PART I

CLASSROOM TRAINING – 16 HOURS

(Theory and Classroom Lab)

NOTE: The trainee cannot provide any direct nursing services to residents until completion of Part I.

Unit I
Communication and Interpersonal Skills
(2 hours theory/ classroom lab)

OBJECTIVE	CONTENT
Discuss the role of the nursing assistant as a member of the health care team.	1. The Health Care Team 1.1 The nursing assistant is a member of The Health Care Team. 1.2 See diagram on cover.
List desirable attitudes and actions which will provide successful job performance for the nursing assistant.	2. Attitudes/Actions Which Lead to Successful Performance of a Nursing Assistant 2.1 Dependability: a. Reporting to work on time. b. Minimum absences. c. Keeping promises. d. Completing assigned tasks promptly and quietly. e. Performing tasks you know should be done without being told. 2.2 Accuracy in following instructions. 2.3 Sensitive to feelings and needs of others. 2.4 Personal appearance: a. Appropriate, neat, clean clothing.
List desirable personal grooming habits for the nursing assistant.	b. Comfortable, neat, clean shoes of an appropriate style. c. Personal hygiene. d. Name tag. e. Watch. f. Ink pen. 2.5 Personal health: a. Good nutrition. b. Adequate sleep and rest. c. Good emotional health. d. How to handle stress.
Define the goals of a long term care facility.	3. Goals 3.1 Goals of a long term care facility: a. Provide a safe environment. b. Maintain and promote health. c. Provide a satisfying social environment. 3.2 Goals of the nursing assistant: a. Learn to set daily goals consistent with the short and long term goals of

Unit I (contd.)

OBJECTIVE	CONTENT
	the Plan of Care. b. Learn to set short and long term personal, job and career goals.
	4. Communication
Define Communication.	4.1 Definition – The sending and receiving of messages.
Identify types of communication.	4.2 Types of communication: a. Nonverbal – Sending a message without words by – 1) Body position & gestures. 2) Facial expression. 3) Touch. 4) Tone of voice. b. Verbal – Sending a message through talking or writing.
List attitudes which promote communication.	4.3 Attitudes which promote communication: a. Courtesy. b. Keeping emotions under control. c. Empathy. 4.4 Behavior which enhances communication between the nursing assistant and the residents: a. Provide opportunity for resident to express thoughts and feelings – 1) Listen to resident's comments. 2) Allow enough time for communication. 3) Allow enough time for silent communication. b. Observe nonverbal behavior during interaction - 1) Body position. 2) Facial Expression. 3) Gestures. c. Listen carefully to expressed thoughts and feelings and to tone of voice. d. Encourage focus on resident concerns – 1) Don't criticize other staff. 2) Be responsive to resident's needs. 3) Self understanding on part of nursing assistant.

Unit I (contd.)

OBJECTIVE	CONTENT
	4.5 Communicating with resident's friends and family: a. Factors which promote good interpersonal relationships with resident's family and friends – 1) Kindness. 2) Patience. 3) Empathy. 4) Listening to family members. 5) Not interfering in private family business. b. Restrictions in information given to families – 1) One designated individual (usually the charge nurse) communicates such information as diagnosis, doctor's orders, medical status. 2) Maintain confidentiality in communicating with family.
Identify basic factors which may block communication between resident, family and staff.	c. Inappropriate behavior or communication between resident, family, and staff may be due to – 1) Family's feelings of guilt or grief at institutionalizing the resident. 2) Resident's feelings of anger, guilt at being institutionalized. 3) Concerns about money, pain, the future, separation from loved ones, etc. 4.6 Information the nursing assistant shall report to charge nurse: a. Information about a resident that could result in harm. b. Any change in resident's behavior or physical condition. 4.7 Using mechanical devices to promote communication:
Identify steps for answering resident's call signal.	a. Answering call signals – 1) Answer as soon as call light goes on. 2) Turn off call signal upon entering the resident's room.

Unit I (contd.)

OBJECTIVE	CONTENT
	3) When finished helping the resident, replace call signal where it can be reached (OLTC Regulation). b. Techniques for using phone or intercom – 1) Identify your area. 2) Identify yourself and your position. 3) Speak slowly and clearly. 4) When taking a message, write it down and who it is from.
List steps to communicate with the vision impaired resident.	4.8 Communicating and assisting the vision impaired resident: a. Identify yourself when approaching the resident and when you are leaving. b. Recognize the use of light touch on the arm or shoulder to get attention. c. Objects (furniture, personal items, etc.) are not to be moved or changed. d. Use descriptions when you talk about – 1) Color. 2) Size. 3) Texture. 4) Location. e. Serve as a sighted guide – 1) Offer resident your elbow. 2) Allow resident to hold your arm. 3) Tell resident when approaching steps/stairs. f. If assisting resident in seating is requested, place resident’s hand on seat of chair.
List steps communicating with the hearing impaired resident.	4.9 Communicating with the hearing impaired: a. Place yourself where the resident can see you and establish eye contact and move closer to the resident if necessary. b. Speak slowly.

Unit I (contd.)

OBJECTIVE	CONTENT
	c. Speak clearly using a moderately loud voice, avoid shouting. d. Sit or stand with the light above or toward you. e. Use body language as needed to emphasize your message. f. Be patient, friendly, kind, and do not patronize.
Describe techniques for communicating with the resident who cannot speak.	4.10 Communicating with the resident who cannot speak or has difficulty speaking: a. Agree upon meaning of signals to be used (i.e. one for yes, two for no) – 1) Eye blinking. 2) Hand squeezes. 3) Head nodding. b. Use communication flash cards/board. c. Verify resident’s communication. d. Share with other team members the methods used to communicate with the resident. 4.11 Communicating with a demanding/angry resident: a. Be courteous. b. Be in control of your emotions. c. Be tactful. d. Be a good listener. e. Be a careful, non-judgmental observer. 4.12 NEVER act or appear condescending to a resident: a. DO NOT “talk down”. b. DO NOT use “baby talk”. c. Address the resident by name. d. Treat the resident as an adult.
Define Confidentiality.	4.13 Respecting confidentiality in communication: a. Confidentiality means keeping residents personal information private.

Unit I (contd.)

OBJECTIVE	CONTENT
List examples of appropriate and inappropriate use of resident information.	b. DO NOT discuss personal information with – 1) Another resident. 2) Relatives of friends of the relative. 3) Representatives of the news media. 4) Fellow workers, except when in conference. 5) One’s own family or friends.

Unit II
Infection Prevention and Control
(2 hours theory/classroom lab)

OBJECTIVE	CONTENT
Identify reasons why infection prevention and control is important.	1. Infection Control 1.1 Practices which help reduce the number and hinder the transfer of disease producing microorganisms from one person to another, or from one place to another may be called infection control.
Identify practices which hinder the spread of infection.	1.2 Infection control practices are important because: a. Microorganisms are always present in the environment. b. Some of these microorganisms can cause disease (pathogens). c. Elderly people and individuals with chronic disease are often more susceptible to pathogens. d. Reducing the number of micro-organisms and hindering their transfer increases the safety of the environment.
Name conditions needed for microorganisms growth.	1.3 Conditions needed for growth of microorganisms: a. Nourishment. b. Moisture. c. Usually warm temperature. d. Usually air. e. Usually darkness.
List ways microorganisms spread.	1.4 Ways microorganisms spread: a. Direct contact with a person who carries it or has the infection. b. Indirect contact – Touching objects contaminated by a person with infection, taking in food or other substances which have been contaminated.
Name the single most important infection control practice. List infection control practices which hinder the spread of infection.	1.5 Practices which hinder the spread of infections: a. Infection control practices Washing your hand WASHING YOUR HANDS!!! Washing your hands is the single most important control practice. b. Cleaning the resident's unit.

Unit II (contd.)

OBJECTIVE	CONTENT
	c. Handling bed linen correctly. d. Disposing of contaminated articles correctly. e. Cleanliness of self and resident.
	2. Handwashing 2.1 Reasons for good handwashing: a. Everything you touch has germs on it. b. In your work you use your hands constantly. c. Our hands carry germs from resident to resident and from resident to you. Washing your hands will help prevent this transfer of germs. d. Handwashing is the first line of defense against spreading microorganisms.
Identify and demonstrate measures of handwashing.	2.2 Handwashing routine: (refer to procedure #9 in the Appendix) a. Wash your hands before and after contact with each resident (OLTC Regulation). b. Use soap dispenser rather than bar soap if available. c. Use enough soap to produce adequate lather. d. Vigorous rubbing over surface of hands helps remove microorganisms. e. Hold your hands lower than you elbows while washing. f. Rinse from the clean to dirty. Elbows (clean) to fingertips (dirty). g. Rinse your hands well after washing and dry thoroughly with paper towel. h. The water faucet is always considered contaminated. Use paper towels to turn faucet off.
	3. Universal Precautions for Blood and Body Fluids
List three objectives of universal precautions for blood and body fluids.	3.1 Objectives: a. To minimize contact with blood and body fluids of ALL residents treated by the facility. b. To minimize the likelihood of

Unit II (contd.)

OBJECTIVE	CONTENT
	transmission of specific blood borne organisms such as Hepatitis B and Human Immunodeficiency Virus (HIV). c. To help achieve a consistent application of infection control principle. 3.2 Universal Precautions:
List and describe universal precautions to be used when caring for a resident with potentially infectious conditions.	a. The blood and body fluids of all residents regardless of their diagnosis or isolation precaution status shall be considered POTENTIALLY INFECTIOUS. b. These universal precautions shall include but are not limited to the following procedures – 1) Hands should always be washed before and after contact with residents. Hands should be washed even when gloves have been used. If hands come in contact with blood, body fluids or human tissue, they should be immediately washed with soap and water. 2) Gloves should be worn when contact with blood, body fluid, tissues or contaminated surfaces are anticipated. Gloves shall be changed after each resident contact. Gloves should be readily available. 3) Mask eye protection and other protective clothing should be worn during procedures which are likely to generate splattering of body fluids. 4) To minimize the need for emergency mouth-to-mouth resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.

Unit II (contd.)

OBJECTIVE	CONTENT
	5) Blood spills, urine, feces and sputum shall be cleaned up promptly with a disinfectant solution. 6) All specimens should be put in a well constructed container with a secure lid to prevent leaking during transport. Contamination of the outside of the container shall be avoided during collection. 7) There are disease specific isolation precautions. The charge nurse will instruct the nursing assistant on them at the time of need.
State reasons for using isolation practices.	4. Isolation 4.1 Residents with certain types of infections may be separated from other residents to: a. Keep the germs that cause disease isolated in the resident's unit where they can be destroyed or specially handled. b. Protect persons outside the resident's room from contact with germs. 4.2 Terms associated with isolation: a. Contaminated – any article that is in contact with the resident in the isolation unit is considered contaminated (dirty with germs). b. Clean – means uncontaminated; refers to all articles and places that have not been contaminated by contact with pathogens. 4.3 Methods of isolation: a. There are diseases specific isolation methods and the charge nurse will give instructions to implement them.

Unit II (contd.)

OBJECTIVE	CONTENT
Identify and demonstrate measures of isolation: 1) Preparing the unit. 2) Isolation handwashing. 3) Gowning/gloving/masking.	4.4 Isolation techniques: (refer to procedure #45 in the Appendix) a. The following precautions <u>may</u> be used - 1) Preparing the unit – caution signs will be placed on the door of the isolation room as an alert (OLTC Regulation). Disposable dishes and utensils will be provided at meals. 2) Double bagging linen and trash before carrying out of room. 3) Gowns, gloves and/or masks will be worn: - Gowns are indicated if soiling of clothes is likely or to prevent cross contamination of clothing. 5) Special handwashing techniques.

Unit III
Safety and Emergency Procedures
(4 hours theory/classroom lab)

OBJECTIVE	CONTENT
Define body mechanics as it applies to the nursing assistant.	1. Employee Safety 1.1 Body Mechanics: a. Definition – Special way of standing and moving one's body. The term body mechanics is commonly used to describe the body movements by the staff when they move residents and/or objects.
Identify the purpose of good body mechanics.	b. Purpose – 1) To make the best use of strength and avoid fatigue. By using good body mechanics you can prevent injuries, e.g., back strain and/or torn ligaments/muscles. 2) Good body mechanics on the part of the nursing assistant decreases the chance of injury.
Identify and demonstrate rules of body mechanics.	c. General Rules – 1) Use as many large muscles or groups of large muscles as possible: -Use both hands rather than one hand to pick up a heavy object. -Use the large muscles in your legs when picking up a heavy object instead of smaller back muscles. -Squat down, bending your knees. Keep your back straight and raise up, using your leg muscles, NEVER bend over at the waist to lift heavy objects. 2) Always stand erect. Good posture is essential to good body mechanics. 3) When lifting, your feet should be approximately with the width of your shoulders, distance apart (at least 12 inches). This gives a broad base of support.

Unit III (contd.)

OBJECTIVE	CONTENT
	4) Be as close as possible to what you are lifting or moving. Don't reach and try to lift or move an object. 5) Use your arms to support the object. The muscles of the legs actually do the job of lifting NOT the muscles of your back. 6) When doing work, always work with the direction of your efforts not against them. Avoid twisting your body as much as possible. 7) If you think the object is too heavy to lift, then get help. Don't try to lift it alone. 8) Always move residents who cannot assist you by two people. It is easier on the resident physically and prevents you from being injured. 9) Lift smoothly to avoid strain. Always count "one, two, three" with the person you are working with. Work in unison. Do this with the resident. 10) When changing the direction of your movements: -pivot. -turn with short steps. -turn your whole body.
	2. Resident Safety
Identify reasons for safety precautions for the residents.	2.1 Reasons for safety precautions for the elderly; increased chance of accidents due to: a. Mental confusion. b. Impaired mobility. c. Diminished senses (sight, hearing, touch, taste, smell).
Identify the basic safety steps the nursing assistant must take to prevent falls.	2.2 Safety precautions the nursing assistant should take to help residents: a. Prevent falls – 1) Have bed rails up as needed and bed in lowest position.

Unit III (contd.)

OBJECTIVE	CONTENT
	2) Resident should wear shoes or slippers with non-skid soles. 3) Have shoelaces tied. 4) Avoid long gowns or robes which may trip resident. 5) Throw rugs should not be used. 6) All liquid spills should be wiped dry immediately. 7) Encourage use of handrails. 8) Canes and walkers should have good non-slip tips. 9) Use caution when skin and bath oils are used because it makes people and tubs slippery. 10) Assistance items such as shower chair and raised toilet seat may prevent falls for residents with limited mobility. 11) Resident should be instructed to ring the call bell for assistance rather than climbing over bed rails.
Identify the basic steps the nursing assistant must take to prevent burns.	b. Prevent burns – 1) Assist a confused person when he is given hot liquids to drink. 2) Bath water must be checked to insure it is a safe temperature before the resident gets in the tub. 3) Confused residents must be watched while in tub or shower so they don't turn on hot water, resulting in burns. 4) A confused person must be supervised when he smokes. 5) Any equipment which produces heat must be carefully watched when in use. Elderly people sometimes have decreased sensation and may not feel that the skin is being burned.

Unit III (contd.)

