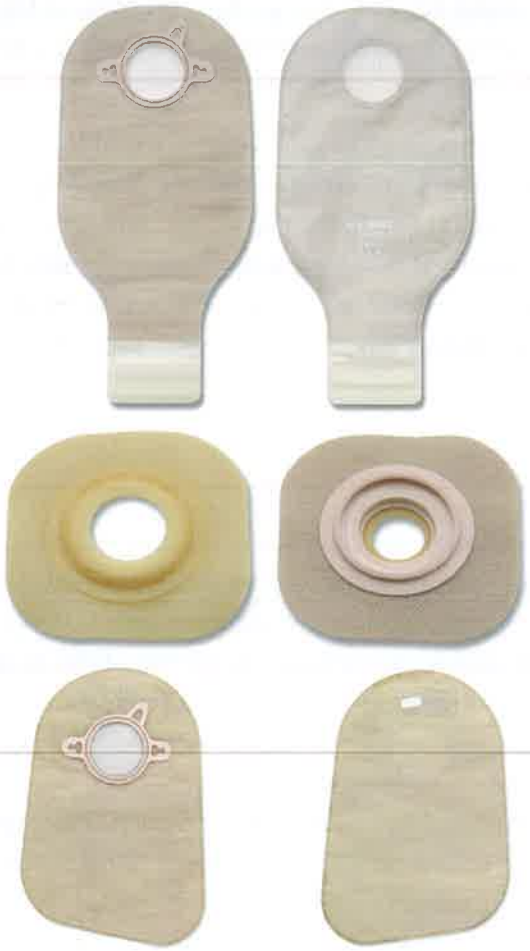


Fig. 14-49. *The top and middle photos show an ostomy drainage pouch and a skin barrier for a drainable (reusable) system. The bottom photo shows a closed (disposable) system that is only used once before being discarded.* (PHOTOS COURTESY OF HOLLISTER INCORPORATED, LIBERTYVILLE, ILLINOIS, WWW.HOLLISTER.COM)

Many people manage the ostomy appliance by themselves. Employers should provide training before home health aides provide this care and will let them know what specific care is allowed.

Guidelines: Ostomy Care

- Always wash hands carefully and wear gloves when providing ostomy care. Follow Standard Precautions.
- Help clients with ostomies wash their hands properly.
- Make sure that the client receives regular, careful skin care. Observe and report any changes in the skin to help prevent skin breakdown.
- Empty and clean the ostomy pouch whenever stool is eliminated.
- Skin barriers protect the skin around the stoma from irritation by the waste products and/or the adhesive material that is used to secure the pouch to the body. Barriers may come in the form of a powder, gel, cream, ring, paste, wafer, or square.
- Clients who have an ileostomy may experience food blockage. A food blockage is a large amount of undigested food, usually high-fiber food, that collects in the small intestine and blocks the passage of stool. Food blockages can occur if the client eats large amounts of foods that are high in fiber and/or if the client does not chew the food well. Follow the diet instructions in the care plan. Chapter 22 contains more information about helping a client eat.
- Encourage fluids and proper diets. Clients with ileostomies need to drink plenty of fluids because they lose extra liquid in their stools. They may also be on high-potassium diets due to rapid elimination.
- Many clients with ostomies feel they have lost control of a basic bodily function. They

may be embarrassed or angry about the ostomy. Be sensitive and supportive when working with these clients. Always provide privacy for ostomy care. Behave professionally and do not act uncomfortable with any aspect of ostomy care.

G Ostomy pouches are made to be odor resistant. If odors are present, it may be due to a leak or improper cleaning. Report odors to your supervisor.

G Observe how the client is reacting to the ostomy and his general attitude. Report any emotional or physical problems with adjusting to the ostomy to your supervisor.

G Most agencies will not allow HHAs to care for a new ileostomy or colostomy or an ileostomy or colostomy that shows any problem, such as skin irritation. Follow your agency's policies. If you have any questions, discuss them with your supervisor.

Observing and Reporting: Ostomies

O/R Changes in color, amount, frequency, or odor of stool

O/R Any skin changes at stoma site, such as sores, excessive redness, or swelling

O/R Leaking stool

O/R Absence of stool

O/R Watery stool with green, stringy material

O/R Abdominal cramps

O/R Vomiting

Caring for an ostomy

Equipment: disposable bed protector, bath blanket, clean ostomy pouching system, belt (if needed), disposable wipes (made for ostomy care), basin of warm water, washcloth, 2 towels, plastic bag, gloves

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy for the client.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Put on gloves.
6. Place the bed protector under the client. Cover the client with the bath blanket. Pull down the top sheet and blankets. Expose only the ostomy site. Offer the client a towel to keep clothing dry.
7. Undo the ostomy belt if used. Remove the ostomy pouch carefully. Place it in the plastic bag. Note the color, odor, consistency, and amount of stool in the pouch.
8. Wipe the area around the stoma with disposable wipes for ostomy care. Discard the wipes in the plastic bag.
9. Using a washcloth and warm water, wash the area in one direction, away from the stoma (Fig. 14-50). Rinse. Pat dry with another towel.

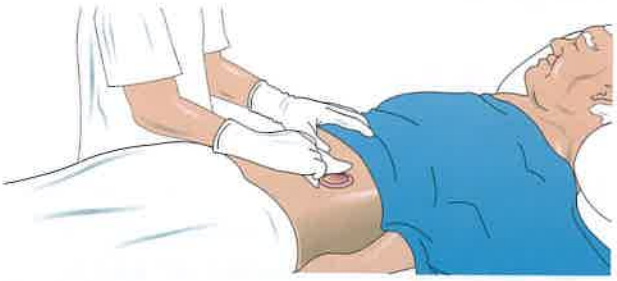


Fig. 14-50. *Wash area gently, moving in one direction, away from the stoma.*

10. Place the clean ostomy drainage pouch on the client, following your supervisor's instructions. Hold in place and seal securely. Make sure the bottom of the pouch is clamped.
11. Remove the disposable bed protector and discard. Place soiled linens in proper containers. Discard the plastic bag properly.

12. Remove and discard your gloves.
13. Wash your hands.
14. Return bed to lowest position if adjusted.
15. Document procedure and any observations. Note any changes to the stoma and surrounding area. A normal stoma is red and moist, and looks like the lining of the mouth. Call your supervisor if stoma appears very red or blue or if swelling or bleeding is present. Report any sign of skin breakdown around the stoma.

The Appendix at the back of this book contains more advanced information on colostomies for HHAs who are allowed to provide this care.

Gastrostomies, tracheostomies, and urostomies are other types of ostomies. A gastrostomy is a surgically created opening into the stomach from the abdomen wall. A tracheostomy is a surgically created opening through the neck into the trachea. A urostomy is a surgically created opening to divert urinary flow away from the bladder. More information on gastrostomies is in Chapter 22. More information on tracheostomies is in the Appendix at the back of the book.

9. Describe how to assist with an elastic bandage

Elastic bandages, also called *nonsterile bandages, self-adhering bandages, ACE bandages,* or *ACE wraps,* are stretchy bandages that are used to hold dressings in place, secure splints, and support and protect body parts (Fig. 14-51). In addition, these bandages may decrease swelling that occurs from an injury.

HHAs may be required to assist with the use of an elastic bandage. Duties may include bringing the bandage to the client, positioning the client to apply the bandage, washing and storing the bandage, and documenting observations. Some states may allow HHAs to apply and remove elastic bandages. If allowed to assist with these bandages, the HHA can follow these guidelines:

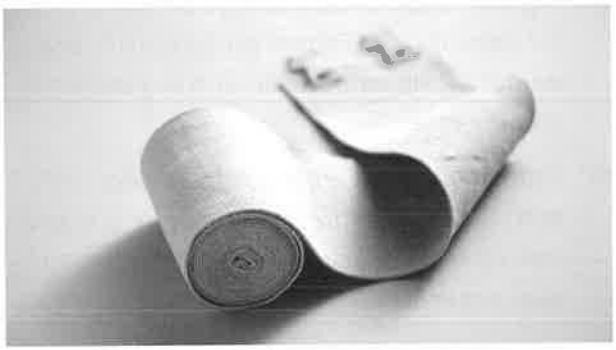


Fig. 14-51. *This is one type of elastic bandage.*

Guidelines: Elastic Bandages

- Keep the area to be wrapped clean and dry.
- Apply elastic bandages snugly enough to control bleeding and prevent movement of dressings. However, make sure that the body part is not wrapped too tightly, which can decrease circulation.
- Wrap the bandage evenly, in a figure eight pattern, so that no part of the wrapped area is pinched.
- Do not tie the bandage because this cuts off circulation to the body part; the end is held in place with special clips, tape, or Velcro.
- Remove the bandage as often as indicated in the care plan.
- Check the bandage often because it can become loose, which causes it to lose effectiveness, or it can become bunched up, which causes pressure and possible discomfort.
- Check on the client 10–15 minutes after the bandage is first applied to see if there are any signs of poor circulation. Signs and symptoms of poor circulation include the following:
  - Swelling
  - Pale, gray, cyanotic (bluish), or white skin

- Shiny, tight skin
- Cold skin
- Sores
- Numbness
- Tingling
- Pain or discomfort

G Loosen the bandage if you note any signs of poor circulation and call your supervisor immediately.