OBJECTIVE	CONTENT
Identify the basic safety steps the nursing assistant must take to prevent falls.	c. Prevent falls from bed, chairs, wheelchairs – 1) Restrain resident who is likely to fall from bed or chair (per physicians order or instruction from the charge nurse). 2) Keep bedrails up. 3) Lock wheels on bed or wheelchair. 4) When transporting resident in bed, geriatric chair or wheelchair "drive safely", slowly, approaching corners with caution with resident facing front. 5) Use transfer belt or hold resident securely when transferring between bed and chair.
Identify basic steps the nursing assistant must take to prevent choking.	d. Prevent choking – 1) Make sure that food is cut or chopped in small enough pieces for resident to swallow. 2) Monitor the portions of food put into the resident's mouth at one time. e. Prevent ingestions of harmful substances – Do not leave potentially poisonous or harmful substances at the bedside or places accessible to the residents (liquid soaps, skin medications).
Identify basic safety precautions for oxygen use.	2.3 Safety precautions for oxygen use: a. Precautions for oxygen safety should be posted outside the room where it is being used. b. Limit any situations which might start a fire because oxygen supports combustion. c. No smoking or open flame. d. Electrical equipment should be grounded. e. If an oxygen tank is used, it should be stabilized so it does not fall over.

Unit III (contd.)

OBJECTIVE	CONTENT
	3. Airway Obstruction
Name causes of airway obstruction.	3.1 Most frequent causes of airway obstruction: a. Elevated blood alcohol level. b. Upper and lower denture slippage. c. Large, unchewed pieces of food. d. Decreased swallowing ability due to weakness in throat muscles. e. Laughing and talking.
List symptoms of possible airway obstruction.	3.2 Partial obstruction: a. Resident is able to take in and exhale some air. b. Results in weak cough. c. Causes high pitched sound while inhaling. d. Increases respiratory difficulty and possible cyanosis. e. If the victim can speak, cough, or breathe, DO NOT INTERFERE.
List symptoms of complete obstruction.	3.3 Complete Obstruction: a. Resident is suddenly unable to speak, cough, or make any sounds. b. Action to aid choking resident (complete obstruction). Emergency care must be given quickly since brain damage may begin within four minutes. The emergency action described here is called the abdominal thrust (Red Cross)
Demonstrate the Heimlich Maneuver.	or Heimlich Maneuver – (refer to procedure #26 in the Appendix) 1) Victim standing or sitting: -If feasible, ask the resident if he/she is choking. -Be aware that the victim may walk or run away due to fear. -Remain calm, give continuous reassurance. Tell the resident you are there to help him/her. -Perform per procedure in Appendix. -When the resident is sitting, the rescuer stands behind the resident's chair and performs the maneuver in the same manner.

Unit III (contd.)

OBJECTIVE	CONTENT
	2) Victim lying down: -Place resident flat on back. -Facing resident, kneel astride hips. -With one of your hands on top of the other, place the heal of your bottom hand on the abdomen slightly above the navel and below the rib cage. -Press into the resident's abdomen with a quick upward thrust. -Repeat several times if necessary.

Unit IV
Promoting Independence/Respecting Resident's Rights
(3 hours theory/classroom lab)

OBJECTIVE	CONTENT
	1. Promoting Independence 1.1 Introduction: a. Everyone needs to feel control over their lives and environment. As people age, many find that their roles as workers and contributing family members diminish as physical capabilities and income declines. b. The best policy is to keep the elderly as an integral part of the community and help them maintain as much independence as possible in the face of increasing difficulty in performing daily activities.
Identify services that promote residents' independence.	1.2 Resident services: a. The highest level of resident participation should be encouraged. b. Encourage the resident to make their own choice and do things for themselves. c. Share the resident's care plan with the resident and family. Involving the resident in their own care stimulates a sense of responsibility. d. Be open to residents' suggestions, complaints and grievances. Comments from residents and their families should never be ignored. e. Resident councils provide an effective way for residents to meet for discussions and make recommendations regarding facility policies, programs, services and other issues. f. It is important to encourage a resident to attend activities. Activities expand horizons, challenge the mind, body and intellect; provide a way to fight loneliness and depression; encourage independence and individuality.

Unit IV (contd.)

OBJECTIVE	CONTENT
	g. Report personal dietary preferences of the resident to the charge nurse or dietary manager. With deteriorating sense of smell due to aging effects, presentation of food becomes especially important. h. Promote the resident's level of independence in managing Activities of Daily Living – 1) Ability to move about the environment independently. 2) Ability to eat independently. 3) Ability to maintain personal hygiene. 4) Ability to dress independently and appropriately. 5) Ability to care for toileting needs. 1.3 Fundamental philosophies of promoting independence: a. Recognize and help the resident and family to accept the frail years as a natural and positive part of the life cycle. b. Within the facility, encourage residents to continue with as familiar a lifestyle as possible. c. Provide residents with opportunities for growth by encouraging and taking them to activities. d. Emphasize the involvement of family members that there is still an important roles and place for them in a resident's life. Encourage volunteerism. e. Focus on the resident's physical and mental capabilities to maintain the optimum level of functioning. 2. Resident Rights 2.1 Arkansas nursing facility residents have all the rights of U.S. citizens as guaranteed by the Constitution of the United States of America.

Unit IV (contd.)

OBJECTIVE	CONTENT
	a. Every resident admitted to an Arkansas nursing facility is informed of specific RESIDENT'S RIGHTS. The staff of the nursing facility is to be informed and protect the rights of residents. This will contribute to more effective resident care by enumerating the responsibilities of physician, staff and facility. b. Resident's Rights may vary from facility to facility but as a minimum the list of rights shall include the following: 1) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility must assert, protect, and facilitate the exercise of these rights. 2) The resident has the right to be fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services. The facility makes available to residents, a list of the kinds of services and articles provided by the facility. Charges for all services and supplies not included in the facility's basic per diem rate are identified. Residents are informed in writing in advance of any changes in the costs or availability of services. The resident has the right to be informed of the rules of the facility upon admission in the language that he/she understands. 3) The resident has the right to exercise rights as a resident, to exercise rights as a citizen or

OBJECTIVE	CONTENT
	resident of the United States, including the right to file complaints. The resident has the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. The resident has the right to recommend changes in policies and services to facility staff and/or outside representatives of his/her choice, free from coercion, discrimination, or reprisal. 4) The resident has the right to information on Federal, state and local agencies concerned with enforcement of long term care facility rules and agencies acting as resident advocates and is afforded the opportunity to contact these agencies. The resident has the right to participate in a representative resident council in the facility. The resident has the right to make choices about significant aspects of his/her life in the facility. 5) The resident has the right to be informed of his/her medical condition and an opportunity to participate in planning his/her medical treatment unless contradicted (as documented by a physician in the medical record). The resident has the right to choose a personal attending physician. The resident has the

Unit IV (contd.)

OBJECTIVE	CONTENT
	right to be informed in advance of any changes in care or treatment that may affect his/her well-being, unless medically contra-dicted. The resident has the right to refuse treatment and to refuse to participate in experimental research. The resident has the right to be advised of alternative courses of care and treatments and their consequences when such alternatives are available. 6) The resident has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. The resident has the right to be free from unnecessary drugs and physical restraints and is provided treatment to reduce dependency on drugs and physical restraint. Restraints may only be imposed: -To ensure the physical safety of the resident or other residents. -Only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances until such an order could reasonably be obtained). The resident has the right to be free from physical, psychological or sexual abuse or punishment. 7) The resident has the right to manage his or her financial affairs. If the facility manages

Unit IV (contd.)

OBJECTIVE	CONTENT
	The financial affairs of the resident, the facility must comply with federal and state rules and regulations. 8) The resident has the right to confidentiality, of personal and clinical records. The resident has the right to approve or refuse the release of information of personal and clinical records to any individual or agency outside the facility, except, in case of his transfer to another health care institution or as required by law or third party payment contract. The resident has the right to approve or refuse to allow photographs to be taken or interviews to be conducted. 9) The resident has the right to personal privacy. The resident has the right to privacy with regard to accommodations, medical treatment, written and telephone communications, visits, and meetings of friends, family and of resident groups, unless medically contradicted. 10) The resident has the right to send and receive mail that is not opened. 11) The resident has the right to receive visitors at any reasonable hour and by arrangements at other times. 12) The resident has the right to have access to the private use of a telephone. 13) The resident has the right to reside and receive services with reasonable accommodations of individual needs and preferences,

Unit IV (contd.)

OBJECTIVE	CONTENT
	Except where the health or safety of the individual or other residents would be endangered and to receive notice before the room or roommate of the resident in the facility is changed. 14) The resident has the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility. 15) The resident has the right to participate and/or refuse to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. 16) The resident has the right not to perform services for the facility and to be compensated for services voluntarily performed, unless informed prior to performing services that services are of a voluntary nature and will not be compensated (unless the services are for therapeutic purposes in the residents plan of care as ordered by the attending physician). 17) The resident has the right to retain and use personal possessions and appropriate clothing, within space allocated by the facility, unless to do so would infringe upon the rights or security of other residents. 18) The resident has the right to privacy of visits with spouse. If both are residents, they have the right to share a room unless medically contraindicated and

Unit IV (contd.)

OBJECTIVE	CONTENT
	documented by the physician in the medical record. 19) The resident has the right to be provided a safe, clean, comfortable and homelike environment. 20) The resident has the right to be provided food that is attractive, proper temperature, meets individual needs. 21) The resident has the right to be provided an on going program of activities appropriate to residents needs and interests, designed to promote opportunities for engaging in normal pursuits, including religious activities of choice. 22) The resident has the right to receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status as defined by a comprehensive assessment and plan of care. 23) The resident has the right to remain in the facility and not to be transferred or discharged unless: -the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility. -the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. -the safety of the individuals in the facility is endangered.

Unit IV (contd.)

OBJECTIVE	CONTENT
	-the resident has failed, after reasonable and appropriate notice, to pay an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with Title XIX. -the facility ceases to operate. In each case, the basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician. Appropriate notice must be made in advance of the resident's transfer or discharge except in urgent medical needs. 24) The resident has the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the governing agency (in Arkansas, the Office of Long Term Care) with respect to the facility and any plan of correction in effect with the facility. 25) A resident's next of kin or legal guardian may exercise a resident's rights when a resident has been ruled incompetent by a Judge in a court of law. c. These rights are not all encompassing, but are specific to long term care facilities. Each facility is responsible for developing its own Resident's Rights policy and procedures for implementing these rights and may make additions to this list of Resident's Rights. 2.2 The nursing assistant is <u>ethically</u> <u>responsible</u> and <u>legally</u> <u>accountable</u> for upholding and protecting Resident's Rights in providing the resident's care:

Unit IV (contd.)

OBJECTIVE	CONTENT
Identify the treatment a nursing assistant shall have toward the resident.	a. Refer to Resident's Rights #1 – This is the responsibility of any staff member who has contact with the resident – 1) The nursing assistant shall treat the resident as a fellow human with consideration, respect and full recognition of the resident's dignity and individuality. 2) The nursing assistant shall always treat the resident as she/he would want to be treated. b. Refer to Resident's Rights #2 – 1) This is the responsibility of administration.
Identify the nursing assistant's responsibilities concerning resident's grievances.	c. Refer to Resident's Rights #3 – 1) It is the role of administration to develop and follow a procedure for the registration and disposition of grievances by the resident/family/legal representative. 2) It is the responsibility of the nursing assistant to report grievances as told per a resident by facility policy and procedures to the appropriate authority. 3) The nursing assistant shall encourage the resident to exercise the Resident's Rights. 4) A nursing assistant is to NEVER coerce, discriminate or give reprisal to a resident who voices grievances. d. Refer to Resident's Rights #4 – 1) This is the responsibility of administration.
Identify the person responsible to keep the resident informed of medical condition.	e. Refer to Resident's Rights #5 – 1) It is the responsibility of the physician to inform and keep the resident updated to medical condition.

Unit IV (contd.)

OBJECTIVE	CONTENT
Identify the nursing assistant's responsibility if asked about a resident's medical condition.	2) Any questions or opinions asked of the nursing assistant about the condition of the resident are to be politely but firmly referred to the charge nurse as upholding the Resident's Rights. 3) The nursing assistant shall refrain from giving or expressing opinions about the resident's condition or treatment. f. Refer to Resident's Rights #6 –
Identify where the nursing assistant receives instructions to restrain a resident.	1) The nursing assistant receives instructions for restraining the resident from the charge nurse. 2) The nursing assistant shall be held responsible for knowing Office of Long Term Care rules and regulations and the facility's policy and procedures regarding restraints. (Refer to section of Restraints.)
Identify result of not reporting knowledge of abuse, neglect, exploitation of a resident.	3) Persons are required by law to report suspected adult abuse, neglect, or exploitation. Persons who have knowledge of suspected adult abuse, neglect, or exploitation and do not report it become an accomplice to the act. (See unit on "Ethics and Legal Aspects"). 4) Avoiding the need for restraints in accordance with current professional standards: -Staff education. -Structured activities. -Attention to individual needs. -Drug dose reductions. -Diversion. g. Refer to Resident's Rights #7 – 1) This is the responsibility of administration.

Unit IV (contd.)

OBJECTIVE	CONTENT
Identify areas of confidentiality.	h. Refer to Resident's Rights #8 – 1) Confidentiality extends beyond the medical records to include all aspects about the residents; personal information, behavior, mental condition, physical condition, etc.
Give appropriate response to questions regarding resident's condition.	2) When questions are asked of the nursing assistant about the condition of the resident, refer them to the charge nurse. Be polite, let it be known that interest is appreciated, but THAT ALL INFORMATION REGARDING THE RESIDENT IS CONFIDENTIAL AND CANNOT BE DICUSSED.
Identify areas of breaking confidentiality.	3) Examples of breaking confidentiality: -Discussing one resident with another resident. -Discussing a resident's condition with relatives or friends of the resident. -Discussing a resident's condition with another staff member in front of another resident, visitor, etc. -Discussing a resident's condition with the news media. -Discussing a resident's condition with fellow workers, except when in conference or in planning resident care. -Anyone requesting to review the medical records of a resident is to be referred to the charge nurse.
Identify ways the nursing assistant provides resident privacy.	i. Refer to Resident's Rights #9 – 1) The nursing assistant shall knock on a closed door and announce entry into the room before opening the door.

Unit IV (contd.)

OBJECTIVE	CONTENT
	2) The nursing assistant shall provide for privacy of the resident during all aspects of care by closing the window curtain to screen from public and by closing the door to the room where care is being given and by the use of privacy screens and curtains. 3) The nursing assistant shall request that persons not involved with the care of the resident are not present during care/examination/ treatment without consent of the resident. j. Refer to Resident's Rights #10 – 1) This is the responsibility of the administration. k. Refer to Resident's Rights #11 – 1) This is the responsibility of the administration. l. Refer to Resident's Rights #12 – 1) This is the responsibility of the administration. m. Refer to Resident's Rights #13 – 1) This is the responsibility of the administration. n. Refer to Resident's Rights #14 – 1) This is the responsibility of the administration. o. Refer to Resident's Rights #15 – 1) This is the responsibility of the administration.
Identify the responsibility of the nursing assistant in encouraging self-care.	p. Refer to Resident's Rights #16 – 1) It is the responsibility of the nursing assistant to attempt to get the resident to perform as many personal care tasks as possible, but NEVER to force a resident to care for self. 2) It is the responsibility of the nursing assistant to encourage the resident to attend activities provided by the facility and to

Unit IV (contd.)

OBJECTIVE	CONTENT
	attend meals in the dining room, but NEVER to force attendance. 3) It is the responsibility of the nursing assistant to inform the charge nurse of resident refusal to participate in self-care/activities. 4) The nursing assistant shall ask the charge nurse for the appropriate manner for handling a resident's refusal of self-care/activities.
Identify when a nursing assistant is to report concerning resident's personal possessions.	q. Refer to Resident's Rights #17 – 1) It is the responsibility to report to the charge nurse if it appears that a resident's personal possessions or clothing infringes upon the rights or security of others. 2) The nursing assistant shall report to the charge nurse if a resident does not appear to have appropriate clothing. r. Refer to Resident's Rights #18 – 1) This is the responsibility of the administration. s. Refer to Resident's Rights #19 – 1) Refer to sections on providing a resident a safe environment and care of resident's unit. t. Refer to Resident's Rights #20 – 1) Refer to sections on nutrition.
Identify the nursing assistant's role in resident's participation in activities.	u. Refer to Resident's Rights #21 – 1) The nursing assistant shall not impose religious beliefs on the residents. 2) The nursing assistant shall encourage but not force the resident to be a participant at activities.
Identify the nursing assistant's role in nursing service.	v. Refer to Resident's Rights #22 – 1) The nursing assistant shall provide nursing care per the instructions of the charge nurse and the resident's individual plan of care.

Unit IV (contd.)

OBJECTIVE	CONTENT
	w. Refer to Resident's Rights #23 – 1) Transfer/discharge arrangements are made per physician and administration. 2) The nursing assistant shall make every effort to make this change easy and pleasant. 3) The nursing assistant shall be sure that all personal belongings are sent with the resident and inventory forms are completed and signed appropriately per facility policy. x. Refer to Resident's Rights #24 – 1) This is the responsibility of the administration. y. Refer to Resident's Rights #25 – 1) This is the responsibility of the administration. 2.3 Civil Rights of the resident: a. Facilities are to admit and treat all residents without regard to race, color, national origin, religious preference, or marital status. b. The same requirements for admission are applied to all and residents are assigned within the facility without regard to race, color, national origin, or religious preference. c. There is no distinction in eligibility for, or in the manner of providing, any resident service provided by or through the nursing home. d. All facilities of the nursing home are available without distinction to all residents and visitors regardless of race, color, national origin, religious preference or marital status. e. All persons and organizations having occasion either to refer residents for admission or to recommend the facility are advised to do so without regard to the resident's race, color, national

Unit IV (contd.)

OBJECTIVE	CONTENT
	origin, religious preference, or marital status.
Identify areas the nursing assistant is held responsible for by law.	2.4 In Arkansas, adults are subject to the protection of the Department of Human Services, if endangered, abused, maltreated, exploited, or neglected: a. Endangered Adult – an adult eighteen years or older who is found to be in a situation or condition which poses an imminent risk of death or serious harm to such person who demonstrates the lack of capacity to comprehend the nature and consequence of remaining in that situation or condition. b. Abuse/Maltreatment – any willful or negligent act which results in negligence, malnutrition, physical assault or battery, physical or psychological injury inflicted by other than accidental means, and failure to provide necessary treatment, rehabilitation, care, sustenance, clothing, shelter, supervision, or medical services. c. Exploitation – any unjust or improper use of another person for one's own profit or advantage. d. Whoever, willfully or by culpable negligence, deprives an adult of, or allows an adult to be deprived of necessary food, clothing, shelter, or medical treatment, or who knowingly or by culpable negligence permits the physical or mental health of the adult to materially endangered, and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the adult, shall be guilty of a Class D felony and shall be punished by law.
Identify ethical responsibilities of the nursing assistant.	3. Ethics and Legal Aspects 3.1 Ethical responsibilities – A set of standards or moral principles governing the conduct of a nursing assistant.

Unit IV (contd.)

OBJECTIVE	CONTENT
	It deals with the relationship of a nursing assistant/ to a resident, to families, to the teammates and associates, to the community:
List ethical responsibilities of the nursing assstant.	a. Integrity – 1) Honesty. 2) Sincerity. 3) Reliability. 4) Carrying out responsibilities of assignments.
Recognize factors which identify the nursing assistant's loyalty to the resident and to the employer.	b. Loyalty – 1) to resident. 2) to employer. c. Performs only those duties which he/she is prepared and which are authorized. d. Respect religious rights and preferences- 1) of residents. 2) of teammates.
Identify ethical responsibilities of the nursing assistant in caring for the resident.	e. Nursing assistant ethical responsibility in caring for the resident – 1) Expected to know content of job description. 2) Expected to know and anticipate the various types of behavior which residents may develop. 3) Expected to be responsible for own acts in providing competent basic care to residents. 4) Expected to perform only those activities for which prepared and which are authorized. 5) Expected to be responsible for helping maintain a safe environment. 6) Expected to be responsible for safeguarding the resident's possessions. f. The nursing assistant does not talk about the resident's behavior in a negative and/or condescending manner. g. The nursing assistant is expected to use a positive approach to meet the resident's needs.

Unit IV (contd.)

OBJECTIVE	CONTENT
	h. The nursing assistant is expected to listen to the resident with a nonjudgmental attitude and reflects the resident's feelings rather than his words. i. The nursing assistant is expected to meet the residents on their own level, is truthful, always keep promises, and is consistent in activities and attitudes. j. The nursing assistant acts to meet the resident's needs rather than own needs. k. The nursing assistant is expected to respect the resident's feelings and protects the resident's right to privacy. l. The nursing assistants assigned residents are the nursing assistant's kingdom. The nursing assistant must always be on guard against becoming authoritative as the residents may interpret the nursing assistants commands as law. m. The nursing assistant must probe and focus on fact rather than feelings. The question "Why?" puts the resident on the defense. It may cause confusion and disorientation as to time, place or person.
Identify examples of confidentiality.	3.2 Confidentiality: a. Confidentiality means keeping resident's personal information private. b. Examples of confidentiality- Do not discuss personal resident information with – 1) One resident about another resident. 2) Relatives or friends of the resident. 3) Representatives of the news media. 4) Fellow workers, except when in conference or in planning resident care. 5) One's own family and friends. 3.3 Respect and uphold the residents' rights: These rights are of such vital importance that "Rights" are addressed in a separate unit.

Unit IV (contd.)

OBJECTIVE	CONTENT
	3.4 Respect and dignity are integral aspects of all care and relationships with residents, families, teammates, and community.
Identify the nursing assistants' legal responsibilities in caring for resident.	3.5 Legal Aspects: a. Nursing assistant's legal responsibility in caring for residents- 1) Is to know the content of the job description. 2) Is to know and anticipate the various types of hazards which may develop for residents.
Identify what conditions the nursing assistant may be held liable for negligence.	b. The nursing assistant may be held liable, if in the opinion of the court, the nursing assistant was negligent in providing protection and care constituting PREVENTION against the development of any situation INJURIOUS to the resident. c. The nursing assistant is legally responsible for carrying out procedures and carrying them out correctly.
Define battery.	d. Battery – physical abuse to resident – 1) Pushing. 2) Shoving. 3) Pinching. 4) Holding the resident too tight. 5) Tripping. 6) Pulling. 7) Hitting.
Define harassment.	e. Harassment – mental and emotional abuse. It can be verbal and/or non-verbal – 1) Argumental with the resident. 2) Making fun of resident behavior. 3) Harsh and/or derogatory (cursing) words. 4) Condescending tone of voice; hateful, derogatory. 5) Laughing at resident. 6) Making fun of resident. 7) Being judgmental. 8) Shaming residents for the way they eat, talk, walk, etc.

Unit IV (contd.)

OBJECTIVE	CONTENT
	f. The nursing assistant is responsible for own acts in providing competent basic care to residents. g. The nursing assistant performs only those activities or duties for which prepared and which are authorized. h. The nursing assistant is responsible for helping to maintain a safe environment for the resident. i. The nursing assistant is responsible for helping safeguard the resident's possessions. (Don't steal from the resident or from the facility). j. All staff have a legal responsibility to respect and uphold the rights of the residents.
Define each area of legal concern.	k. Areas of legal concern – 1) Libel. 2) Negligence. 3) Abuse. 4) Battery. 5) Assault. 6) Invasion of resident privacy. 7) Defamation: -slander. -libel. 8) Exploitation. 9) Self abuse.
State Arkansas law as it relates to reporting of abuse, neglect or exploitation of a resident.	3.6 Reporting and Investigation: a. Persons are required by law to report suspected adult abuse, neglect, or exploitations. Persons, who are acting in good faith, have immunity from civil or criminal liability that might result from this action.
Identify nursing assistant's responsibility in reporting suspect abuse or neglect of the resident.	b. Persons failing to report suspected abuse, neglect, or exploitation if they know about it become accomplices to the act. c. Truthful statements and facts (not your feelings or interpretations of events) are to be given during an investigation.

Unit IV (contd.)

OBJECTIVE	CONTENT
Identify the agencies responsible to investigate suspected abuse, neglect or exploitation of residents.	d. Violations of all reported incidents of failure to maintain legal aspects will be investigated by the Office of Long Term Care and/or the Attorney Generals Office and/or the state or local police.

Unit V
Introduction to Resident Care
(5 hours theory/classroom lab)

OBJECTIVE	CONTENT
Identify measures which make the bed safe and comfortable.	1. Bedmaking – 2 hours 1.1 Making a comfortable bed: a. Older people have less tissue padding over their bones and wrinkles can actually cause them pain. b. The resident's skin is very easily damaged. Wrinkles can restrict circulation resulting in pressure areas (bedsores/decubiti). c. If a resident is unable to get out of bed, all activities of daily living will be carried out in bed. d. Residents who remain in bed all of the time need their linens straightened and checked frequently throughout the day and night. e. Many times residents are incontinent of urine and/or feces. Check these residents frequently. Change linens when soiled. 1.2 Types of bedmaking: a. Unoccupied – The resident is able to leave the bed while it is made. Closed bed – 1) Is made with the top sheets and spread pulled all the way up. 2) Is usually used if the resident is to remain up for most of the day. 3) The pillow can be enclosed or left out depending upon the facility. Open bed – 1) Has the top sheet and spread fan-folded to the bottom of the bed. 2) Allows easy access by the resident and when in, bed sheets and spread can be pulled up easily by the resident. b. Occupied bed (see Unit VI).
Identify and demonstrate measures of bedmaking (unoccupied – open and closed).	1.3 Measures of bedmaking: (refer to procedure #27 in the Appendix)

Unit V (contd.)

OBJECTIVE	CONTENT
	a. Measures for resident comfort – 1) Preventing wrinkles. 2) Allowing toe room. b. Measures for resident safety – 1) Using bedrails. 2) Having bed in lowest position to floor. c. Measures for infection control – 1) Don't shake linens. 2) Linens are not to be on floor. 3) Carry clean and dirty linens away from uniform. 4) Place linens in dirty linen hamper, not in with resident's dirty clothes. 5) Wash your hands. d. Use good body mechanics.
	2. Meal Service – 2 hours
List steps to promote a positive environment at mealtime.	2.1 Assisting the resident at mealtime. a. Promoting a positive atmosphere for mealtime – 1) The resident should be physically comfortable. 2) The surrounding should be pleasant and comfortable. 3) The social aspect of mealtime should be considered. 4) Residents who are physically able should eat in the dining room rather than in the isolation of their rooms.
Identify steps to help residents remain independent while eating.	5) The resident should be encouraged to remain independent; food is provided in a manageable form (e.g. bread is buttered, meat cut). Assist visually impaired persons in locating food and utensils.
Demonstrate assisting devices.	6) Use special eating devices such as a plate guard or adapted spoon to aid handicapped residents in self-feeding.

Unit V (contd.)

OBJECTIVE	CONTENT
	b. A resident may require a therapeutic diet, which is prescribed by the doctor, and planned by the dietitian. Therefore, do not interchange food from one resident's tray to another. Never eat food served to a resident, even if the resident does not want it.
Identify and demonstrate measures of serving a tray correctly.	c. Serving a tray correctly – (refer to procedure #8 in the Appendix) 1) Wash your hands. 2) Diet card must accompany tray to resident's room (OLTC Regulation). 3) Check diet card for: -Name of resident. -Special instructions. -Diet order. -Allergies. 4) Observe the food content of tray, if there is a question about content versus diet card, return the tray to the kitchen/serving personnel. 5) Check tray for necessary items: -Self-help devices. -Napkin on tray or table. -Condiments. 6) Prepare tray and food. 7) Place tray according to need such as visual impairment, weakness, paralysis, etc. 8) Serve tray immediately. d. Encourage and assist the resident as needed – 1) Open pre-packaged food and condiments. 2) Cut up food. 3) Place butter and jelly on bread. e. For vision impaired – 1) Place silverware, cup, etc. in same place each time.

Unit V (contd.)

OBJECTIVE	CONTENT
	2) Ask resident if assistance is needed: -If no, respect resident's wishes. -If rendering assistance, tell what foods are on tray in clockface order. f. Feeding a resident – Refer to Unit IV, #5.
Describe how to report changes in eating habits of residents and other pertinent information.	2.2 Reporting/record: a. Amounts consumed of food and fluids. b. Difficulty of resident – 1) Drinking. 2) Chewing. 3) Swallowing. c. If resident is refusing to eat. d. If resident is eating less than usual. e. The need for special eating utensils – 1) Spoons, forks. 2) Cup and/or plate. f. Report complaints/recommendations for seating changes at dining table to charge nurse. 3. Caring for the Resident's Environment – 1 hour 3.1 The Resident's Unit – Proper furniture and equipment
Identify ways of keeping the resident's environment comfortable.	3.2 Ways of providing environmental comfort in the resident's unit: a. Provide ventilation according to the resident's preference and condition. b. Adjust temperature for personal differences, keeping in mind that the elderly cannot adjust as well to extremes of temperatures. c. Provide extra humidity for residents with respiratory disorders, as directed by the nurse in charge. d. Adjust lighting for day and night safety. Place lights to avoid glaring. 3.3 Daily maintenance of the resident's unit:
Identify steps to be taken to assure the resident's unit is safe and completely furnished.	a. Be sure call bell is within reach (OLTC Regulation). Do this EACH TIME YOU LEAVE THE RESIDENT'S UNIT. This is VERY IMPORTANT to

Unit V (contd.)

OBJECTIVE	CONTENT
	remember. Accidents happen when residents try to help themselves. b. Chairs should be placed out of the mainstream of traffic areas, when not in use by the residents. c. Urinal should be within easy reach of male residents. Urinal needs to be emptied to prevent spilling (OLTC Regulation). d. The bedside stand should be within easy reach and contain items used frequently by the resident. Discourage hoarding while being sensitive to resident's desires. e. Fluids should be offered at frequent intervals. Water pitchers shall be refilled at least once each shift and should be kept in reach of patients. Clean drinking glasses shall be kept with each water pitcher (OLTC Regulation). f. The bed should always be in the lowest position. In case of falls, the resident is closer to the floor which might prevent serious injuries. g. Bed rails should be used consistently as the patient's condition requires. h. Each time you enter a resident's unit, look around for possible dangers such as spills on the floor, items that could trip someone, frayed electrical cords. i. The unit should be cleaned daily. The nursing assistant or resident should straighten the resident's personal belongings. Housekeeping personnel will clean the remainder of the room.

PART II

CLASSROOM & CLINICAL TRAINING – 59 HOURS

(Theory, Classroom Lab, and Clinical)

NOTE: Each unit in Part II has the required number of hours specified, accounting for class room activity (theory and lab) and clinical on the floor. Each sub-unit has the number of hours specified for the classroom activity (theory/lab) but not clinical. Clinical training shall take place at the end of each Unit, with the students performing tasks/skills under the supervision of the instructor.