Chapter Review

1. List four vital signs that must be monitored.
2. What are the sites for measuring the body's temperature?
3. Which temperature site is considered to be the most accurate?
4. What is the most common site for monitoring the pulse?
5. Where is the apical pulse located?
6. Why should respirations be counted immediately after measuring the pulse rate?
7. List and define the two phases of measuring blood pressure.
8. List seven measures to reduce pain.
9. Why must HHAs report any weight loss or gain that a client has?
10. List the types of specimens HHAs may be asked to collect.
11. When is the best time of day to collect a sputum specimen?
12. What is a clean-catch urine specimen?
13. Define fluid balance.
14. How many milliliters (mL) are equal to one ounce (oz)?
15. A home health aide serves Mrs. Wyant a glass of milk. The HHA knows the glass holds 180 milliliters (mL). Mrs. Wyant finishes most, but not all, of the milk. The HHA measures the leftover milk, and it is ¼ cup. How many milliliters of milk are left?
16. Ms. Cahill drinks tea in the morning. Her mug holds 10 ounces, and 3 ounces are left in the mug. What was her input in milliliters (mL)?
17. Why must an HHA document emesis (vomitus)?
18. Why should the catheter drainage bag always be kept lower than the hips or the bladder?
19. Why should catheter tubing be kept as straight as possible?
20. What are the benefits of warm applications? What are the benefits of cold applications?
21. When are nonsterile dressings usually used?
22. When should elastic stockings be applied?
23. How often should an ostomy pouch be emptied?
24. List six signs of poor circulation that an HHA should look for when an elastic bandage is applied.

15 Medications and Technology in Home Care

1. List four guidelines for safe and proper use of medications

People who need home care often need medications. Clients who have problems such as coronary artery disease, high blood pressure, and diabetes may take many drugs, all with different purposes and effects. Home health aides do not usually handle or give medications. However, HHAs need to understand the kinds of medicine clients may be taking. They also need to know what to do if a client experiences side effects or refuses to take medication.

Guidelines: Safe and Proper Use of Medications

- Never handle or give medications unless you are specifically trained and assigned to do so. Do not touch the inside of a medicine bottle or the pills or medicines themselves. Do not put any medication into a client's mouth. Handling or giving medication can have serious consequences. Only people who have had special training are allowed to give medications.
- Observe clients taking their medication. Although you cannot handle or give medication, you can remind clients to take their medications. You can also bring medication containers to clients, and provide water or food as needed to take with the medication. Always observe, report, and document as appropriate.
- Know the difference between prescription and nonprescription (over-the-counter, or OTC) medication. Antibiotics (such as penicillin), heart medication (such as nitroglycerin), and potent pain medication (such as codeine) are examples of prescription drugs. Aspirin or cold medications, such as decongestants, are over-the-counter drugs (Fig. 15-1).

Fig. 15-1. *Be aware of all medications a client is taking. Know the difference between prescription and over-the-counter medications.*

- Be aware of all medications a client is taking. There are many possible side effects and interactions among medications. Watch for symptoms such as itching, trembling or shaking, anxiety, stomachache, diarrhea, confusion, vomiting, rash, hives, or headache. Any of these symptoms could indicate a side effect or interaction. Report any of these symptoms to your supervisor.

2. Identify the "rights" of medications

Knowing the five basic "rights" of medications will help prevent mistakes.

1. **The Right Client**: Always check the label on the medication container to make sure the client's name is on it.
2. **The Right Medication**: Check the expiration date and the name of the medication before giving the container to the client. Make sure the medication name on the container matches the name listed in the care plan.
3. **The Right Time**: Make sure the instructions on the medication label about what time or how often to take the medication match the instructions in the care plan.
4. **The Right Route**: Check the label for instructions on how the medication is to be taken. Make sure the instructions on the label match those in the care plan.
5. **The Right Amount**: Make sure the instructions on the container label for how much medication to take match the instructions in the care plan.

An HHA should call her supervisor if the medication label and the care plan do not agree on any of the five rights. She should also call her supervisor if there is not enough information on the label or in the care plan, or if there is another problem with the medication (for example, the client's name is not on the container).

Some rights have been added to this list in recent years in an effort to reduce medication errors. They include things like the *right documentation, right reason, right response, right to refuse,* and *right equipment.* Not all agencies use this longer list, so HHAs should follow agency policy.

Dosages

Prescription medication comes from the pharmacy with the instructions printed on the label (Fig. 15-2). The information listed on the label includes the name of the medication, dosage instructions, how the medication should be taken, the quantity of medication included, the amount of refills allowed, the medication's expiration date, and any specific warnings. The patient's name and the pharmacy's name and contact information are also included.

When assisting a client to self-administer medication, the HHA should read the directions on the bottle before handing the bottle to the client. Dosage means how much medication should be taken each time (the right amount). A capsule, tablet, or pill will be ordered with both the strength of one pill and how many are to be taken each time. For example, the bottle may read *Zolpidem 10 mg tablets, take one tablet by mouth at bedtime as needed.*

The label will state how the medication should be taken (the right time and route). For example, the zolpidem should be taken by mouth at bedtime. Sometimes the prescription states to *Take as needed.* This means the client is not required to take the drug; the drug should be taken when the client has symptoms. The zolpidem is to be taken as needed for sleep. However, medications that are ordered as needed will have a maximum daily dose/limit stated on the label.

Liquid oral medications may be ordered in teaspoons, tablespoons, or milliliters. The HHA should provide the client an oral syringe or medication dosing cup—not a spoon used at the table (and ideally not a measuring spoon used for cooking either)—to measure the dose. Medications which are to be put into the eyes or ears will be labeled with the number of drops per dose. A nasal spray label will state how many sprays are in one dose. Medications for inhalers may be pre-measured into dose-sized packages.

The HHA should learn the abbreviations that are approved by his agency, and he should always call his supervisor if he has a concern or question.

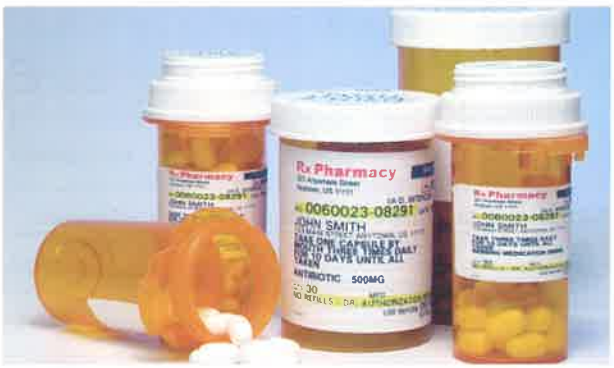
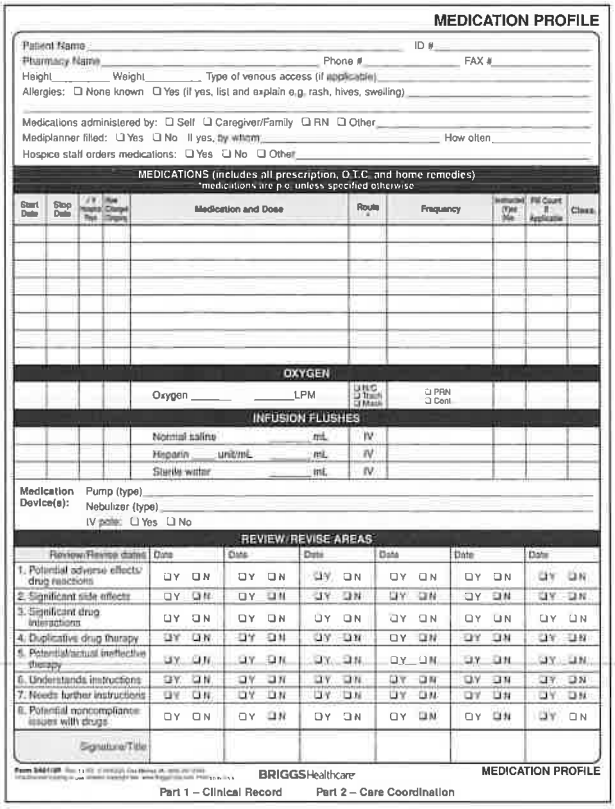


Fig. 15-2. *Medications come with instructions from the pharmacist. Instructions include the dosage and when and how to take the medication.*

3. Explain how to assist a client with self-administered medications

Some elderly people have a hard time remembering to take all their medications. In addition, there may be instructions to remember. Examples of instructions include taking pills with food or on an empty stomach, or drinking plenty of fluids. HHAs must pay close attention to the medication schedule. The nurse usually sets this schedule. HHAs should become familiar with all doctors' instructions on how and when to take medications and should use forms as ordered (Fig. 15-3). If the specified time for a dose passes, an HHA should remind the client to take the medicine. If a client does not take a medication that has been ordered, it should be reported to the supervisor.