NOTE: The trainee may work in the staffing of a facility while completing Part II of the training course. However, the trainee can only perform the task/skills they have been trained and determined as competent to perform.

Unit VI
Personal Care Skills
(23 hours theory/lab and 7 hours clinical)

OBJECTIVE	CONTENT
	1. Bathing – 4 hours 1.1 Factors affecting hygiene needs and practices:
List factors which affect a resident's hygiene needs and practices.	a. Proper hygiene promotes health and helps to prevent infections. b. The condition of the resident may change frequency of care. c. Individuals have preferences based on past habits. Allow flexibility in hygiene routines while maintaining standards of cleanliness.
Identify purposes for bathing	1.2 Reasons for bathing: a. Clean the skin. b. Eliminate odors. c. Cool and refresh. d. Stimulate circulation.
Identify types of baths.	1.3 Types of baths: a. Complete bed bath – For the resident who is too weak or sick to assist with their bathing. b. Partial bed bath – For the resident who is able to take care of most of their own bathing needs. The nursing assistant will bathe only the areas that are hard to reach. c. Whirlpool bath – For the resident whose doctor may order for therapeutic reasons. d. Tub/shower bath – For residents who are strong enough to get out of bed and walk around.
Identify guidelines to follow when bathing the resident.	1.4 Guidelines for bathing: a. Protect the resident's modesty and prevent chilling by closing the door, drawing the curtains and exposing the resident as little as possible. b. Soap can dry out the skin, especially on the elderly. Be sure to rinse the soap off well. Special cleaning and/or moisturizing liquids may be used.

OBJECTIVE	CONTENT
Demonstrate bathing techniques: 1) Bed bath. 2) Tub bath. 3) Shower. 4) Whirlpool.	c. Bathe per accepted procedures – (refer to procedures #40, 42, & 43 in the Appendix) 1) Keeping water temperature comfortably warm and clean. Water should be approximately 100 degrees or comfortable when felt on back of hand or elbow. 2) Making a mitt from the washcloth or showing other methods of keeping tails of washcloth under control. 3) Washing and drying one part of the body at a time. 4) Giving a backrub and massaging other bony prominences with warmed lotion. d. Never leave the resident unattended. e. Examine the resident's skin during bath. Carefully clean under all skin folds and in contracted areas. Report any changes in skin; redness, rashes, broken skin or tender places. f. Give range of motion exercises (ROM) during bath time (see Unit IX). g. Follow procedures for cleaning bathing area.
List purposes for a backrub.	1.5 Backrub: a. Purpose – 1) Refresh and relax resident. 2) Stimulate circulation.
Demonstrate backrub.	b. Backrub per accepted procedure (refer to procedure #24 in the Appendix).
	2. Grooming – 4 hours 2.1 Oral hygiene – cleaning the resident's mouth, lips, and teeth:
List purposes for oral hygiene.	a. Purpose – 1) Helps prevent inflammation to mouth and gums and damage to the teeth by removing food particles which promote bacterial growth.

Unit VI (contd.)

OBJECTIVE	CONTENT
	2) Refreshes the resident's mouth.
Identify and demonstrate measures of oral hygiene.	b. General practices/measures – (refer to procedure #15 in the Appendix) 1) Brush teeth or dentures at a minimum in the morning and at bedtime. 2) Use soft, moist brush. 3) Encourage the resident to help as much as possible. 4) Gently cleanse tongue, teeth and gums. 5) Take special care to rinse out resident's mouth. 6) Check teeth, bums, color, shape, loose teeth, ulcers, odor, etc.
Identify and demonstrate measures of denture care.	c. Denture care (partial or full) – (refer to procedure #16 in the Appendix) 1) Dentures are slippery, handle with care. 2) Cleanse denture per accepted procedure. 3) Resident is to rinse out mouth, using water or mouthwash and brush gums and tongue with soft, moist toothbrush. 4) Return dentures to resident, replacing in mouth while moist. 5) Store dentures in fresh water or prepared solution when not in use.
Identify and demonstrate measures of oral hygiene for the unconscious resident.	d. Mouth care for the unconscious resident – (refer to procedure #47 in the Appendix) 1) Mouth care for the unconscious resident must be done more frequently than regular mouth care, since the resident may not have enough saliva secretion to keep mouth moist. Lips and gums may become cracked and sore. 2) Position on side or have head turned to side to keep liquids

OBJECTIVE	CONTENT
	from running down throat. 3) Use packaged mouth care swab or gauze wrapped tongue blades moistened in mouthwash. 4) Wipe all mouth surfaces. 5) Explain each step of the procedure to the unconscious resident. Even though a resident seems to be unconscious, they still may be able to hear you. 6) Keep mouth and lips moistened continuously. 2.2 Hair Care: a. Shampooing a resident's hair – (refer to procedure #21 in the Appendix)
Identify and demonstrate measures of hair care.	1) The cleanliness and grooming of both men's and women's hair is frequently associated with a resident's sense of well-being. 2) The frequency with which a resident needs to have hair shampooed is highly individualized. Hair is to be shampooed at least weekly (OLTC Regulation). 3) If a resident's hair tends to tangle after it has been washed, a conditioning rinse is to be used. 4) All of the shampoo is to be rinsed out of the hair to prevent drying and itching of the scalp.
Identify and demonstrate measures of combing the resident's hair.	b. Combing a resident's hair – (refer to procedure #22 in the Appendix) 1) Hair is to be combed at least daily and kept neat at all times. 2) Residents feel better about self if hair is combed and styled attractively. 3) Brushing and combing the hair stimulates the blood circulation in the scalp. It brings oils to the surface and spreads them evenly over the hair.

OBJECTIVE	CONTENT
	4) Brush up from the neck toward the top of the head. This stimulates the blood circulation in the scalp. It brings oils to the surface and spreads them evenly over the hair. 5) While combing, hold a small section of hair between the scalp and comb to prevent pulling. If the hair is long, start at the ends and work towards the scalp. 6) Try to style hair the way the resident likes it. 7) Residents are to always be encouraged to comb their own hair. c. Beard care – 1) Wash beard either when hair is shampooed or with bath. 2) Wash beard more often if food or liquid is frequently spilled in beard. 3) Comb or brush beard when hair is groomed. 4) Trim as needed.
Identify and demonstrate measures of proper nail care.	2.3 Nail Care: (refer to procedure #19 in the Appendix) a. Nails are to be cleaned at bathtime. b. Soaking the nails in warm, soapy water helps to loosen any material that might have collected. c. Be careful when cleaning the nails not to injure the skin surrounding the nail itself. d. Fingernails are to be trimmed to an oval shape. Toenails are to be cut straight across with a blunt-tipped scissors or heavy nail clippers. e. Nails of a diabetic resident or a resident with poor circulation are to be cut with extreme care. Check with charge nurse. f. Nails are to be given care every two weeks or more frequently as needed. (OLTC Regulation).

Unit VI (contd.)

OBJECTIVE	CONTENT
	2.4 Shaving: (refer to procedure #18 in the Appendix) a. All male residents shall be shaved every other day or as needed, unless they have a beard (OLTC Regulation).
Demonstrate shaving of a male resident.	b. Encourage male residents to shave themselves and assist as needed. c. Shave and care for equipment per accepted procedure. 2.5 Foot Care: a. Feet need special care. b. Apply lotion to feet and toenails daily. c. Observe for changes in feet and report changes to charge nurse –
Identify changes in feet to report to charge nurse.	1) red spots. 2) corns or calluses. 3) cracks in feet or toenails. 4) loose toenails. 5) swelling/edema. 6) pain. d. Observe and report too tight socks, shoes, stockings, etc.
Identify and demonstrate measures of foot care.	e. Use footboards to prevent – 1) footdrop. 2) pressure from linens. f. Follow accepted procedure (refer to procedure #20 in the Appendix). 3. Dressing – 1.5 hours 3.1 Dressing and undressing a resident: (refer to procedure #25 in the Appendix)
Identify and demonstrate measures of dressing and undressing a resident.	a. Residents in a long term care facility should be dressed in their own "street" clothes whenever possible and their choice when feasible. b. Residents should dress themselves whenever possible. c. If they need assistance – 1) Remove one arm of a shirt or blouse at a time. Older people do not bend as easily as a younger person.

Unit VI (contd.)

OBJECTIVE	CONTENT
	2) Sometimes raising both arms over the head and putting on or removing the sleeves on both arms at once prevents stretching of the shoulder muscles and pain, especially with people that have arthritis. 3) If the resident is paralyzed on one side, dress that arm or leg first and remove that arm or leg last from the clothing. 4) NEVER jerk or pull clothing off. Be gentle and remove clothing slowly. 4. Toileting/Elimination – 3.5 hours 4.1 Urinary Elimination:
Describe normal and abnormal appearance of urine and abnormal sensation while urinating.	a. Urine – 1) Normal appearance: -Straw colored. -Clear. 2) Abnormal appearance: -Cloudy – sedimentation in urine. -Dark – concentrated from medication and/or dehydration. -Red – blood in urine or medication. 3) Abnormal sensation: -Burning. -Painful urination. -Small amount. -Frequent voiding. b. Assisting the resident with urination (bedpan) – (refer to procedure #23 in the Appendix) 1) WASH YOUR HANDS. 2) Close door and curtain to provide for privacy. 3) Position resident comfortably: -Pillow behind back. -Elevate head of bed. -Warm bed pan before placing under resident. -Check frequently.

Unit VI (contd.)

OBJECTIVE	CONTENT
	4) Use warm running water on hands, over perineum or other techniques to promote urination, if necessary. 5) Infection control: Cleanse resident's perineum, hands and WASH HANDS of resident and self.
Identify and demonstrate measures of assisting a resident with bedpan, urinal or bedside commode.	c. Assisting a resident with urinal – (refer to procedure #1 in the Appendix) 1) WASH HANDS. 2) Provide privacy. 3) Place urinal if resident is unable to do so. 4) Urination for the male may be easier if he can stand up to use the urinal or sit on side of bed. 5) WASH HANDS of resident and self. d. Assisting resident to use bedside commode or toilet – 1) WASH HANDS. 2) Provide privacy. 3) Stay with resident if necessary for safety. 4) Restrain per accepted facility procedure/physician order.
Identify and demonstrate steps in measuring and recording urinary output.	e. Measuring and recording of urinary output – (refer to procedure #3 in the Appendix) 1) Amount of urine. 2) Characteristics of urine; color, odor, appearance.
Identify and demonstrate measures for collecting urine specimens.	f. Collecting urine specimen – (refer to procedure #12 in the Appendix) 1) General guidelines: -WASH YOUR HANDS before and after obtaining specimen. -Right resident – right time-right method. -Cleanse perineum/penis before collecting specimen. -Label specimen correctly.

OBJECTIVE	CONTENT
	-Store specimen correctly. -Report anything abnormal to charge nurse. 2) Reason for urinalysis: it tells the physician if any abnormalities or infections are present. 3) Collecting a mid-stream urine specimen: -Used to determine if bacteria is present in the urine. -Strict asepsis must be obtained if urine is to be free of contamination.
Recognize how a urinary catheter works.	g. Urinary catheter care – 1) The urinary system is sterile, thus a nursing goal when a catheter is in place in the bladder is to avoid introducing microorganisms via the catheter drainage system. 2) A common reason for elderly residents to have a urinary catheter is to control incontinence, frequent UTI and poor skin condition. h. The closed drainage system consists of – 1) Catheter – a hollow tube having a small balloon at the end. The balloon is inflated after the catheter is inserted into the bladder to keep it from falling out. 2) Tubing – connects catheter to drainage bag. 3) Drainage bag – catches and stores the urine. Is to be emptied at the end of each shift. 4) The drainage bag may be a leg bag which straps to leg and allows more mobility. A leg bag should not be used by a resident when in bed.

Unit VI (contd.)

OBJECTIVE	CONTENT
	5) Drainage bas or leg bags are to be changed only by a licensed nurse.
Identify and demonstrate measures of catheter and tubing care.	i. Maintaining a closed system and prevention of urinary tract infection- (refer to procedure #36 in the Appendix) 1) To prevent microorganisms from entering the body at any point along the drainage system. 2) Do not disconnect tubing at any point. 3) Do not allow tubing or bag to drag on the floor. 4) Never position catheter drainage bag above bladder. 5) Catheter shall be cleaned at point it enters the body (meatus) according to procedure. 6) Urine is emptied from clamp at the bottom of the bag. DON'T ALLOW TUBING END TO TOUCH CONTAINER into which urine is emptied.
Identify measures which help keep a urinary catheter draining correctly.	j. Maintaining continuous drainage of urinary catheter – 1) If the catheter does not drain, the bladder becomes distended. This can be harmful. 2) Observe to see that urine is flowing into catheter bag. DO THIS FREQUENTLY. If urine is not flowing, report this to the charge nurse. 3) Keep catheter and tubing free of kinks. 4) Keep resident from closing off tubing by keeping the resident from lying on tubing.
Identify measures to avoid injury to the bladder opening from pressure on the catheter.	k. Measures to avoid injury from pulling on the catheter – 1) Tape catheter to leg for females. 2) Tape catheter onto abdomen for males.

Unit VI (contd.)

OBJECTIVE	CONTENT
	3) Fasten drainage bag to part of bed which moves with the resident. (DO NOT FASTEN BAG TO BED RAIL.) 4) Take catheter, tubing and bag everywhere with the resident. 5) If confused resident is pulling on catheter, sometimes trousers over catheter can prevent this.
Identify observations made about the chatherized resident.	l. Observations/reporting/recording – 1) Amount of urine. 2) That urine is continually draining. 3) Characteristics of urine/ color, odor, appearance. 4) Exudate at urinary opening. 5) Leaking anywhere in drainage system.
Describe normal and abnormal appearance of feces.	4.2 Colon Elimination: a. Appearance of feces (stool) – 1) Normal – bile-colored, formed, not necessarily one each day. 2) Abnormal – containing blood or mucous or undigested food: -Tarry. -Liquid. -Very dry and hard. -Clay colored. b. Constipation – 1) Symptoms: -Hard stool. -No stool. -Liquid seepage from anus. -Distention. -Flatus. -Discomfort (restlessness, irritability).
List measures to relieve constipation.	2) Measures to relieve constipation: -Encourage the resident to take fluids. -Prompt response to the natural urge (usually after meals, especially after breakfast).

Unit VI (contd.)

OBJECTIVE	CONTENT
	-A diet which includes fruit, fiber, vegetables (allow enough time for meals to be eaten). -Exercise. -Proper positioning. -Provide privacy.
Demonstrate assisting the resident with a bedpan.	c. Assisting the resident with elimination – 1) Bedpan (refer to procedure #23 in the Appendix) 2) Bedside commode/toilet – (refer to 4.1,d. in this section).
Identify and demonstrate measures of a collecting fecal (stool) specimen.	d. Collecting a fecal (stool) specimen – (refer to procedure #11 in the Appendix) 1) Usually performed when infection or bleeding in the colon are suspected. 2) Make sure to collect the specimen in a bedpan or commode. 3) Do not allow the specimen to touch the outside of the collection container. 4) Use throat sticks to handle the specimen. 5) Make sure that the specimen is properly labeled and promptly transported.
Identify observations made about elimination.	e. Observation/reporting/recording – 1) Time. 2) Description: -Color. -Consistency (hard, soft, formed, liquid or loose). 3) Amount (smear, small, medium, large).
Define colostomy.	f. Colostomy – A surgical procedure which creates a new opening on the abdomen for release of solid waste (feces) from the body.
Define ileostomy.	g. Ileostomy – A surgical procedure which creates a stoma on the abdomen for release of feces. The ileum (part of the small intestine) is brought to the abdomen.

Unit VI (contd.)

OBJECTIVE	CONTENT
	4.3 Fecal impaction:
Define fecal impaction.	a. Definition – hard stool caught in the lower bowel which prevents normal passage of feces.
List symptoms of fecal impaction.	b. Symptoms – 1) No normal stool. 2) Liquid fecal seepage from anus as small amount of fluid present in the colon is able to pass around the impacted mass. 3) Constant feeling of needing to have a bowel movement. 4) Rectal pain.
Identify causes of fecal impaction.	c. Causes of fecal impactions – 1) Decreased muscle tone or stimulation in the lower bowel. 2) Inactivity. 3) Inadequate fluid intake. 4) Insufficient bulk in diet. 5) Uncorrected constipation, which may be caused by any of the above.
Identify role of the nursing assistant in prevention of fecal impaction.	d. Role of the nursing assistant in prevention of fecal impactions – 1) Observe resident's bowel movements: -Amount. -Consistency (firm, formed, liquid, hard). -Frequency.
Identify and demonstrate measures of checking for a fecal impaction.	e. Checking for fecal impaction – (refer to procedure #31 in the Appendix) 1) This procedure is done by the nursing assistant when directed to do so by the charge nurse. Some facilities do not allow nursing assistants to do this procedure. 2) The removal of fecal impactions are to be done by a licensed nurse only.

Unit VI (contd.)

OBJECTIVE	CONTENT
	4.4 Enema:
Identify the purpose of an enema.	a. Purpose – to cause the emptying of the lower bowel.
Identify and demonstrate measures of administering a prepackaged enema.	b. Prepackaged ready to use saline solution enema – (refer to procedure #32 in the Appendix) 1) To be administered upon instruction of the charge nurse. This is the only type of enema a nursing assistant may administer. 2) A small amount of saline solution pre-packaged in a squeezable plastic container with pre-lubricated tip is instilled into the rectum. If resident can hold this solution about 20 minutes, it pulls body fluid into the bowel, stretching it and thus causing evacuation. 3) Observe, report, and record according to procedure. c. All other types of enemas are to be administered by a licensed nurse.
	4.5 Incontinence: a. Incontinence is the loss of control of the bladder or bowel or both.
List physical causes of incontinence.	b. Physical causes – 1) Injuries. 2) Spasms. 3) Disease. 4) Loss of sphincter control.
List psychological causes of incontinence.	c. Psychological causes – 1) Environment. 2) Lack of effort on part of resident and nursing staff. 3) Poor motivation. 4) Stress. 5) Fear. 6) Anxiety. 7) Anger. 8) Frustration.

Unit VI (contd.)

OBJECTIVE	CONTENT
List signs/symptoms of a distended bladder to be reported to charge nurse.	d. Report any signs and/or symptoms of a distended bladder – 1) Dribbling. 2) Frequent small voidings. 3) Distention over pubic area.
Identify and demonstrate measures for incontinent care.	e. Measures for incontinent care – (refer to procedure #35 in the Appendix) 1) Maintain good skin condition. 2) Keep resident comfortable. 3) Check resident at least every two hours. 4) When resident is incontinent: -Wash and dry all affected skin. -Put on dry clean clothes. -Change bed linens as necessary. 5) Use protective pads on bed. 6) May use an adult undergarment. 7) DO NOT scold or treat resident like a child.
Describe feelings/behavior of incontinent resident.	f. Feelings/behavior of the incontinent resident – 1) Embarrassment. 2) Frustration. 3) Anger. 4) Depression. 5) Withdrawal. 6) "Giving Up". 7) Shame. 8) Loss of self esteem. 9) Social rejection.
Describe feelings of family of the incontinent resident.	g. Feelings of family of the incontinent resident – 1) Impatience. 2) Criticism (scolding). 3) Fear. 4) Denial. 5) Overly sympathetic.
Describe the proper attitudes/actions of the nursing assistant toward the incontinent resident.	h. Attitude/actions of the nursing assistant toward the incontinent resident – 1) The nursing assistant needs to explore feelings and attitudes about incontinence.

Unit VI (contd.)

OBJECTIVE	CONTENT
	2) The nursing assistant must deal with self negative feelings/ attitudes about incontinences. 3) The nursing assistant shall adopt a positive approach toward the incontinent resident: -Calm. -Matter of fact. -Pleasant. 5. Feeding – 1.5 hours 5.1 Role of the nursing assistant in promoting good nutrition: a. The nursing assistant shall encourage the resident to eat a variety of foods presented at mealtime. The resident's food is prepared under the guidance of the food service supervisor and is planned as a balanced diet. b. A resident who is consistently unable to eat the prepared diet shall be identified to the charge nurse so that the diet can be modified to meet the resident's needs. 5.2 Feeding a resident: (refer to procedures #34 & 44 in the Appendix) a. To help prevent choking, assist the resident to a sitting position if possible. Raise the head of the bed if the resident is unable to get into a chair.
Identify and demonstrate measures of proper feeding techniques: 1) for total feeding 2) for syringe feeding 3) for the vision impaired.	b. Protect the resident's clothing by using a bib or napkin. Encourage the resident to help by holding finger foods. c. Feed hot foods and liquids cautiously to prevent injuring the resident. d. Allow adequate time for the resident to chew thoroughly. e. Offer only small amounts of food at a time and make sure the resident has swallowed all food before offering more. f. Alternate liquids and solids as the resident prefers.

Unit VI (contd.)

OBJECTIVE	CONTENT
	g. A feeding cup or feeding syringe should be used with care to prevent aspiration of liquid. The tip should be placed inside the resident's cheek instead of the top of the tongue providing opportunity to control the liquid and swallow it. h. Vision impaired resident – 1) Describe food on the plate, as well as content of each bite. 2) Determine if the resident prefers one food at a time or a variety. 3) Allow resident to make as many choices as possible to help him/her feel less dependent.
Identify alternate methods of feeding.	5.3 Alternate methods of feeding: a. Sometimes residents are too ill or weak to consume even a liquid diet. b. Alternate methods of providing nutrition- 1) Nasogastric tube –introduced through the nose and into the stomach so that liquid or pureed food may be directly fed. 2) Gastrostomy (an opening into the stomach through the abdominal wall) may be made and feedings are given through a gastrostomy tube. 3) Intravenous feedings - special fluids and nutrients are administered directly into the blood stream. c. These alternate methods of feeding are performed by a licensed nurse. The nursing assistant should inform the charge nurse if any of the tubes become dislodged. d. In some cases, limited oral feeding is still continued for residents using these alternate feeding methods.

Unit VI (contd.)

OBJECTIVE	CONTENT
	6. Hydration – 1.5 hours 6.1 Importance of adequate fluid intake: a. Helps prevent constipation. b. Helps dilute wastes and flush out urinary system. c. Promotes skin elasticity. 6.2 To encourage a resident to drink fluids, offer small amounts frequently and let the resident have his preference of fluids.
Identify how fluid balance is maintained.	6.3 Fluid Balance: a. Fluid balance is maintained when the amount of fluid taken in is near the same amount eliminated.
Identify nursing assistant role in maintaining fluid intake.	b. The nursing assistant aides the resident in maintaining this balance. c. Amount of water requirements vary -A resident shall be encouraged to drink at least 8 to 10 glasses of fluids each day <u>unless</u> <u>restricted</u>. d. The nursing assistant's role in maintaining fluid intake – 1) Changing water at bedside at least once a shift (OLTC Regulation). 2) Water pitcher shall be placed within reach of resident. 3) Clean water glass or cup kept next to water pitcher. 4) Offer water to resident frequently. 6.4 Measuring and recording of fluid intake: a. Imbalances in fluid intake and output can result in severe fluid imbalances such as – 1) edema (water retention). 2) dehydration (excessive water loss). b. The intake and output (I&O) is frequently measured and recorded – 1) Intake includes everything taken in that is liquid at room temperature:

Unit VI (contd.)

OBJECTIVE	CONTENT
	-Water, tea, etc. -Jello, ice cream, etc. -Fluids given directly into a vein (IV). 2) Output includes all fluids lost: -Amount of urine eliminated. -Perspiration. -Blood. -Diarrhea. -Vomiting. c. Measuring and recording of urinary output (refer to item 4.1,e. in this section).
Demonstrate measuring and recording of fluid intake.	d. Measuring and recording of fluid intake – (refer to procedure #2 in the Appendix)
Define dehydration.	6.4 Dehydration: a. Is abnormal loss (depletion) of body fluids. b. Can become a life threatening problem.
Identify signs and symptoms of dehydration.	c. Signs and symptoms to observe for and report to charge nurse – 1) Tongue becomes coated and thickened. 2) Eyes and mouth very dry. 3) Eyes sunken. 4) Lips cracked. 5) Skin "stands alone" when pulled up between thumb and forefingers. 6) Skin warm to touch. 7) Drowsiness. 8) May become suddenly confused. 9) Below normal amount of urine output. 10) Concentrated urine. 11) Weight loss. 6.5 Edema: a. Swelling – tissues contains too much fluid.

Unit VI (contd.)

OBJECTIVE	CONTENT
Identify signs and symptoms of edema.	b. Signs and symptoms – 1) Swelling/puffiness. 2) Sudden weight gain. 3) Shortness of breath, congested breathing. 4) Decrease in amount of urine output.
Identify ways to relieve edema.	c. Some ways to relieve edema – 1) Observe and release tight fitting clothes and shoes. 2) Elevate (feet and legs) lower extremities. 3) Frequent position changes. 4) Ambulate at intervals (if condition permits). 5) Measure intake and out put accurately. 7. Skin Care – 1.5 hours 7.1 Skin care factors: a. Skin is the first line of defense against infection. b. Skin assists in regulating body temperatures. c. Skin assists to remove body wastes (perspiration). d. Aging may cause changes in the skin- 1) Becomes scaly and dry. 2) Becomes delicate, thin and fragile (bruises and tears easily). 3) Wrinkles. 4) Loses its sensitivity to temperature changes and pain. 5) Becomes susceptible to decubiti (bedsores or pressure sores). e. A resident may not realize that a skin irritation is present due to loss of sensitivity. Therefore, check – 1) Bony prominences. 2) Scalp, head, neck, behind ears. 3) Skin folds. 4) Fingernails and toenails. 5) Change and color of skin.

Unit VI (contd.)

OBJECTIVE	CONTENT
List changes in skin condition that shall be reported to the charge nurse.	f. Observe and report changes in skin – 1) Redness. 2) Rashes. 3) Broken skin. 4) Tender places. 5) Blue areas. 6) Any changes in color or appearance.
	7.2 Decubitus ulcers (Bedsores/Pressure sores):
Identify resident's skin changes which are signs and symptoms of a decubitus ulcer.	a. Signs and symptoms – the resident's skin change will be – 1) Discolored: red, blue and/or white. 2) Warm. 3) Tender. 4) Painful. 5) Have feeling of burning. 6) Open as a sore. Damage may occur in underlying tissue before the skin breaks. Places to check on the body for a decubitus are the bony prominences, such as:
Describe places to check on the body for a decutitus ulcer (pressure sore).	7) Shoulder blades. 8) Elbows. 9) Knees. 10) Ankles. 11) Backbone. 12) Behind ears. 13) Buttocks. 14) Hips. 15) Heels.
State reasons why the elderly are prone to skin problems.	b. Older people are more prone to development of decubitus – 1) Their skin is very easily damaged. 2) They may not have an adequate amount of tissue padding over their bones. 3) They need to be reminded to turn and encouraged to be up in the chair.

Unit VI (contd.)

OBJECTIVE	CONTENT
	c. Obese residents tend to get decubitus formation on areas where their body parts rub together. Places to check for formation of bedsores are the folds of body where skin touches skin. 7.3 Prevention of decubitus:
List measures for preventing skin breakdown and decubitus.	a. Prevention is the responsibility of everyone involved in the resident's care. b. Observe skin daily and every time you reposition the resident for signs and symptoms of decubitus. c. Prevention involves removing causes – 1) Pressure: -Turn the resident often. Change his position at least every two hours (OLTC Regulation). -Don't leave a resident on a bedpan for a long time. -Keep bed linens or residents clothing free from wrinkles under his body. -Keep resident well hydrated.
Identify measures which help prevent decubitus ulcers.	2) Shearing: -Lift, rather than slide, resident when positioning in bed or chair. 3) Irritation: -Keep resident's skin clean and dry. -Keep linen and clothing clean and dry. -Check incontinent residents frequently. -Clean up urine and feces immediately. 4) Poor circulation: -Lightly massage the bony prominences with lotion each time you turn a resident. d. Devices used in preventing pressure – 1) Sheep skin/foam pads for elbows and heels.

Unit VI (contd.)

OBJECTIVE	CONTENT
	2) Flotation pad. 3) Water bed. 4) Alternating air mattress. 5) Air cushions. 6) Sponge rubber bed cushions. 8. Transfers/Positioning/Turning – 3 hours 8.1 Lifting and moving: a. Principles –
Identify general principles for lifting and moving.	1) Before procedure, explain it to resident. 2) Protect all tubing when moving someone. 3) Give most support to heaviest parts of the body. 4) Hold resident close to the body for best support. 5) Use smooth, steady, not jerky motions. 6) Lock bed and chair wheels. 7) Raise bed when moving someone remaining in bed. 8) Use "draw" or turn sheet whenever possible. 9) Use transfer belt around resident's waist for safety.
Demonstrate ability to move resident: -Raise to sitting position. -Move toward head of bed. -Move to one side of bed. -Turn from side to side. -Transfer from bed to chair and chair to bed. -Transfer from bed to stretcher.	b. Demonstrate the ability to – (refer to procedures #14, 38, & 41 in the Appendix) 1) Raise resident to sitting position. 2) Move resident toward head of bed. 3) Slide helpless resident to one side of bed. 4) Turn resident from side to side. 5) Transfer non-ambulatory resident from bed to wheelchair or chair. 6) Transfer from bed to stretcher.
Describe correct body alignment.	8.2 Body alignment: a. The correct positioning of the resident's body is referred to as body

Unit VI (contd.)

OBJECTIVE	CONTENT
	alignment. When a person's body is in correct body alignment – 1) Head is erect, not flexed forward nor extended backwards. 2) Vertebral column is in normal alignment. 3) The extremities are positioned according to the position of the resident. 4) Feet are in the "walking" position, not slanted forward. 5) The wrists are neither flexed or extended. 6) Fingers are slightly flexed. 7) Hips are straight in line with the thighs.
List the steps and demonstrate proper use of geriatric chairs and wheelchairs.	8.3 Safety with wheelchairs and geriatric chairs: (refer to procedure #13 in the Appendix) a. Resident shall be covered to protect from chilling. Blankets shall be kept away from wheels. Tuck the blanket firmly around the resident. b. The wheelchair or geriatric chair shall be wiped off with a disinfectant solution after each use, if it is to be used by others. c. Push the wheelchair from behind except when going in and out of elevators, pull the wheelchair into and out of the elevator backwards. d. If moving a resident down a ramp, take the wheelchair or geriatric chair down backwards. Glance over your shoulders to be sure of your directions and prevent collision and possible falls. e. Sets the brakes when – 1) Assisting a resident into a wheelchair or geriatric chair. 2) Assisting a resident out of a wheelchair or geriatric chair.