MEDICATION PROFILE

Patient Name _____ ID # _____

Pharmacy Name _____ Phone # _____ FAX # _____

Height _____ Weight _____ Type of venous access (if applicable) _____

Allergies: ☐ None known ☐ Yes (if yes, list and explain e.g. rash, hives, swelling) _____

Medications administered by: ☐ Self ☐ Caregiver/Family ☐ RN ☐ Other _____

MediPlanner filled: ☐ Yes ☐ No If yes, by whom _____ How often _____

Hospice staff orders medications: ☐ Yes ☐ No ☐ Other _____

MEDICATIONS (includes all prescription, O.T.C. and home remedies)
*medications are p.o. unless specified otherwise

Start Date	Stop Date	✓ if Hospice Rx	Rx Changed (Origin)	Medication and Dose	Route *	Frequency	Instructed (Yes / No)	Pill Count if Applicable	Class

OXYGEN

				Oxygen _____ _____LPM	☐ NC ☐ Trach ☐ Mask	☐ PRN ☐ Cont			

INFUSION FLUSHES

				Normal saline _____mL	IV				
				Heparin ____unit/mL _____mL	IV				
				Sterile water _____mL	IV				

Medication Device(s): Pump (type) _____
Nebulizer (type) _____
IV pole: ☐ Yes ☐ No

REVIEW/REVISE AREAS

Review/Revise dates	Date	Date	Date	Date	Date	Date
1. Potential adverse effects/ drug reactions	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
2. Significant side effects	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
3. Significant drug interactions	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
4. Duplicative drug therapy	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
5. Potential/actual ineffective therapy	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
6. Understands instructions	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
7. Needs further instructions	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
8. Potential noncompliance issues with drugs	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Signature/Title						

BRIGGS Healthcare MEDICATION PROFILE
Part 1 – Clinical Record Part 2 – Care Coordination

Fig. 15-3. *Many home health agencies use medication forms to help the client or aide document the client's self-medication.* (REPRINTED WITH PERMISSION OF BRIGGS HEALTHCARE®, BRIGGSHEALTHCARE.COM, 800-247-2343)

If specified, HHAs may be instructed to help a client with self-medication in these ways:

- Remind the client when it is time for medication.
- Check for the right person, medication, time, expiration date, route, and amount.
- Read the medication label for the client.
- Identify the container and bring the bottle or container of medication to the client.
- Bring the client equipment needed to prepare and self-administer medication.
- Provide food or water to take with the medication as directed.
- Shake liquid medications if ordered by the care plan.
- Open and close containers.
- Position the client for taking the medication.
- Observe the client taking the medication.
- Document that the client took the medication, the time, and any other medications or food taken at the same time.
- Report any possible reactions to the supervisor. Call the supervisor if there are any problems or questions.
- Clean and store or properly dispose of special medication equipment after use.
- Return the medication to storage.

Home health aides are NOT allowed to do any of the following:

- Break apart or crush capsules or tablets.
- Mix medication with food or drink.
- Pour or mix medication from one bottle into another, even if both contain the same medicine.
- Touch medication directly with their hands.
- Assist with self-administration of medication if the client's name is different from that on the label.

- Assist with medication whose label has been removed or changed.
- Assist with medicine if the medication name does not match the name in the care plan.
- Use appearance alone to identify a medication.
- Assist the client in taking more or less of a medication than is ordered.
- Remove or change a medication label.
- Assist the client with medicine at a time when it is not ordered.
- Provide the wrong liquid for swallowing medications.
- Put medication into the client's mouth.
- Draw up a solution for injections.
- Give the client an injection.
- Dispose of used injection needles/syringes.
- Insert suppositories or other medication into the rectum.
- Insert or apply vaginal medication.
- Do special cleaning of the client's eyelids or eyelashes to prepare for eye medications.
- Put drops into the eye, ear, or nose.
- Apply prescription medications to the skin.

Some clients have reactions to certain medications, and some medications may interact with others, causing problems. To avoid these problems, all medication that is taken must be documented. The HHA should report drugs, prescription or nonprescription, that the client takes that are not part of the care plan. Even a pill as common as aspirin should be noted. Reporting and documenting any reactions the client may have to medications is important.

Avoiding certain foods or substances can be important when taking certain medications. For example, drugs that have sedative or calming effects should never be mixed with alcohol. If the client does not follow these restrictions, the HHA must notify her supervisor immediately. The doctor and pharmacist will inform the client and the family of any possible side effects from the medication. Common side effects include dizziness, drowsiness, headache, nausea and vomiting, and confusion. More serious side effects occur when there is an allergic reaction to the medication. Allergic reactions with symptoms like hives, fever, rash, or difficulty breathing can be life-threatening. They may require emergency help.

4. Identify observations about medications that should be reported right away

If a client shows signs of a reaction to a medication, or complains of side effects, the HHA must report it right away. Her supervisor can assess whether or not the symptom is caused by the medication. The HHA's responsibility is to report her observations.

Observing and Reporting: Medications

- O/R Dizziness or fainting
- O/R Nausea, vomiting, or diarrhea
- O/R Rash, hives, or itching
- O/R Difficulty breathing or swelling of the throat or eyes
- O/R Drowsiness
- O/R Headache or blurred vision
- O/R Abdominal pain
- O/R Any other unusual sign

In addition, report any of the following problems immediately:

- O/R Client refuses to take the medication as directed.
- O/R Client takes the wrong dose (amount) of medication.
- O/R Client takes the medication at the wrong time.
- O/R Client takes the wrong medication.
- O/R A medication container is missing or empty.

5. Describe what to do in an emergency involving medications

If a client has a severe allergic reaction to a medication, takes the wrong dose, or takes medications together that cause complications, emergency medical treatment is necessary. An overdose, whether it is accidental or intentional, must be treated as poisoning. The HHA must call the local poison control center immediately and should follow their instructions (aapcc.org). Poison control will send paramedics if needed.

For severe drug reactions or interactions, the HHA should call 911 for emergency help. She should stay with the client and not give any liquids, food, or other medications unless instructed to do so by emergency personnel. The supervisor should be notified as soon as possible.

6. Identify methods of medication storage

When assisting with the proper storage of medications, the HHA should follow these guidelines:

Guidelines: Proper Storage of Medications

- Keep the client's medications in one place, separate from medicine used by other members of the household.
- If there are young children or a disoriented elderly person in the home, recommend to the family that medications be locked away.
- All medications should be kept in childproof containers if children are in the home. To avoid an accidental overdose, keep medications out of reach of children.
- If medicine requires refrigeration, store the bottle toward the back on an upper shelf, out of a child's reach (Fig. 15-4).
- Store all medications away from heat and light.
- The client or a family member should discard medications that have expired, are not labeled, or are discolored. Medications should not be discarded in the trash; children or animals may have access to them. Ask your supervisor for specific disposal instructions if the client or family will not dispose of expired medications. Do not dispose of them yourself.

Fig. 15-4. *Store medication properly. Keep medications out of the reach of children.*

7. Identify signs of drug misuse and abuse and know how to report these

Drug misuse and abuse may be accidental or deliberate. It includes the following:

- Refusing to take medications
- Taking the wrong dose or taking it at the wrong time
- Mixing medication with alcohol
- Taking drugs that have not been prescribed
- Taking illegal drugs
- Sharing drugs with others

Misuse and abuse of drugs is extremely dangerous. It can even be fatal.

If a client refuses to take certain medications, an HHA can explain that recovery often depends on taking the right medication. If the client still refuses, the HHA should notify his supervisor. The HHA should not push the client to take the medication, but he can try to find out what is making the client reluctant to take it. Getting the client to express concerns may help the

HHA give information to the care team. A doctor or nurse can then either persuade the client to take the medication or adjust the treatment.

People may avoid taking prescribed medication because they cannot afford it or because they have difficulty obtaining it. Sometimes the client is confused about which drugs to take, at what hour, and in what quantities. Home health aides can help. If the client wants to know why he needs to be taking certain medications, an HHA can ask the nurse or doctor to provide an explanation. People who have conditions that affect mental function, such as dementia, will greatly benefit from friendly reminders. Other reasons people do not take medication are that they dislike the side effects and they have difficulty swallowing pills. These problems can be overcome once the supervisor is aware of them. HHAs should be alert to the signs of misuse or abuse and report them immediately.

Observing and Reporting: Drug Misuse and Abuse

- O/R Depression
- O/R Anorexia
- O/R Change in sleep patterns
- O/R Withdrawn behavior or moodiness
- O/R Secrecy
- O/R Verbal abusiveness
- O/R Poor relationships with family members

The drugs that pose the highest risk for causing drug dependency are pain medications, tranquilizers, muscle relaxers, and sleeping pills. Chapter 18 contains more information about opioid painkillers and dependency.

8. Demonstrate an understanding of oxygen equipment

Oxygen therapy is the administration of oxygen to increase the supply of oxygen to the lungs. This increases the availability of oxygen to the body tissues. Oxygen therapy is used to treat breathing difficulties and is prescribed by a doctor. Home health aides should never stop, adjust, or administer oxygen for a client.

Oxygen will be delivered to the home in cylinders or tanks or produced by an oxygen concentrator. Compressed oxygen and liquid oxygen are stored in tanks of varying sizes (Fig. 15-5). An oxygen concentrator produces and distributes oxygen, but does not store oxygen. The agency that supplies the oxygen will service the equipment and provide training on its use.

Fig. 15-5. *This is one type of oxygen tank.*

Some clients receive oxygen through a **nasal cannula** (*KAN-ye-la*). A nasal cannula is a piece of plastic tubing that fits around the face and is secured by a strap that goes over the ears and around the back of the head. The face piece has two short prongs made of tubing. These prongs fit inside the nose, and oxygen is delivered through them (Fig. 15-6). A respiratory therapist fits the cannula. The length of the prongs (usually no more than half an inch) is adjusted for the client's comfort. The client can talk and eat while wearing the cannula.