Unit VI (contd.)

OBJECTIVE	CONTENT
	3) When the wheelchair or geriatric chair is to remain stationary. f. Put foot rests up when assisting resident in and out of wheelchairs or geriatric chairs. g. Have resident's feet on foot rests when moving. Never push the wheelchair if the foot rests are in an up postion. h. If safety straps are needed they shall be fastened correctly. This may be considered a restraint, so follow accepted policy. i. Observe the resident's feet when turning the wheelchair or geriatric chair or when going down corridors. Pay attention where you are going and push chair slowly. j. Slow down at corners and LOOK before moving the wheelchair to prevent collisions with other residents, staff, etc. k. Elderly residents depend on the nursing assistant for safety – 1) Never assume that corridors are empty. 2) Push the wheelchair or geriatric chair slowly to prevent accidents.
Identify and demonstrate measures of proper use of mechanical hydraulic lifts.	8.4 Hydraulic lifts: (refer to procedure #48 in the Appendix) – a. Purpose – 1) Used for resident who cannot assist in transfer. 2) Used to move resident from bed to chair or into tub. b. General safety rules – 1) The wheelchair to which the resident is to be moved is placed nearby. 2) Allow enough room for the lift to be turned. 3) Wheelchair brakes are locked.

Unit VI (contd.)

OBJECTIVE	CONTENT
	4) Never operate a mechanical lift without the assistance of another staff person. Safety requires that at least two people are present. 5) LOCK ALL brakes after positioning lift. 6) Be sure that all locks and straps are fastened securely before operating lift. 7) When resident is secured in straps or slings, raise them slowly. 8) One person guides the resident's legs in the direction to go. Be careful that their legs do not bump into any objects. 9) The other person moves the lift. 10) Reassure the resident while transferring. 11) Elderly people are very frightened about falling.
Identify and demonstrate safe and proper use of walkers, canes and crutches.	8.5 Safe use of walkers, canes and crutches: a. All devices shall have skid-proof tips. b. Residents should wear skid-proof shoes. c. Walkers – 1) Stand still. 2) Place walker forward with all four legs solidly on floor. 3) Step forward toward walker, repeat. d. Crutches – 1) Should have some space between top of crutch and axilla. 2) Arms should be completely extended. 3) Weight supported on palms of hands. e. Cane – 1) Plain care (one foot). 2) Quad cane (having four feet to

OBJECTIVE	CONTENT
	put on the floor) is more stable than plain cane.
Identify and demonstrate steps to follow in assisting resident to walk.	8.6 Assist resident with walking: a. Resident should wear skidproof shoes. b. When assisting a resident from bed to walking, move resident slowly to avoid dizziness. c. Assist on weak side. d. Allow resident to use strong side for holding onto hand rails. e. When assisting a visually impaired resident, walk slightly ahead, allow resident to hold nursing assistant's arm. Explain hazards in path as necessary. f. Transfer belt may be used for safety.
	9. Occupied Bed – 1 hour 9.1 Used for a resident who is unable to be out of bed. 9.2 Important facts and considerations: a. To provide the resident with a clean, comfortable and dignified environment. b. To prevent skin irritation and breakdown by providing clean, dry and wrinkle-free linens. c. Is usually made after the resident's bed bath is completed.
Identify and demonstrate measures of making an occupied bed.	9.3 Measures of making an occupied bed: (refer to procedure #46 in the Appendix) a. Respect the resident's privacy – 1) Knock before entering the room and wait for the resident's permission to enter. 2) Identify yourself to the resident and what you plan to do. 3) Use the resident's privacy curtain and do not expose the resident any more than is necessary.

OBJECTIVE	CONTENT
Demonstrate ability to make an occupied bed.	b. Much the same as the unoccupied bed (see Part I, Unit V). c. Bottom sheets are to be smooth, tight and wrinkle-free under the resident. d. Be constantly aware of infection control. e. Do not rush the procedure. f. Place signal cord or call bell within reach of the resident.
Give the purpose of restraints.	10. Restraints – 1.5 hours 10.1 Purpose – for the protection of the resident to prevent injuries or interruption by the resident of needed treatments. 10.2 Applied after other measures have been tried and <u>documented</u> only on physician's order:
Identify the length of time restraints may be applied.	a. Use is to be temporary. Not applied longer than 12 hours. b. To be applied properly.
Tell how frequently restraints are to be checked.	c. To be checked every 30 minutes.
Tell how frequently the restraints are to be released and for how long.	d. To be released every 2 hours and resident exercised for 10 minutes and resident's position changed. 10.3 Types of restraints: a. Hand and foot restraints – 1) Used to keep a limb immobilized. 2) Wrist/ankle is padded with special felt pads. The cloth restraints are then applied by using a clove hitch (which will not tighten when pulled). The ends are then tied to the bed frame. NEVER attach a restraint to the side rails. b. Cross over jacket restraints (posey vest) –
Identify and describe the types of restraints.	1) Are put on like a jacket. 2) Ends are crossed over in back or front (as directed by manufacturer).

Unit VI (contd.)

OBJECTIVE	CONTENT
	3) Ends are tied behind wheel chair or on bed frame. c. Safety belts – 1) Locked restraints are not allowed (OLTC Regulation). 2) Belt goes around resident's waist. 3) Attaches to a longer belt which is fastened behind wheelchair or on bed frame. d. Mitt restraints – 1) Are used for confused residents who could harm themselves with their hands or fingers. 2) A mitt is similar to a paddle that encloses the hands.
Identify and demonstrate measures in the application of restraints.	10.4 Guidelines to follow in the application of restraints: (refer to procedure #10 in the Appendix) a. Allow resident as much movement as possible but still serving the intended purpose. b. Resident's circulation shall not be occluded by the restraint. c. Pad bony points under a restraint in order to prevent trauma. d. The restraint shall be applied so that the resident's body is in a normal position. e. Use the least amount of restraint that will protect the resident. f. Never apply restraints without a direct order from charge nurse.
Identify symptoms of occlusion.	g. Check the resident's extremity every 30 minutes for the following symptoms of occlusion: pallor, blueness, cold tingling, pain, pulses not present. If any of these symptoms are present, loosen restraints immediately and report to the charge nurse. h. Remove restraints every two hours. Exercise for at least 10 minutes

Unit VI (contd.)

OBJECTIVE	CONTENT
	and provide skin care. Ambulate resident if possible (OTLC Regulation). i. Never apply a restraint without checking the resident's circulation before leaving the room. Pulses shall be felt. Loosen restraint if they are not felt. j. Resident's medical record shall include: physician's order for restraint, reason for use, when applied and released, type of restraint, nursing care provided (OLTC Regulation). 10.5 PHYSICAL RESTRAINTS ARE NOT TO BE USED TO LIMIT RESIDENT MOBILITY FOR THE CONVENIENCE OF STAFF. If a resident's behavior is such that it will result in injury to self or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure designed to modify the behavioral problems for which the resident is restrained or as a last resort, after failure of attempted therapy.

Unit VII
Basic Nursing Skills
(10 hours theory/lab and 5 hours clinical)

OBJECTIVE	CONTENT
	1. Vital Signs – 7 hours
Identify why measuring vital signs are important as it relates to the nursing assistant.	1.1 Vital signs are the signs of life. Vital signs are the measurements of the function of the vital organs. Included in vital signs are temperature, pulse, respiration and blood pressure (T.P.R. and B.P.).
Describe what causes body temperature.	1.2 Temperature: a. Description – 1) Is a measurement of the amount of heat in the body, a balance between heat created and lost. 2) Is lost from the body to the environment by contact, perspiration, breathing and other means. 3) Is created as the body changes food to energy.
Define normal temperatures.	b. "Normal" or average temperature – 1) Oral – 98.6 degrees F (Fahrenheit). 2) Rectal – 99.6 degrees F. 3) Axillary – 97.6 degrees F. 4) Older people have a greater variation in normal range. One individual may have a usual temperature of 97 degrees F, another 99 degrees F. To determine deviations from "normal", it is helpful to know what is usual for that resident.
List situations that cause variations from "normal" temperature.	c. Variations from "normal" – 1) Some situations causing higher than normal readings are: eating warm food, time of day, infection or other diseases, smoking, snuff or other tobacco use. 2) Situations causing lower readings: eating cold food, time of day, dry mouth, approaching death.

Unit VII (contd.)

OBJECTIVE	CONTENT
Define fever.	d. Fever – elevated body temperature – 1) Warm skin.
Describe the signs and symptoms of above normal body temperature.	2) Flushed color. 3) Chills/teeth chattering. 4) Eyes burning. 5) Confusion. 6) Skin moist as fever breaks.
Describe the signs and symptoms of below normal body temperature.	e. Below normal body temperature – 1) Finger/toenails blush color. 2) Skin ashen color (gray/blue). 3) Cool/dry to touch.
Describe the types of thermometers.	f. Types of thermometers – 1) Glass – made of hollow glass tube containing mercury, has markings on outside for reading level. Types of glass thermometers: -slender tip – mercury filled tip is longer and slender; used for oral or axillary checks. -stubby or safety tip – mercury filled tip is short and rounded; used for any temperature check. 2) Electronic (battery powered) – has a probe which is covered with a disposable plastic sheath before inserting. Temperature registers on a digital display. 3) Chemically treated paper – changes color to indicate reading. g. Care of thermometers – 1) Easily breakable. Handle with care. 2) Avoid hot water in cleansing. 3) Disinfect after each use, as specified by facility or accepted nursing text procedure.

Unit VII (contd.)

OBJECTIVE	CONTENT
	h. Method of checking temperature –
Identify and demonstrate measures of taking an oral temperature.	1) Oral: -Used in most all situations, when not contraindicated. -Take per accepted procedure (refer to procedure #17 in the Appendix). -Stay with resident. -**Wash your hands.**
Identify and demonstrate measures of taking rectal temperature.	2) Rectal: -Used when oral is contraindicate, is unsafe or inaccurate. -Resident cannot hold mouth closed around thermometer. -Resident's mouth is dry or inflamed. -Resident is a mouth breather. -Resident is comatose. -Resident is using oxygen. -Take per accepted procedure (refer to procedure #28 in the Appendix). -Stay with resident. -**Wash your hands.**
Identify and demonstrate measures of taking an axillary temperature.	3) Axillary: -Used when other methods are unsafe or inaccurate. -This is a less accurate measurement than other methods of checking temperature. -Place bulb of thermometer in center of armpit. -Take per accepted procedure (refer to procedure #5 in the Appendix). -Stay with resident, holding thermometer in place. -**Wash your hands.**

Unit VII (contd.)

OBJECTIVE	CONTENT
Identify how the nursing assistant should record and report temperature measurement. Describe the cautions when taking a resident's temperature.	i. Recording/Reporting/Cautions – 1) Mark chart with "R" (rectal) and "Ax" (axillary) for the method used in taking the temperature. 2) Notify charge nurse when: -Resident's temperature is above his normal range or has changed by more than 2 degrees from last measurement. -There is difficulty obtaining temperature. 3) Cautions: -When removing the glass thermometer/electronic thermometer probe covering, the sheath <u>shall</u> be removed and destroyed. -Stay with the resident, holding the thermometer in place. -If thermometer breaks in the resident's mouth or rectum, report immediately to charge nurse. -The glass thermometer shall register below 96 degrees F before taking a temperature. -Ascertain that the electronic thermometer is fully charged and operable. 1.3 Pulse: a. Description – a measurement of the number of times the heart beats, a simple method of observing how the circulatory system is functioning. b. "Normal" or average pulse – 1) 60 to 90 beats per minute for an older resident. 2) Should be regular in rate, rhythm and strength or force.

Unit VII (contd.)

OBJECTIVE	CONTENT
	c. Variations in the pulse – 1) Abnormal force: -Bounding pulse. -Feeble, weak and thready. 2) Abnormal rate: -A pulse beat of under 60 beats for one full minute. -A pulse beat of over 90 beats for one full minute (exercise or activity normally cause a temporary increase in the pulse rate. Fever may increase the pulse rate). 3) Abnormal rhythm: -Irregularity of beats. -Feeling like beats are being "skipped" when pulse is counted for one full minute. d. Common sites for checking pulse – 1) Radial. 2) Apical. 3) Femoral. 4) Temporal. 5) Carotid.
Identify and demonstrate measures of taking the radial pulse.	e. Take per accepted procedure (refer to procedure #6 in the Appendix). f. Time – take pulse for one full minute. g. Recording and reporting – 1) Mark the chart with the symbol "Ap" when recording an apical pulse. 2) Notify the charge nurse when: -Pulse begins to show variations from "normal". -There is difficulty in obtaining pulse. 1.4 Respiration:
Identify what is meant by respiration and an average respiratory rate.	a. Description – respiration is the inspiration (taking in) and expiration (letting out) of air. b. Average respiratory rate – 16-24 inspiration/expiration per one full minute for a resident.

Unit VII (contd.)

OBJECTIVE	CONTENT
	c. Variations in respiration –
Identify variations from normal respiration which should be reported.	1) Rate: -Increased by exercise, fever, lung disease, and heart disease. -Decreased by sleep, inactivity, and pain medication. -Report rate greater than 28. -Report rate less than 12.
Identify character of respirations.	2) Character: -Labored – difficulty breathing, extra muscles used for breathing. -Noisy – sounds of obstruction, wheezing gurgling. -Shallow – small amounts of air exchanged. -Cheyenes-stokes – pause between labored/shallow respirations.
Demonstrate taking respiration rate.	3) Take per accepted procedure (refer to procedure #7 in the Appendix).
	1.5 Blood pressure:
Define blood pressure.	a. Blood pressure is the force of blood against artery.
Describe blood pressure.	b. A description of blood pressure – 1) The rate of strength of heart beat. 2) The ease with which the blood flows through the blood vessels. 3) The amount of blood within the system.
	c. Terms –
Define systolic.	1) Systolic pressure – the force when the heart is contracted; the top number of BP; the first sound heard when measuring BP.
Define diastolic pressure.	2) Diastolic Pressure – the force when the heart is relaxed; the lower number of BP; the level of which pulse sounds changed or cease.

Unit VII (contd.)

OBJECTIVE	CONTENT
Identify "normal" blood pressure range for systolic and diastolic blood pressure for an elderly resident.	d. "Normal" or average blood pressure range for an elderly resident is – 1) Systolic – 100 to 160 mmhg (mercury). 2) Diastolic – 60 to 90 mmhg. e. Variations in blood pressure – 1) Blood pressure may increase with age.
Define hypertension.	2) Hypertension – blood pressure higher than normal.
Define hypotension.	3) Hypotension – blood pressure lower than normal.
Define postural hypotension.	4) Postural hypotension – the elderly resident's body is unable to rapidly adjust to maintain normal blood pressure in the head and upper body when the resident moves from lying to standing, or sitting to standing. The resident will complain of dizziness or feeling faint.
Identify common causes of hypotension.	f. Common causes of hypotension – 1) Hemorrhage (loss of blood). 2) Shock. 3) Blood diseases.
Identify common causes of hypertension.	g. Common causes of hypertension – 1) Narrowing and hardening of the arteries. 2) Rupture of blood vessels in the brain (stroke). 3) Aged resident. 4) Overweight (obesity). 5) Kidney disorders.
Identify instruments to check blood pressure.	h. Instruments for checking blood pressure – 1) Sphygomanometer (blood pressure cuff and gauge). 2) Stethoscope.
Identify and demonstrate measures of taking blood pressure.	i. Procedure for taking blood pressure – 1) Choose a cuff appropriate size for the resident's arm.