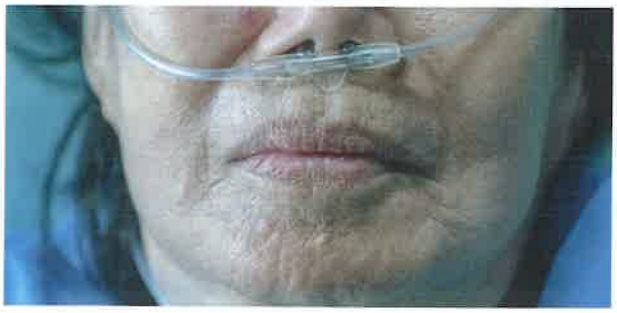


Fig. 15-6. *A nasal cannula.*

An **oxygen concentrator** is a box-like device that changes air in the room into air with more oxygen. Oxygen concentrators are quiet machines. They can be larger units or portable ones that can move or travel with the client (Fig. 15-7). They have at least one filter that typically needs to be cleaned once per week. Oxygen concentrators run on electricity. They are plugged into wall outlets and are turned on and off by a switch. It may take a few minutes for the oxygen concentrator to reach full power after it is turned on. Clients who use oxygen concentrators will often have a backup oxygen tank available in case of a power outage.

Fig. 15-7. *These are a type of oxygen concentrator.*
(PHOTOS COURTESY OF PHILIPS, WWW.USA.PHILIPS.COM, 1-800-744-5477)

Clients who do not need concentrated oxygen all the time may use a face mask when they need oxygen. The face mask fits over the nose and mouth. It is secured by a strap that goes over the ears and around the back of the head. Plastic tubing connects the mask to the oxygen source. The mask should be checked to see that it fits snugly on the client's face, but it should not pinch the face. It is difficult for a client to talk when wearing an oxygen face mask. The mask must be removed for the client to eat or drink anything.

Oxygen is a very dangerous fire hazard because it makes other things burn (supports combustion). **Combustion** (*kom-BUS-chuhn*) means the process of burning. Working around oxygen requires special safety precautions.

Guidelines: Working Safely around Oxygen

- Post *No Smoking* and *Oxygen in Use* signs. Never allow smoking in the room or area where oxygen is used or stored.
- Remove all fire hazards from the area. Fire hazards include electrical equipment, such as electric razors and hair dryers. Other fire hazards are cigarettes, matches, space heaters, and flammable liquids. **Flammable** means easily ignited and capable of burning quickly. Examples of flammable liquids are alcohol and nail polish remover. Read the labels on liquids if you are unsure. If they say *flammable*, remove them from the area. Notify your supervisor if a fire hazard is present and the client does not want it removed.
- Do not burn candles, light matches, or use lighters around oxygen. Any type of open flame near oxygen is a dangerous fire hazard.
- Do not use oxygen near wood-burning or gas stoves, gas space heaters, or fireplaces.
- Do not use an extension cord with an oxygen concentrator.
- Do not place electrical cords or oxygen tubing under rugs or furniture.
- Avoid using fabrics such as nylon and wool that can cause static electricity discharges.
- Oxygen can be irritating to the nose and mouth. The strap of the nasal cannula or face mask can also cause irritation around the ears. Check the nasal area and behind the ears for signs of irritation. Report and document any irritation you observe.
- Do not use any petroleum-based products, such as Vaseline or Chapstick, on the client or on any part of the cannula or mask. Oil-based lubricants can be a fire hazard.
- Learn how to turn oxygen off in case of fire. Never adjust the oxygen setting or dose.

In addition, follow these guidelines for oxygen tanks, liquid oxygen, and oxygen concentrators:

For clients using oxygen tanks:

- Count and record pulse and respirations before and after the client uses the oxygen tank to see if there are any changes.
- The flow meter shows how much oxygen is flowing out to the client at any time. It should be set at the amount stated in the care plan. If it is not, report this to your supervisor. Do not adjust the oxygen level.
- Make sure the humidifying bottle has distilled water in it and is attached correctly. Wash the humidifying bottle according to the care plan or equipment supplier's instructions.
- Change the nasal cannula when ordered. It will need to be changed when it is hard or cracked, at least once every two weeks. It should also be changed after the client has had a cold or the flu. Wash the plastic tubing once or twice per week with soap and water and rinse it well.
- Make sure the oxygen tank is secured and will not tip over.

For clients using liquid oxygen:

- Turn off supply valves when the reservoir is not in use.
- Do not tip the reservoir on its side.
- Make sure the reservoir is not in a closet, cupboard, or other closed-in space.
- Do not cover the reservoir with bed linens or clothing.
- When lifting the reservoir, lift with two hands. Do not roll the reservoir or walk it on its edge.
- Do not touch frosted parts of the equipment, because the cold can cause frostbite. Do not touch liquid oxygen; it can also cause frostbite. Report if the reservoir is leaking.

For clients using oxygen concentrators:

- Count and record pulse and respirations before and after client uses the oxygen concentrator to see if there are any changes.
- The oxygen concentrator dial must be set at the same rate as indicated in the care plan. If it is not, report this to your supervisor. Do not adjust the oxygen level.
- Check the humidifying bottle each time the device is used to see that it has distilled water in it and that it is screwed on tightly. Distilled water, not tap water, must be used because minerals in tap water may clog the tubing.
- Make sure the concentrator is in a well-ventilated area, at least six inches from a wall.
- Because the air filter cleans the air going into the machine, brush it off daily to remove dust.

Humidifier

A humidifier is a device that puts moisture into the air. Clients who use oxygen equipment or who have breathing problems may use humidifiers. Making the air moist or humid can make clients more comfortable.

There are different types of humidifiers; some humidifiers put warm moisture into the air and some put cool moisture into the air.

For cleaning and care of a humidifier, the HHA should follow the manufacturer's instructions. Because pathogens grow in moist areas, the water tank of the humidifier should be washed often. Other HHA responsibilities may include adding water to the humidifier when needed, and possibly adding special tablets to prevent mineral buildup.

9. Explain care guidelines for intravenous (IV) therapy

Intravenous (*in-tra-VEE-nus*) **therapy**, often called *IV therapy*, is the delivery of medication, nutrition, or fluids through a vein. When a doctor prescribes IV therapy, a nurse inserts a needle or tube into a vein. This allows direct access to the bloodstream. Medication, nutrition,

or fluids either drip from a bag suspended on a pole or are pumped by a portable pump through a tube and into the vein (Fig. 15-8). Some clients with chronic conditions may have a permanent opening for IV lines, called a *port*. This opening has been surgically created to allow easy access for IV fluids.

Fig. 15-8. *A client receiving intravenous medication.*

Home health aides never insert or remove IV lines. They are not responsible for care of the IV site. Their only responsibility for IV care is to report and document any observations of changes or problems with the IV line.

Observing and Reporting: IVs

Report any of the following to your supervisor:

- O/R The tube/needle falls out or is removed
- O/R The tubing disconnects
- O/R The dressing around the IV site is loose or not intact
- O/R Blood is in the tubing or around the site of the IV
- O/R The site is swollen or discolored
- O/R The bag is broken, or the level of fluid does not seem to decrease
- O/R The IV fluid is not dripping or is leaking
- O/R The IV fluid is nearly gone
- O/R The pump beeps, indicating a problem
- O/R The pump is dropped
- O/R The client complains of pain or has difficulty breathing

The home health aide should document his observations, any instructions received from his supervisor, and the care he provided. The HHA should not do any of the following when caring for a client who has an IV:

- Measure blood pressure on an arm with an IV line
- Get the IV site wet
- Pull or catch the tubing on anything, such as clothing (special gowns with sleeves that snap and unsnap are available to lessen the risk of pulling out IV lines)
- Leave the tubing kinked
- Lower the IV bag below the IV site
- Touch the clamp
- Disconnect the IV from the pump or turn off the alarm

Assisting in changing clothes for a client who has an IV

Equipment: clean clothes

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy if the client desires it.
4. Wash your hands.
5. If the bed is adjustable, adjust the bed to its lowest position. If the bed is movable, lock the bed wheels.
6. Assist the client to a sitting position, making sure her feet are flat on the floor. Adjust the bed height if needed (if possible). Let the client sit for a few minutes to adjust to the change in position.

7. Ask the client to remove the arm without the IV from clothing. Assist as necessary.
8. Help the client gather the clothing on the arm with the IV. Carefully lift the clothing over the IV site and move it up the tubing toward the IV bag (Fig. 15-9).

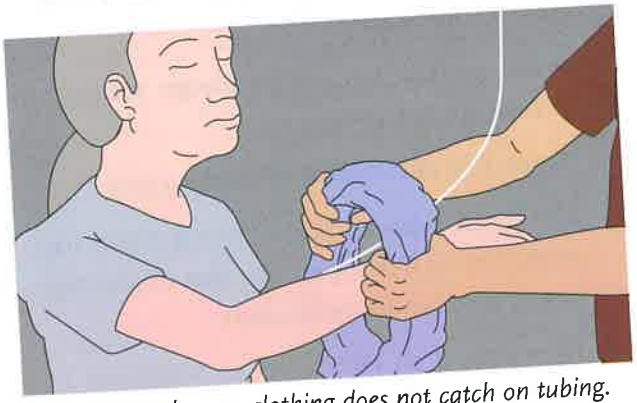


Fig. 15-9. *Make sure clothing does not catch on tubing.*

9. Lift the IV bag off its pole, keeping it higher than the IV site. Carefully slide the clothing over the bag. Place the bag back on the pole.
10. Set the used clothing aside to be placed with the soiled laundry.
11. Gather the sleeve of the clean clothing.
12. Lift the IV bag off its pole and, keeping it higher than the IV site, carefully slide the clothing over the bag (Fig. 15-10). Place the IV bag back on the pole.

Fig. 15-10. *Always keep the IV bag higher than the IV site.*

13. Carefully move the clean clothing down the IV tubing, over the IV site, and onto the client's arm.
14. Have the client put her other arm in the clothing. Assist as necessary.
15. Observe the IV for one minute to make sure that it is dripping properly (Fig. 15-11). If it is not dripping at all or if the drops are coming too slowly or too rapidly, notify the supervisor. Make sure none of the tubing is dislodged and the IV site dressing is in place. Make sure the tubing is not kinked.

Fig. 15-11. *Observe the IV to make sure it is dripping properly.*

16. Assist the client with changing the rest of her clothing as necessary.
17. Leave the bed in its lowest position. Place soiled clothes in the laundry hamper.
18. Wash your hands.
19. Document procedure and any observations.

Complementary or Alternative Health Practices

Many people use complementary or alternative health practices. **Complementary medicine** refers to treatments that are used in addition to conventional medical treatments prescribed by a doctor. **Alternative medicine** involves practices and treatments that are used instead of conventional methods. Clients may use any of the following:

- Chiropractic medicine concentrates on the spine and musculoskeletal system. Chiropractors believe that a misaligned spine can interfere with the body's proper function. Chiropractors do not use drugs or surgery; they use hands-on manipulations, also called adjustments, of the spine or other joints. They also teach exercises and provide nutrition and other health counseling.

  Heat, cold, and muscle stimulation are used to improve function. Chiropractors are frequently consulted for back, neck, and joint pain, as well as for headaches.

- Massage therapy manipulates soft body tissues with touch and pressure and is used to reduce stress, promote relaxation, aid circulation, and give relief from pain.

- Acupuncture is a very old Chinese healing technique. Very fine needles are inserted into specific points on the body in order to restore health, relieve pain, or treat other conditions.

- Homeopathy involves giving small doses of a substance to stimulate the body's ability to heal itself.

- Herbs and other dietary supplements may be taken for prevention as well as treatment of diseases or conditions. If an HHA knows that a client is taking herbs or supplements, she should report this to the supervisor because some can cause serious problems if taken with certain medications.

If clients are using complementary or alternative medicine, the HHA should not make judgments about treatment or discuss her opinions. She should not make recommendations about these methods or offer suggestions. If an HHA has concerns, she can talk to her supervisor.

Chapter Review

1. What are four guidelines for promoting safe and proper use of medications? Briefly describe why each guideline is important.
2. List five basic "rights" of medications and explain what they mean.
3. What does dosage tell a person about medication?
4. What should an HHA do if she notices any problem with a client's medication?
5. List 10 tasks an HHA may perform if she is instructed to help a client with self-medication.
6. List 18 tasks an HHA may NOT do with regard to medications.
7. What are four signs of an allergic reaction to a medication?
8. Name five side effects of medications.
9. List seven signs an HHA should report immediately to her supervisor that might indicate a reaction to medication.
10. How should an HHA treat an overdose? Whom should she call?
11. What is the best place to keep medications if there are young children in the home?
12. List five signs of drug abuse and misuse.
13. What are two common reasons people avoid taking prescribed medications?
14. What is a nasal cannula?
15. What is an oxygen concentrator?
16. Why is oxygen a dangerous fire hazard?
17. List two examples of fire hazards that must be removed from the area when oxygen is in use.
18. List two examples of flammable liquids.
19. What is a home health aide's only responsibility as far as IV therapy is concerned?
20. What is complementary medicine? What is alternative medicine?

16 Rehabilitation and Restorative Care

1. Discuss rehabilitation and restorative care

When a client loses some ability to function due to an illness or injury, rehabilitation may be ordered. **Rehabilitation** is care that is managed by professionals to help restore a person to her highest possible level of functioning. It involves helping clients move from illness, disability, and dependence, toward health, ability, and independence. Rehabilitation involves all parts of the person's disability, including physical needs (e.g., eating, elimination) and psychosocial needs (e.g., independence, self-esteem). Goals of a rehabilitative program include the following:

- To help a client regain function or recover from illness
- To develop and promote a client's independence
- To allow a client to feel in control of his life
- To help a client accept or adapt to the limitations of a disability

Rehabilitation will be used for many clients, particularly those who have suffered a stroke, accident, joint replacement, or trauma.

When the goals of rehabilitation have been met, **restorative care** may be ordered. The goal of restorative care is to keep the client at the level achieved by rehabilitative services. Restorative care works to maintain a client's functioning, to improve her quality of life, and to increase independence.

Both rehabilitation and restorative care use a holistic, person-centered approach. Because home health aides spend many hours with clients, they are a very important part of the team. They play a critical role in helping clients recover and regain independence.

Rehabilitation is one of the great joys of working as a caregiver. HHAs should enjoy seeing clients progress toward independence or recovery and take pride in their contributions to clients' improving health.

2. Explain the home care rehabilitation model

Home health aides who work with clients who need rehabilitation or restorative care will be working as part of a team (Fig. 16-1). Some different members of the team and their roles are listed below.

Fig. 16-1. *A team of specialists, including doctors, nurses, physical therapists, and other kinds of therapists, helps assist clients with rehabilitation.*

The physician and nurses will establish goals of care. These include promoting independence in activities of daily living (ADLs) and restoring health to optimal condition.

The physical therapist, occupational therapist, and/or speech-language pathologist will work with the client to help restore or adapt specific abilities (Fig. 16-2). Mental health professionals such as therapists, psychologists, or other counselors may see the client to help promote attitudes of independence and acceptance. The effects of the illness or injury cannot always be reversed. Mental health professionals help people adjust to trauma and loss.

Fig. 16-2. *A physical therapist will help restore specific abilities.*

The home health aide will be in the home, carrying out instructions of the other care team members. The HHA will assist in achieving the client's goals and will also observe and report the client's progress.

3. Describe guidelines for assisting with rehabilitation and restorative care

When assisting with rehabilitation and restorative care, these guidelines are critical to clients' progress:

Guidelines: Rehabilitation and Restorative Care

- Be patient. Progress may be slow, and it will seem slower to you and your clients if you are impatient. Clients must do as much as possible for themselves. Encourage independence and self-care, regardless of how long it takes or how poorly they are able to do it. The more patient you are, the easier it will be for them to regain abilities and confidence.
- Be positive and supportive. A positive attitude can set the tone for success. Family members and clients will take cues from you as to how they should behave. If you are encouraging and positive, you will help create a supportive atmosphere for rehabilitation (Fig. 16-3).

Fig. 16-3. *Being optimistic and encouraging can have a positive effect on clients and their progress.*

- Focus on small tasks and small accomplishments. For example, dressing themselves may seem like an overwhelming task to some clients. Break the task down into smaller steps. Today the goal might be putting on a shirt without buttoning it. Next week the goal could be buttoning the shirt if that seems manageable. When the client is able to put the shirt on without assistance, congratulate him on reaching this goal. Take everything one step at a time.
- Recognize that setbacks occur. Progress occurs at different rates. Sometimes a client can do something one day that he cannot do the next. Reassure clients that setbacks are normal. Focus on the things that the client can do and not on what he cannot do. However, document any decline in a client's abilities.
- Be sensitive to the client's needs. Some clients may need more encouragement than others. Some may feel embarrassed by

certain kinds of encouragement. Get to know your clients and understand what motivates them. This is part of providing person-centered care. Adapt your encouragement to fit a client's personality.

- G Encourage independence. A client's independence may help his ability to be active in the process of rehabilitation. Independence improves self-image and attitude. It also helps speed recovery.
- G Provide privacy when clients are attempting to do skills or activities of daily living. Doing this promotes dignity and maintains clients' legal rights.
- G Involve clients in their care. Clients who feel involved and valued may be more motivated to work hard in rehabilitation. Fears may be eased by including family and friends in the rehabilitation program. A team approach is inspiring.

Observing and Reporting: Restorative Care

- O/R Any increase or decrease in abilities (for example, "Yesterday Mr. Schiff used the bedside commode without assistance. Today he asked for the bedpan.")
- O/R Any change in attitude or motivation, positive or negative
- O/R Any change in general health, such as changes in skin condition, appetite, energy level, or general appearance
- O/R Signs of depression or mood changes

4. Describe how to assist with range of motion exercises

Exercise is important for improving and maintaining physical and mental health. Inactivity and immobility can result in loss of self-esteem, depression, pneumonia, urinary tract infection, constipation, blood clots, and dulling of the senses. People who are in bed for long periods of time are more likely to develop contractures (*kon-TRAK-churs*) or muscle atrophy. A **contracture** is the permanent and often painful shortening of a muscle, tendon, or ligament. It is generally caused by immobility. Contractures can result in the loss of ability. When **atrophy** occurs, the muscle wastes away, decreases in size, and becomes weak.