Unit VII (contd.)

OBJECTIVE	CONTENT
	2) Position cuff on upper arm and position gauge for accurate reading.
Identify how to record and report blood pressure.	j. Recording and reporting – 1) Record – systolic over diastolic (e.g. 120/80). 2) Notify charge nurse when a resident's blood pressure is higher or lower than his normal range. 3) Difficulty in obtaining the blood pressure.
	1.6 Height and Weight (refer to procedure #4 in the Appendix).
Identify and demonstrate height measurement: -for the bedfast resident. -for the ambulatory resident.	a. Height – 1) Explain to the resident what you are going to do. 2) Wash your hands. 3) Have resident stand with arms to the side. 4) Make sure resident is standing as straight as possible. 5) Measure from top of head to bottom of feet. 6) If resident is unable to stand, have resident lie flat in bed and measure from head to feet. 7) Record height on paper and report to the nurse.
Identify importance of body weight.	b. Weight – 1) Importance: -Indicates nutritional status. -Weight loss/gain indicates change in medical condition.
Be able to explain accurate measurements and variance.	2) Accurate measurements shall be taken: -If weight varies more than 5 pounds, verify accuracy of weight and report to charge nurse.

OBJECTIVE	CONTENT
	3) Types of scales: -Wheelchair. -Bedscales. -Standing scales. -Scales attached to hydraulic lifts. -Bathroom.
Identify and demonstrate measures for weighing.	4) Procedure for weighing (refer to procedure #4 in the Appendix).
Identify when weights are taken.	5) Weight taken: -On admission (OLTC Regulation). -Once a month unless ordered more often by physician (OLTC Regulation).
	2. Recognizing and Reporting Abnormal Changes (1 hour) 2.1 Attitudes and actions prerequisite to making observation about residents:
List some attitudes and actions which are prerequisites for making observations about residents.	a. Making observations is continuous during resident care. b. Be alert at all times. c. Use senses to observe – 1) See changes such as skin rash or edema. 2) Feel changes such as fever or change in pulse. 3) Hear changes such as changes in breathing sounds. Listen to resident complaints. 4) Smell odor of urine. 2.2 Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor. Some examples of abnormal changes are: a. Shortness of breath. b. Rapid respiration. c. Fever. d. Coughs. e. Chills. f. Pains in chest. g. Blue color to lips.

Unit VII (contd.)

OBJECTIVE	CONTENT
	h. Pain in abdomen. i. Nausea. j. Vomiting. k. Drowsiness. l. Excessive thirst. m. Sweating. n. Pus. o. Blood or sediment in urine. p. Difficulty urinating. q. Frequent urination in small amounts. r. Pain or burning during urination. s. Urine has dark color or strong odor. 2.3 Reporting observations: a. Changes in resident's condition should be reported to charge nurse. b. The nursing assistant is encouraged to recall the observation of what was actually seen, heard, felt, rather than the interpretation of these observations. 2.4 Some of the more common diseases:
Define Alzheimer's Disease.	a. Alzheimer's Disease – 1) Progressive, age related brain disease that impairs thinking and behavior. 2) Causes decline in intellectual functions and ability to perform routine activities. 3) Disease has gradual onset and resident may experience confusion, personality change, impaired judgment and difficulty finding words, finishing thoughts or following directions. 4) Eventually the resident becomes totally unable to care for themselves.
Recognize that there are changes in the brain caused by Alzheimer's.	5) Changes in the brain are: -Senile plagues. -Neurofibraillary tangles in

Unit VII (contd.)

OBJECTIVE	CONTENT
	those areas of the brain responsible for memory and intellectual functions. -Lack of brain chemical acetylcholine which is involved in the processing of memory by the brain. 6) There is no treatment available to stop or reverse the mental deterioration of Alzheimer's Disease. b. Diabetes Mellitus –
Define Diabetes.	1) Diabetes is the result of the body's inability to break down and use carbohydrates (starches and sugars) to nourish the body cells in the production of insulin.
Identify the purpose and use of insulin.	2) Insulin is the hormone that produces the amount of glucose to be secreted into the blood stream to nourish the body cells. 3) If the body does not produce insulin, glucose builds up in the blood stream (hyperglycemia) and the cells cannot be nourished. The glucose spills out through the kidney into the urine (glycosuria). 4) The cells begin to use fats for metabolism. When fat is used too much a by-product (acetone) is excreted. Acetone is a type of ketone and when there are too many ketones in the body, it is excreted through the kidney. When the acetone/ketone level is very high the body is unable to excrete poison toxic substances causing acidosis. Coma and

Unit VII (contd.)

OBJECTIVE	CONTENT
	death are a result of severe acidosis. 5) Symptoms to report to nurse in charge; hunger, nervousness, weakness, headache, sweating, drowsiness, blurred vision, tingling sensations, stupor, death, thirst, increase in urine, nausea, vomiting, abdominal pain, slow mental response, flushed face, dry skin, and sweet breath. c. Respiratory Diseases – 1) Conditions which interfere with breathing and prevent the intake of sufficient oxygen.
Discuss the respiratory conditions which prevent the intake of sufficient oxygen.	2) Causes of problem are; Emphysemia, cancer, colds and flu, pneumonia, muscle weakness, changes in lungs, tuberculosis. 3) Symptoms; shortness of breath, wheezing, tightening and raising of shoulders, respiration faster and more shallow breathing, coughing, bluish or grayish skin color. 4) Report any symptoms to the charge nurse. d. Cerebrovascular Accident (CVA) –
Identify nursing assistant responsibility in caring for resident with a stroke.	1) A "stroke" is caused by; bleeding in the brain, blood clot in the brain, partially blocked blood vessel in the brain that impair the circulation of blood. 2) Symptoms; changes in vital signs, impaired memory, speech difficulty, changes in behavior, paralysis of part of the body, incontinence, difficulty swallowing, mental confusion, loss of sensitivity, and balance impairment.

Unit VII (contd.)

OBJECTIVE	CONTENT
	3) Care is to prevent complications, injury, provide safety and to restore maximum amount of independence: physically, mentally, and emotionally. e. Fractures – 1) Break in a bone. 2) Symptoms; loss of strength and movement, pain, tenderness over break area, bruising and swelling, deformity or misaligned body position. 3) Stay with resident. DO NOT MOVE RESIDENT. Call charge nurse when appropriate. Need to insure patient has adequate intake of fluids even though patient does not express "being thirsty."
Define fracture.	
Define AIDS. Identify modes of transmission of AIDS.	f. Acquired Immune Deficiency Syndrome (AIDS) – 1) AIDS is a body fluid and sexually transmitted disease in which a virus invades the body, damages the immune system, and allows other infectious agent to invade the body and cause death. 2) ARC (AIDES Related Complex) refers to a variety of conditions caused by secondary infections related to AIDS. 3) AIDS /ARC is caused by the Human Immune Deficiency Virus (HIV). 4) Transmission: -Spreads through body fluids, primarily blood and semen. -All body fluids and tissues should be regarded as potentially infectious.

Unit VII (contd.)

OBJECTIVE	CONTENT
	-AIDS is transmitted by sexual contact, by needle sharing, and through contaminated blood products. 5) Symptoms; may have no symptoms, may have AIDS Related Complex, enlarged lymph nodes, fungal infection of mouth accompanied by fatigue, weight loss.
Identify nursing assistants responsibilities in caring of the resident with heart disease.	g. Heart Disease – 1) Is the leading cause of death in the elderly. 2) Muscles of the heart do not pump as well. 3) The vessels leading to the heart become narrow. 4) Symptoms; changes in blood pressure, perspiration and weakness, pale, clammy skin, kidney output decreases, ankles and feet may swell, and nail beds may turn blue. 5) Nursing assistant responsibilities: -Follow directions of charge nurse. -Make resident as comfortable as possible. -Rest periods should be encouraged. -Help keep environment quiet. -Position residents to help breath easier.
Identify society's attitude about death.	3. Death and Dying (1 hour) 3.1 Stages of reaction to dying:
Describe stages of reaction to dying.	a. DENIAL – denying that death will occur – 1) Behaviors: -Unrealistically cheerful. -Ask lots of questions. -Disregard medical orders.

Unit VII (contd.)

OBJECTIVE	CONTENT
	2) Response to this behavior: -Listen and be accepting. -Do not probe. b. ANGER – anger that this is happening to me, and anger at others because it is not happening to them – 1) Behaviors: -Complaining. -Unreasonable requests. -Anger at family, doctor, and nursing staff. 2) Response to this behavior: -Listen. -Remain open and calm. -Don't try to place blame. c. BARGAINING – trying to make an agreement for postponing death – 1) Behaviors: -May be difficult to observe this stage. -Person vacillates between doubt and hope. 2) Response to this behavior: -Listen. -Do not contradict plans. -Promote a sense of hope. d. DEPRESSION – reality of death is unavoidable; is a reaction to getting sicker; and is grieving for the losses they will experience – 1) Behaviors: -Turn face away from people. -Not speak or speaks in expressionless voice. -Separating self from the world. 2) Response to behaviors: -Stay with the person as much as is possible. -Avoid cheery phrases and behavior. -Encourage the person to express feelings.

Unit VII (contd.)

OBJECTIVE	CONTENT
	e. ACCEPTANCE – realizes that death is inevitable. 3.2 Physical care of the dying resident: a. Physical care to meet the resident's needs continues to the person's death. b. Provide for keeping resident warm. c. Keep room well-lighted since vision diminishes. d. Provide for skin cleanliness due to perspiration and perhaps incontinence. e. Change position at least every 2 hours unless contraindicated. f. Give special attention to mouth care and take measures to moisten mouth to promote comfort. g. Speak to the resident in a normal voice. Assume that they can hear you even if they appear unconscious and speak accordingly. h. Provide for spiritual support, respecting the resident's personal wishes and not imposing one's own beliefs. i. Communicate through touch if the person appears unconscious.
Identify and demonstrate measures of post mortem care.	3.3 Post mortem care: (refer to procedure #37 in the Appendix). a. Meaning – caring for the body of the deceased. b. When a person dies, their physician is called to certify the death. c. The purpose for much of the post mortem care which is done is to prepare the body for reviewing at the funeral. d. How much is done by nursing home personnel depends on the local situation. If mortuary personnel pick up the body soon after death, care provided by the nursing home may consist of only-

Unit VII (contd.)

OBJECTIVE	CONTENT
	1) Place body in supine position. 2) Remove tubes, replace soiled dressings. 3) Account for what is done with or to whom personal effects are given. 4) Follow facilities policy and procedures. 4. Admission/Transfer/Discharge (1 hour) 4.1 Admission: a. Before admission – 1) Check the unit to insure furniture is present and in good condition. 2) Make sure that necessary equipment is available.
Identify feelings of resident/family on admission of resident.	b. Feelings of resident/family – 1) May be acutely aware of losses experienced with aging and illness. 2) Resident may feel lonely, lost, confused or relieved. 3) Family may experience guilt.
Identify and demonstrate responsibilities of the nursing assistant during the admission of a resident.	c. Responsibilities of the nursing assistant during admission – (refer to procedure #33 in the Appendix). 1) Greet the resident/family. Call the resident by proper name or the name the resident prefers. 2) Introduce yourself to the resident/family giving your name and position. Be courteous and friendly. <u>REMEMBER</u>, first impressions are often lasting impressions. 3) Show the resident the room, bathroom and how to use the call bell. 4) Assist in unpacking clothing and belongings.

Unit VII (contd.)

OBJECTIVE	CONTENT
	5) All items are to be properly labeled according to a policy of a facility. 6) Follow an approved inventory list of valuables, possessions, and clothing. 7) Give instructions as to time and place of meals. 8) Orient the resident/family to the facility. 9) Introduce resident/family to other residents and staff. 10) Make sure that the resident is comfortable. Check on the resident frequently.
Identify and demonstrate the responsibilities of the nursing assistant on transfer/discharge of a resident.	4.2 Transfer/Discharge: (refer to procedure #30 in the Appendix). a. Transfer/discharge arrangements are made by the attending physician and administration. b. The nursing assistant shall allow the resident to talk about anxieties and shall make every effort to insure the change is easy and pleasant. c. The nursing assistant shall be sure that all personal clothes and belongings are sent with the resident. d. When appropriate, the nursing assistant shall complete and sign inventory forms and transfer/discharge forms. e. Following the resident's discharge the room shall receive a thorough cleaning.

Unit VIII
Social/Cognitive/Behavioral
(5 hours theory/classroom lab)

OBJECTIVE	CONTENT
	1. Cognitive (Mental Functions)
Define the term cognitive as it relates to the responsibility of the nursing assistant.	1.1 Cognitive (Mental) Achievements: a. Memory and orientation. b. Immediate recall. c. Memory for recent and remote events. d. Orientation in time, place, and person. e. Concentration and good judgment. f. Current social and physical performance. g. Insight and judgments excellent.
Define cognitive functions as it refers to mental process of the resident.	1.2 Cognitive (Mental) Impairments: a. Comprehension. b. Judgments. c. Memory. d. Reasoning.
Identify the various mental abilities as it relates to level of consciousness, orientation, and intellectual capacity.	1.3 The various mental abilities do not decline at the same rate of speed: a. Level of consciousness – 1) The resident alert and quick to respond. 2) The resident drowsy and slow to respond. 3) The resident semiconscious and difficult to arouse. 4) The resident comatose and unable to respond. b. Orientation – 1) The resident alert to time, to place, to person. 2) The resident does not pay attention or understand when someone else is talking. 3) The resident wanders about, not oriented to place. 4) The resident is not knowing of self and others. c. Intellectual Capacity – 1) The nursing assistant should recognize factors which may block resident's intellectual abilities.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	2) The nursing assistant must be patient. The resident will most likely respond to kindness. 3) The nursing assistant must use a tone of voice that carries respect for the resident.
Identify factors which affect the resident's ability to recall, understand, for self awareness and judgment.	d. Ability to recall – 1) Events recent and past. 2) Attention span short. 3) Attention span normal. e. Ability to understand – 1) Ideas. 2) Planned daily activities. 3) Slow to follow planned daily activities. 4) Unable to follow planned daily activities. f. Level of ability to understand – 1) Quick to understand and make friendly relationships with others. 2) Slow to understand and to make friendly relationships with others. g. Self-awareness – 1) Has insight into own health problems. 2) Little or no insight into own health problems. h. Judgment – 1) Resident's ability to concentrate and make reasonable and appropriate decisions. 2) Selecting clothes to wear. 3) Taking part in care plan. 4) Expresses desires and needs as to individual resident's rights of long term care facility. i. Resident's ability to understand the rules and regulations of the long term care facility.

Unit VIII (contd.)