Range of motion (**ROM**) exercises put a particular joint through its full arc of motion. The goals of range of motion exercises are to decrease or prevent contractures or atrophy, improve strength, and increase circulation. **Active range of motion** (**AROM**) exercises are performed by a client himself, without help. The HHA's role in AROM exercises is to encourage the client. **Active assisted range of motion** (**AAROM**) exercises are performed by the client with some assistance and support from the home health aide or other caregiver. **Passive range of motion** (**PROM**) exercises are used when clients are not able to move on their own. PROM exercises are performed by caregivers, without the client's help. When assisting with PROM exercises, the HHA should support the client's joints while moving them through the range of motion.

Range of motion exercises are specific for each body area. They include the following movements (Fig. 16-4):

- **Abduction**: moving a body part away from the midline of the body
- **Adduction**: moving a body part toward the midline of the body
- **Extension**: straightening a body part
- **Flexion**: bending a body part
- **Dorsiflexion**: bending backward
- **Rotation**: turning a joint
- **Pronation**: turning downward
- **Supination**: turning upward
- **Opposition**: touching the thumb to any other finger

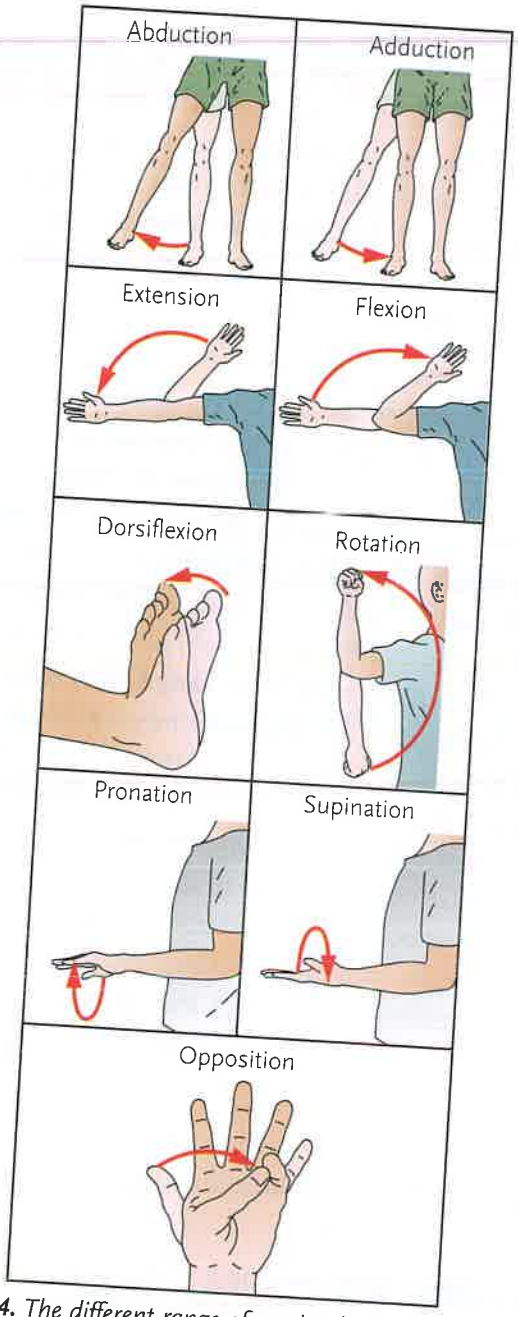


Fig. 16-4. *The different range of motion body movements.*

Range of motion exercises are not performed without a specific order from a doctor, nurse, or physical therapist. The HHA will repeat each exercise three to five times, once or twice a day, working on both sides of the body. When performing ROM exercises, the HHA should begin at the client's shoulders and work down the body. The upper extremities (arms) should be exercised before the lower extremities (legs). The HHA should give support above and below the joint. The joints should be moved gently, slowly, and smoothly through the range of motion to the point of resistance. The HHA should ask the client to let her know if the client experiences pain and should watch for nonverbal signs that the client is in pain. The HHA should also ask if the exercises are causing pain during the procedure. The HHA should stop the exercises if the client complains of pain and report the pain to the supervisor.

Assisting with passive range of motion exercises

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy if the client desires it.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Position the client lying supine—flat on her back—on the bed. Use proper alignment. Ask the client to let you know if she has any pain during the procedure.
6. While supporting the limbs, move all joints gently, slowly, and smoothly through the range of motion to the point of resistance. Repeat each exercise at least three times. Ask the client if an exercise is causing pain. Watch for signs of pain and stop performing the exercises if the client appears to be in pain or reports pain. Report to your supervisor.
7. **Shoulder.** Support the client's arm at the elbow and wrist while performing ROM for the shoulder. Place one hand under the elbow and the other hand under the wrist. Raise the straightened arm from the side position upward toward the head to ear level and return the arm down to side of the body (extension/flexion) (Fig. 16-5).

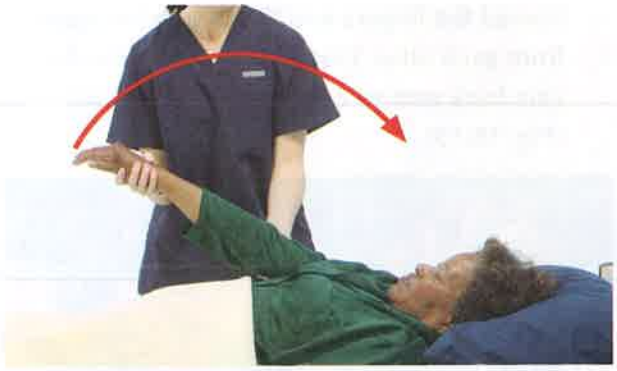


Fig. 16-5. *Raise the straightened arm upward toward the head to ear level, and return it to the side of the body.*

Keep one hand under the elbow and one under the wrist. Move the straightened arm away from the side of the body to the shoulder level and return the arm to the side of the body (abduction/adduction) (Fig. 16-6).

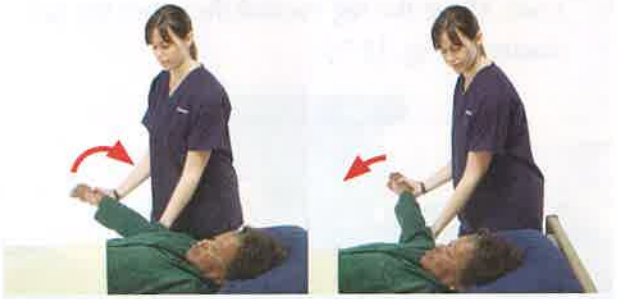


Fig. 16-6. *Move the straightened arm away from the side of the body to the shoulder level and return the arm to the side.*

8. **Elbow**. Hold the client's wrist with one hand and the elbow with the other hand. Bend the elbow so that the hand touches the shoulder on that same side (flexion). Straighten the arm (extension) (Fig. 16-7).

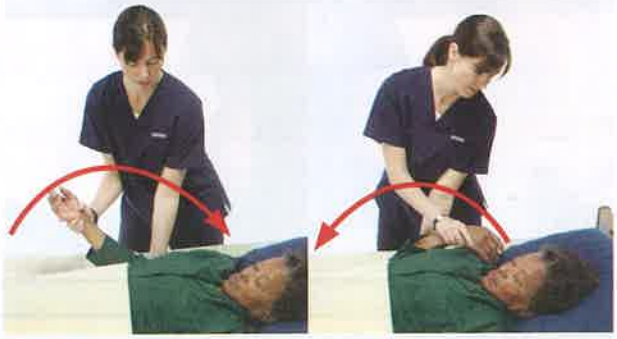


Fig. 16-7. *Bend the elbow so that the hand touches the shoulder on the same side, and then straighten the arm.*

Exercise the forearm by moving it so the palm is facing downward (pronation) and then the palm is facing upward (supination) (Fig. 16-8).

Fig. 16-8. *Exercise the forearm so that the palm is facing downward and then upward.*

9. **Wrist**. Hold the wrist with one hand and use the fingers of your other hand to move the joint through the motions. Bend the hand down (flexion). Bend the hand backward (dorsiflexion) (Fig. 16-9).

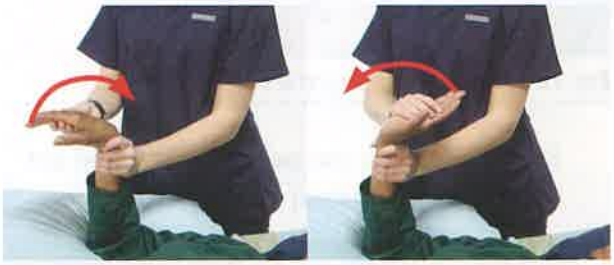


Fig. 16-9. *While supporting the wrist, gently bend the hand down and then backward.*

Turn the hand in the direction of the thumb (radial flexion). Then turn the hand in the direction of the little finger (ulnar flexion) (Fig. 16-10).

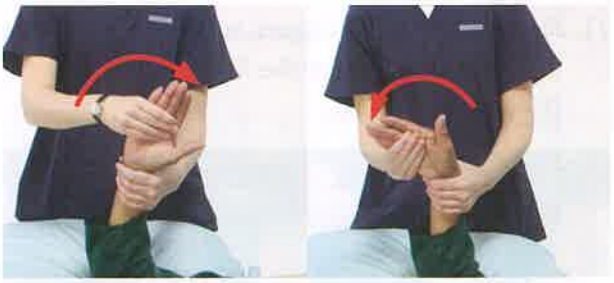


Fig. 16-10. *Turn the hand in the direction of the thumb, then turn it in the direction of the little finger.*

10. **Thumb**. Move the thumb away from the index finger (abduction). Move the thumb

back next to the index finger (adduction) (Fig. 16-11).

Fig. 16-11. *Move the thumb away from the index finger and then back to the index finger.*

Touch each fingertip with the thumb (opposition) (Fig. 16-12).

Fig. 16-12. *Touch each fingertip with the thumb.*

Bend thumb into the palm (flexion) and out to the side (extension) (Fig. 16-13).

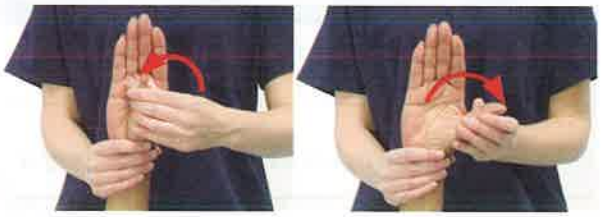


Fig. 16-13. *Bend the thumb into the palm and then out to the side.*

11. **Fingers**. Make the fingers into a fist (flexion). Gently straighten out the fist (extension) (Fig. 16-14).

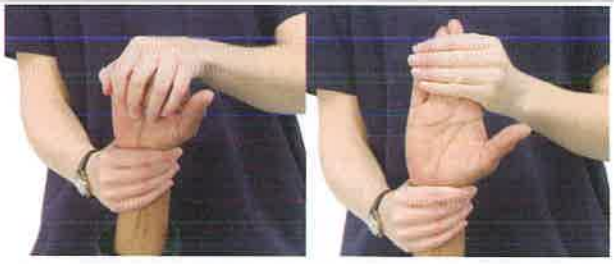


Fig. 16-14. *Make the fingers into a fist and then gently straighten out the fist.*

Spread the fingers and the thumb far apart from each other (abduction). Bring the fingers back next to each other (adduction) (Fig. 16-15).

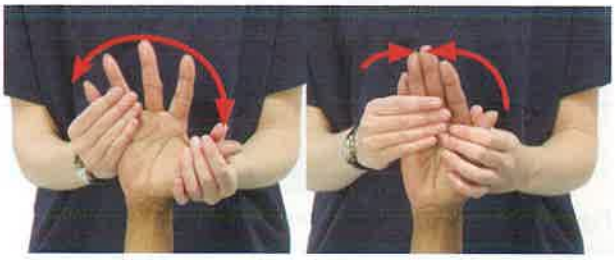


Fig. 16-15. *Spread the fingers and thumb far apart from each other and then bring them back next to each other.*

12. **Hip**. Support the leg by placing one hand under the knee and one under the ankle. Straighten the leg and gently raise it upward. Move the leg away from the other leg (abduction). Move the leg toward the other leg (adduction) (Fig. 16-16).

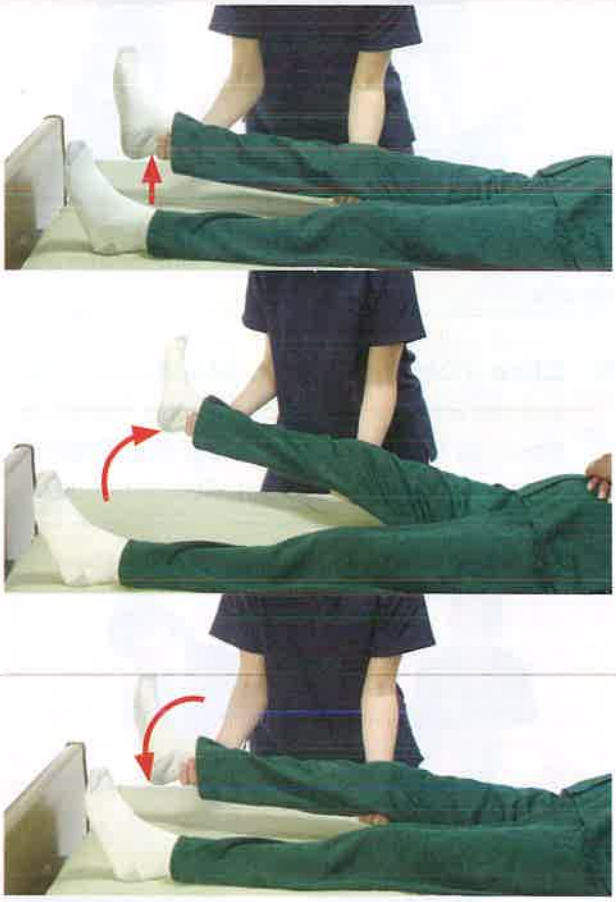


Fig. 16-16. *Straighten the leg and gently raise it. Move the leg away from the other leg and then back toward the other leg.*

Gently turn the leg inward (internal rotation), then turn the leg outward (external rotation) (Fig. 16-17).

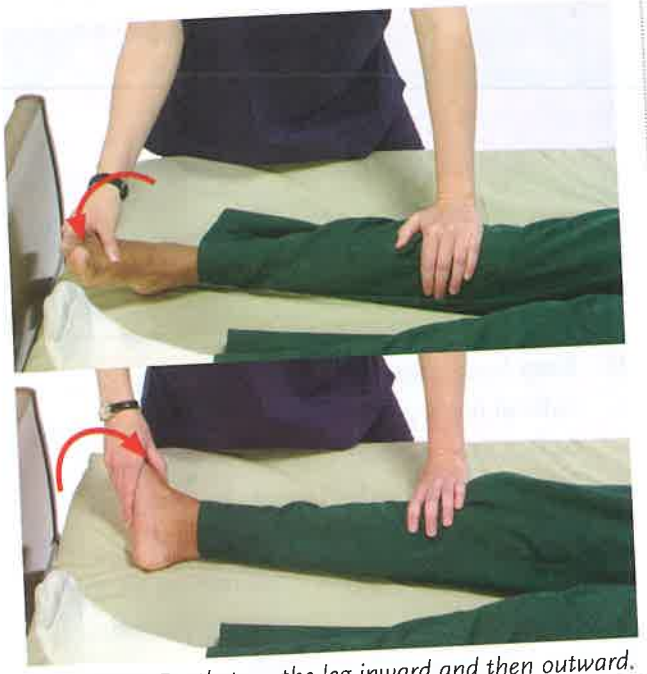


Fig. 16-17. *Gently turn the leg inward and then outward.*

13. **Knee**. Support the leg under the knee and under the ankle while performing ROM for the knee. Bend the knee to the point of resistance (flexion). Return the leg to the client's normal position (extension) (Fig. 16-18).

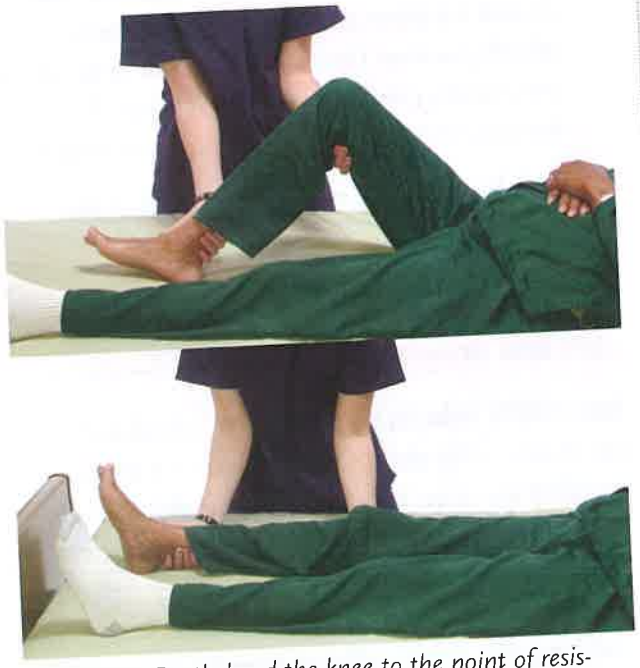


Fig. 16-18. *Gently bend the knee to the point of resistance and return the leg to its normal position.*

14. **Ankle**. Support the foot and under the ankle close to the bed while performing ROM for the ankle. Push/pull the foot up toward the head (dorsiflexion). Push/pull the foot down, with the toes pointed down (plantar flexion) (Fig. 16-19).

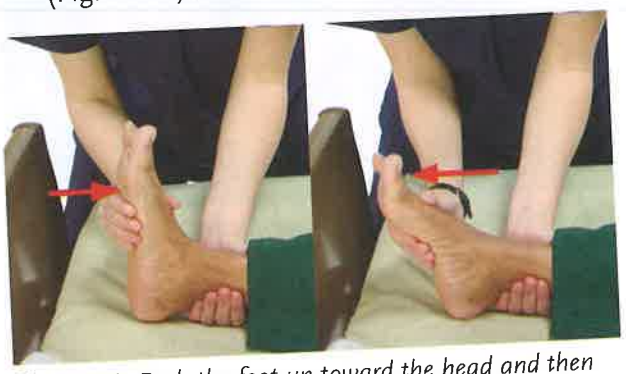


Fig. 16-19. *Push the foot up toward the head and then push it back down.*

Turn the inside of the foot inward toward the body (supination). Bend the sole of the foot so that it faces away from the body (pronation) (Fig. 16-20).

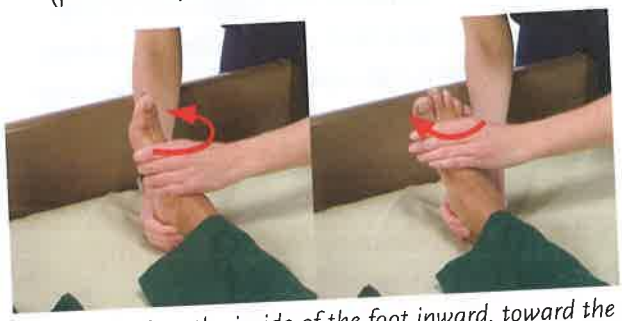


Fig. 16-20. *Turn the inside of the foot inward, toward the body, and then bend it to face away from the body.*

15. **Toes**. Curl and straighten the toes (flexion and extension) (Fig. 16-21).

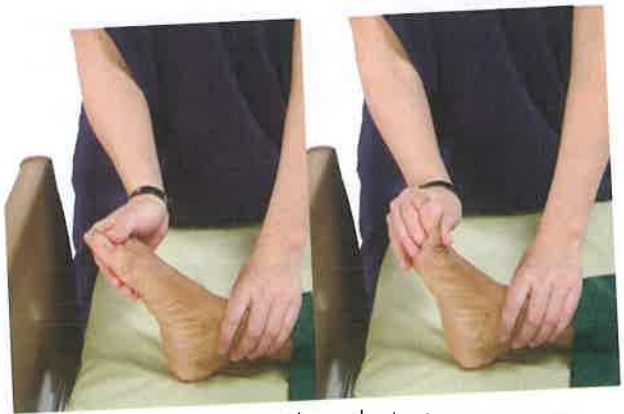


Fig. 16-21. *Curl and straighten the toes.*

Gently spread the toes apart (abduction) (Fig. 16-22).

Fig. 16-22. *Gently spread the toes apart.*

16. Return the client to a comfortable resting position and cover as appropriate. If you raised an adjustable bed, be sure to return it to its lowest position.
17. Wash your hands.
18. Document the procedure. Note any decrease in range of motion or any pain experienced by the client. Notify the supervisor or the physical therapist if you find increased stiffness or physical resistance. Resistance may be a sign that a contracture is developing.

5. Explain guidelines for maintaining proper body alignment

Clients who are confined to bed need to maintain proper body alignment. This promotes recovery and prevents injury to muscles and joints. Chapter 12 includes specific instructions for positioning clients. These guidelines help clients maintain proper alignment and make progress when they are able to get out of bed:

Guidelines: Alignment and Positioning

G Observe principles of body alignment. Remember that proper alignment is based on straight lines. The spine should lie in a straight line. Pillows or rolled or folded blankets can support the small of the back and raise the knees or head in the supine position. They can support the head and one leg in the lateral position (Fig. 16-23).

Fig. 16-23. *Pillows or rolled or folded blankets help provide extra support.*

G Keep body parts in natural positions. In a natural hand position, the fingers are slightly curled. Use a rolled washcloth, gauze bandage, or a rubber ball inside the palm to support the fingers in this position. Use bed cradles to keep covers from resting on the feet if the client is in the supine position.

G Prevent external rotation of hips. When legs and hips turn outward during long periods of bed rest, hip contractures can result. A rolled blanket or towel that is tucked alongside the hip and thigh can prevent the leg from turning outward.

G Change positions frequently to prevent muscle stiffness and pressure injuries. This should be done at least every two hours. Which position the client uses will depend on the client's condition and preference. Check the client's skin every time you reposition her.

G Give backrubs as ordered for comfort and relaxation.

6. List guidelines for providing basic skin care and preventing pressure injuries

Immobility reduces the amount of blood that circulates to the skin. Clients who have restricted mobility are at an increased risk for skin deterioration and pressure injuries. Breaks in the skin can cause serious, even life-threatening, complications. It is much better to prevent skin problems and keep the skin healthy than it is to treat skin problems after they happen. In addition to the

observing and reporting information located in Chapter 9, these guidelines are important for home health aides, as well as family caregivers, to follow.

Guidelines: Basic Skin Care

- Report changes you observe in a client's skin.
- Provide regular care for skin to keep it clean and dry. Check the skin daily, even when complete baths are not given or taken every day.
- Reposition immobile clients often (at least every two hours).
- Provide frequent and thorough skin care as often as needed for clients who are incontinent. Change clothing and linens often as well.
- Do not scratch or irritate the skin in any way. Keep rough, scratchy fabrics away from the client's skin. Report to your supervisor if a client wears shoes that cause blisters or sores.
- Avoid harsh soaps or laundry detergents. Report to your supervisor if your client has these products in the home.
- Massage the skin frequently, using light, circular strokes to increase circulation. Do not massage bony areas. Do not massage a white, red, or purple area or put any pressure on it. Massage the healthy skin and tissue around the area.
- Elderly clients may have very fragile, thin skin. This makes the skin more susceptible to injury. Be gentle during transfers. Avoid pulling or tearing fragile skin.
- Clients who are overweight may have poor circulation and extra folds of skin. The skin under the folds may be difficult to clean and to keep dry. Pay careful attention to these areas and give regular skin care. Report signs of skin irritation.
- Serve clients well-balanced meals. Proper nutrition is important for keeping skin healthy. Nutrition affects the color and texture of the skin. Very thin clients may be malnourished, which puts them at risk for skin injuries and poor wound healing. Be gentle when moving and positioning them. Chapter 22 contains information about nutrition.
- Keep plastic or rubber materials from coming into contact with the client's skin. These materials prevent air from circulating, which causes the skin to sweat.
- The care plan may include instructions on giving special skin care for dry, closed wounds or other conditions. The skin may have to be washed with a special soap, or a brush may have to be used on the skin. Follow the care plan and ask your supervisor if you have any questions.

For clients who are immobile or who cannot change positions easily:

- Keep the bottom bedsheet tight and free from wrinkles and the bed free from crumbs. Keep clothing or gowns free of wrinkles, too.
- Do not pull the client across sheets during transfers or repositioning. This causes shearing, which can lead to skin breakdown, as explained in Chapter 12.
- Place an absorbent bed pad under the back and buttocks to absorb moisture or perspiration that may build up. This also protects the skin from irritating bed linens. Absorbent pads are also available for wheelchairs.
- Relieve pressure under bony prominences. Use pillows and other positioning devices to keep elbows and heels from resting on the surface of the bed (Fig. 16-24).

Fig. 16-24. *This foam boot suspends the heel to help reduce pressure.* (© MEDLINE INDUSTRIES, INC. 2020)

- A bed or chair can be made softer with flotation cushions or special foam overlays.
- Use a bed cradle to keep top sheets from rubbing the client's skin. A bed cradle is made of metal or from a cardboard box (Chapter 12).
- Clients seated in chairs or wheelchairs need to be repositioned often, too. Reposition clients at least every hour if they are in a wheelchair or chair and cannot change positions easily.

7. Describe the guidelines for caring for clients who have fractures or casts

Fractures are broken bones caused by accidents or by osteoporosis. Osteoporosis causes brittle bones that crack or break easily. Osteoporosis occurs more frequently in elderly people, particularly women. It may be due to any one or a combination of the following: a lack of calcium in the diet, the loss of estrogen, a lack of regular exercise, reduced mobility, or age. Signs and symptoms of a fracture are pain, swelling, bruising, changes in skin color at the site, and limited movement.

When bones are fractured, the sections of broken bone must be placed back into alignment so the body can heal. The body can grow new bone tissue and fuse the sections of fractured bone together. The bone must be unable to move to allow this healing to occur. This is often, although not always, accomplished by the use of a cast.

Casts are generally made of fiberglass. A fiberglass cast is lightweight and dries quickly after it is made. A cast must be completely dry before a person can bear weight on it.

Guidelines: Caring for a Client Who Has a Cast

- Elevate the extremity that is in a cast (Fig. 16-25). This helps stop swelling. Use pillows to assist with elevation. If the client is in bed, elevate the arm or leg slightly above the level of the heart.

Fig. 16-25. *To stop swelling, elevate the extremity that is in a cast.*

- Observe the affected extremity for swelling, skin discoloration, cast tightness or pressure, sores, skin that feels hot or cold, pain, burning, numbness or tingling, drainage, bleeding, or odor. Compare to the extremity that does not have a cast. Report any of these signs or symptoms to a supervisor, along with any signs of infection, such as fever or chills.
- Protect the client's skin from the rough edges of the cast. The stocking that lines the inside of the cast can be pulled up and over the edges and secured with tape. Inform your supervisor if cast edges are irritating the client's skin.
- Keep the cast dry at all times. Although fiberglass is waterproof, the padding inside the cast is not. Some fiberglass casts may have a waterproof lining, but unless instructed otherwise, keep the cast dry. Keep the cast clean.
- Do not insert or allow the client to insert anything inside the cast, even when the skin itches. Pointed or blunt objects may injure the skin, which is already dry and fragile. Skin can become infected under the cast.
- Assist the client with cane, walker, or crutches as needed (Chapter 12).
- Use bed cradles as needed to reduce pressure from bed linens.