OBJECTIVE	CONTENT
List factors which affect memory and reasoning of the resident.	1.4 Memory: a. Mental registration, mental retention, mental recall of past experiences of – 1) Knowledge. 2) Ideas. 3) Sensations. 4) Thoughts. b. Forgetfulness is a normal process of aging. 1.5 Reasoning: the ability to think and/or respond and/or make choices.
Identify factors which affect cognitive impairments of the resident.	1.6 Cognitive Impairments: a. Factors which influence are – 1) Reactions to stress. 2) Progressive loss of brain cells. 3) Poor nutrition. 4) Interactions of medications. 5) Alcoholism. 6) Strokes. 7) Other diseases and/or disorders.
Define behavior as it relates to the residents.	2. Behavior 2.1 Behavior is defined as: a. Ability to adapt and adjust. b. To behave appropriately in situations. c. To behave in accordance with culturally approve standards. d. Satisfactions are achieved through love, work, and interpersonal relationships.
List factors which influence behavior of the resident.	2.2 Factors which influence behavior: a. Attitudes. b. Past and present experiences. c. Illness. d. Fever. e. Loss of self-confidence.
Identify ways in which the resident may express feelings through their behavior.	2.3 Appearance and behavior: a. Dress, posture, facial expression. b. Motor activity such as – 1) Agitation. 2) Impulse mannerism. 3) Retardation.

Unit VIII (contd.)

OBJECTIVE	CONTENT
Identify factors which affect the residents thought process.	2.4 Thought process – When any of these thought processes are observed, they should be reported to the charge nurse: 1) Stream of talk. 2) Impairment of thought process. 3) Pace and progression of speech. 4) Whether the speech is logical and to the point. 5) Whether the speech is confusing and irrelevant. 6) Whether there is a presence of thought disorder such as flight of ideas or obsessive thoughts.
	3. Cognitive/Behavior Improvements
Identify observations to be made during care of the confused or withdrawn resident.	3.1 Caring for the confused or withdrawn resident: a. Symptoms of confusion – 1) Not knowing self or others. 2) Talking incoherently. 3) Forgetful. 4) Not paying attention or understanding when someone is speaking. 5) Sleep disorders. 6) Hallucinate, visual and auditory. 7) Wanders about, not oriented to place. 8) Combative, hostile. b. Symptoms of Psycho-social impairments – 1) Frightened, unhappy, bewildered. 2) Unaware of environment; thus, does not sense danger. 3) Reduced intellectual and emotional contact with others. 4) Loss of self-expression. 5) Loss of independence. 6) Insecurity.

Unit VIII (contd.)

OBJECTIVE	CONTENT
List medical problems related to the residents care.	3.2 Possible causes of confusion: a. Medical problems including – 1) Chronic disease, such as heart, liver, kidney, and lung problems. 2) Stresses such as surgery or injury. 3) Degenerative brain conditions such as Alzheimer's Disease. 4) Arteriosclerosis. b. Poor nutrition. c. Medication – 1) Older people may not tolerate drugs as well. 2) Combination of drugs may cause confusion. 3.3 Causes of withdrawal: a. Losses, including sight and hearing. b. Depression. c. Mental illness. d. Confusion.
Identify the purpose of reality orientation of the resident.	3.4 Therapies for confusion and withdrawal: a. Reality orientation (R.O.). b. Purpose – to maintain reality contact and halt or reverse confusion or withdrawal.
List the responsibilities of nursing assistant in the reality orientation for residents.	c. Technique – 1) Consistent, constant (all 3 shifts) 24 hour repetition of information about person, place, time expectations. 2) Aids such as calendars, clocks, information boards can be used. 3) Reality orientation: -Introduce yourself upon entering a resident's room. -Explain what you are doing in the room. -Tell the resident the date, time and place. -Frequently ask the resident the date, time and place. -Ask the resident who he/she is and family members names, etc.

Unit VIII (contd.)

OBJECTIVE	CONTENT
Identify the nursing assistants role in response to the residents combativeness.	3.5 Responses to combativeness: a. Use non-threatening approach. b. Give recognition to feelings behind behavior. c. Request directions from charge nurse for proper plan of care. d. When approaching combative resident, go with enough assistance to complete procedure. e. If resident suddenly becomes combative, call for help, IMMEDIATELY. f. Do not try to physically restrain a combative resident by yourself. g. Report to charge nurse.
Define the purpose of the re-motivation program for the resident.	3.6 Re-motivation: a. Purpose – 1) Prevent withdrawal. 2) Increase interest in reality. 3) Stimulate thinking. 4) Participate/perform activities of daily living (ADL's). 3.7 Reminiscing: a. The resident has the right to reminisce about his/her life and to share feelings about the past, to promote feelings of worth and to reduce feelings of loneliness. 4. Understanding and Managing Behavioral Symptoms of Alzheimer's Disease and Related Disorders 4.1 Social Facade: a. Description – 1) Ability of the resident to look "not sick". 2) Ability of the resident to make casual conversation or general comments based on well ingrained memories. 3) While not looking ill, apparent energy can fool a casual observer.

OBJECTIVE	CONTENT
	b. Approaches – 1) Build on any and all attempts to have adult conversation with the resident. 2) Never remind the resident that self care is not possible. 3) Keep your conversation with the resident brief and pleasant. 4) Introduce the resident with a remark that calls upon the resident's past or present experience or interest. 4.2 Depression/Apathy/Withdrawal: a. Description – 1) Depression must last awhile, be fairly severe, and not be a grief reaction after the death of a loved one. 2) Older people may withdraw, appear listless or restless, have difficulty concentrating, not feel life is worth living. 3) Depression is sometimes different in older persons. 4) Alzheimer's residents function even more poorly than others who are depressed. b. Approaches – 1) If resident is sad and with - drawn, are there certain things that cheer the resident up? 2) Alert the doctor or nurse. 3) Spend special time with just the resident. 4) Reassure the resident of the resident's value as a person. 5) Reassure the resident that he/she will be cared for. 6) A special relationship with a staff person, favorite family visitor or a minister can relieve depression.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	7) Respect the resident's right to feel sad and give reassurance that you're there to help the resident to feel better. 8) It's wise to remove potentially dangerous objects and check the resident more frequently. 4.3 Rummaging, Pillaging, and Hoarding: a. Description – 1) Many Alzheimer's residents seem to be driven to search for something which they believe is "missing". 2) The resident has lost the ability to tell the difference between things that belong and things that are out of place. 3) Alzheimer's residents often lose memory of good manners. May enter a room without knocking or take their clothes off in public. 4) The resident believes things are taken away from him/her. 5) It is hard for the resident to tell which bed is his/hers so will sometimes enter the wrong bed. b. Approaches – 1) Best strategies are preventive. 2) Try to keep the resident occupied with a drawer of his/ her belongings. 3) Don't give moral judgment or rational explanations to the resident. 4) Distract the resident if he/she is in someone else's room by asking them if they want to go see TV, etc. 5) Learn the resident's favorite hiding place. 6) Persuade the resident that their chair is more comfortable if

Unit VIII (contd.)

OBJECTIVE	CONTENT
	he/she keeps sitting in the wrong chair or bed. 7) Wandering may be part of a search for the bathroom. 4.4 Wandering: a. Description – 1) There are more theories and proposed solution about wandering in dementia residents than any other symptoms of the disease. 2) Wandering has major implications for the family, facility and the community. 3) Some professionals see wandering as an expression of aimlessness, excessive restless-ness, or the need for self stimulation that comes from brain damaging illness. b. Approaches – 1) See if the resident is hungry, feels uncomfortable, needs to void, or is genuinely lost. 2) Removing from view, shoes, coat and suitcase may remove the immediate idea of the desire to "leave". 3) Try to keep the resident busy and in view of the staff. 4) Placing a picture on resident's door may help the resident to locate his/her room. 5) Avoid putting the resident in close, crowded situation where he/she may experience stress and confusion. 6) Give the resident something to occupy his/her time. 7) If the resident wanders away from the facility, approach the resident calmly and reassure him/ her. Do not interrogate the resident.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	4.5 Suspiciousness: a. Description – 1) Resident experiences more and more difficulty making sense of their experience and environment. 2) Residents are suspicious because it is hard for them to accept the fact that they forget where they put things. 3) The dementia resident feels victimized by something that robs him/her of his/her previous well being. 4) Whispering between staff or family and staff is interpreted as a plot to steal their money, power, influence or possessions. b. Approaches – 1) Don't argue or rationally explain disappearances. This only makes the resident feel stupid. Arguing only backs the resident into a corner, making him/her more insistent. 4.6 Delusions: a. Description – 1) Delusions are fixed or persistent beliefs of the resident that remain despite all rational evidence to the contrary. 2) Delusions can be frustrating or frightening to the resident. 3) Some delusions are harmless and can be ignored or glossed over. 4) Some delusions are based on real possibilities. b. Approaches – 1) Try to judge how much the delusion bothers the resident.

UNIT VIII (contd.)

OBJECTIVE	CONTENT
	2) Don't use rational explanations to convince the resident that a delusion is incorrect. 3) Reassure the resident and try to divert him/her to a less stressful subject. 4.7 Hallucinations: a. Descriptions – 1) Hallucinations are sensory experience (seeing, hearing, or feeling) which can't be verified by anyone else. 2) Seeing or hearing things is common in adults with brain disorders. 3) Symptoms may be worse if the resident has visual or hearing defects. b. Approaches – 1) If the resident is not too upset or disturbed by the hallucination then the resident can usually be diverted or distracted. 2) Frightening hallucinations especially if resulting from dream states usually subside in the well lighted company of others with plenty of attention and reassurance. 3) Anti-psychotic medication may be ordered in instances where the resident believes bugs are crawling on him/her or is in his/her food. 4) Residents with frightening hallucinations are best reassured by someone they trust. 4.8 Catastrophic Reactions: a. Description – 1) Catastrophic reactions is a term describing the behavior of a

Unit VIII (contd.)

OBJECTIVE	CONTENT
	dementia patient when a situation overwhelms his/her ability to think and react. 2) Behavior may be any of the following: suddenly changing mood, crying inconsolably for a long time, anger, increasing suspicious, increasing restless-ness, pacing, wondering off, combativeness, stubbornness, and worry or tension. 3) The resident appears stubborn, overly critical or overly emotional, all out of proportion to what has actually happened. 4) Reactions can be set off by a number of things: several questions being asked at once, being asked "why" questions, feeling lost, small accidents, too many people in a new place, being scolded or contradicted, having an argument, staff members that are tense, rushed or impatient, and if a patient tries and fails to complete a task he/she once regarded as simple. 5) Dementia residents experience a loss of impulse control. 6) The resident loses adult judgment. 7) The resident is unable to evaluate the seriousness of an incident therefore he/she "over-reacts". b. Approaches – 1) Try to head off or prevent situations that lead to catastrophic reaction. 2) Give directions one step at a time. 3) Using a rocking motion, patting, holding hands or

OBJECTIVE	CONTENT
	soothing music to calm the resident. 4) Distract the resident gradually with something new. 5) Allow the resident plenty of space during a catastrophic reactions. Move slowly and tell the resident exactly what you are doing. 6) Don't force a resident to spend time with someone that frightens or upsets him/her today because tomorrow may be a whole different story. 7) Don't take attacks personally. Attacks usually take place on whomever is closest. 4.9 Sundowning: a. Description – 1) Persons with acute or chronic confusion become more confused, restless and insecure late in the day and especially after dark. 2) Attention span and concentration become even more limiting. 3) No one knows what causes sundowning. 4) Patients with Alzheimer's tire more easily, even from minimal demands on their thinking ability, and become more restless and hard to manage when tired. 5) Sundowning may relate to a lack in sensory stimulation and the absence of routine daytime noises and dim lighting may trigger the Sundown behavior. 6) Alzheimer's residents may become more anxious late in the

Unit VIII (contd.)

OBJECTIVE	CONTENT
	day because they think they should be “going home” (all those feelings indicate a need for security and protection). b. Approaches – 1) An early afternoon rest may help if sundowning is caused by fatigue. 2) Keep the resident active in the morning. 3) Don’t physically restrain the resident. 4) Let the resident pace back and forth where he/she can be watched. 5) Give the resident something to fiddle within his/her hands to distract him/her. 6) Don’t ask the resident to make decisions. 4.10 Inappropriate Behavior: a. Description – 1) Loss of impulse control seen in brain diseases means infantile behaviors reappear. 2) Has nothing to do with success or failure of childhood discipline or training. 3) Resident may lose awareness that his/her behavior is not considered proper in public. 4) Time sense is severely affected and the resident becomes intolerable to even slight delays. b. Approaches – 1) Resident’s tactless insults don’t necessarily mean displeasure with one person but rather he/she is upset with his/her situation and the lack of control. 2) Ignore insults or cursing of the resident.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	3) Reassure the resident that you won't leave and that the doctor told you how to take care of him/her. 4) Childish patients who exhibit attention getting behavior may be craving more stimulation and will respond to a hug, pat or the chance to move around a little. 5) Don't over react to incidents.
	5. Social Care
List the basic human needs described.	5.1 There are five basic human needs which each individual needs are to be nurtured, accepted, loved and assisted to reach their highest potential (see Maslow's chart in Appendix): a. 1st level – 1) Food. 2) Air. 3) Water. 4) Activities. 5) Sleep. 6) Physiological survival. 7) Need. b. 2nd level – 1) Protection from harm. 2) Violence. 3) Disease. 4) War. 5) Poverty. 6) Assurance of continuing income and employment security. 7) Safety needs. c. 3rd level – 1) Love. 2) Accepted by others. 3) Approval. 4) Membership in group. 5) Belonging. 6) Social need.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	d. 4th level – 1) Worth. 2) Status. 3) Power. 4) Recognition. 5) Self-confidence-esteem. 6) Ego Needs. e. 5th level – 1) Full potential. 2) Creativity. 3) Self-actualizing needs.
List the emotional needs of the resident in a long term care facility.	5.2 Meeting emotional needs of the resident in a long term care facility: a. Independence – 1) Encourage decision-making in areas about which there can be a choice; foods when there is a selection, activities, when to do activities of daily living. 2) Encourage resident to be in control of his own body; self-care as is possible, choice of clothing. b. Need for supportive environment – 1) Supportive physical environment: -Proper medical and dental care. -Safe, comfortable clothing. -Room and halls free of accident-causing situations. -Protection from others. c. Need for social interaction – 1) Encourage contact between residents and persons outside facility. 2) Encourage interaction among residents. 3) Keep charge nurse informed of expressed needs or wants of resident. 4) Encourage resident to do as much as he can as well as he can for as long as he can.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	5) Encourage resident to maintain sense of belonging and self-esteem. 6) Insure resident does not become isolated or withdrawn from others by establishing rapport and becoming acquainted. 7) Promote interaction among other residents. d. Need for recognition as an individual- 1) Be respectful of each resident and allow for as much privacy as is possible. 2) Encourage self-expression in crafts, listening to their stories, recognizing past accomplishments. e. Spiritual needs – 1) Encourage and help resident to participate in spiritual observances. 2) Encourage and facilitate visits by clergy, if desired. 3) Respect individual beliefs; don't impose your own beliefs on residents.
Identify ways to help the residents meet their needs status.	f. Status needs – 1) Speak to the resident by proper name and title. 2) Listen to their memories and fears. 3) Recognize residents past experiences. 4) Remind resident to be proud and feel important. 5) Discuss current events and ask their opinion.
Identify the aspects of sexuality in the aging.	5.3 Social aspects of sexuality in the aging: a. Sexuality fulfills strong needs for elderly in close relationship to another. b. Sexuality is part of a person's individuality.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	c. There is continued need among the elderly for respect and privacy in sexual matters. d. Individuals should be protected from unwanted advances of others and from embarrassing themselves if confused. e. Masturbation – allow privacy and don’t interfere with this. However, if it occurs in public, it should be managed in a sensitive way to prevent offending others and degrading the individual. The nursing assistant should inform the charge nurse of this type of occurrence.

Unit IX
Basic Restorative Services
(5 hours theory/lab and 4 hours clinical)

OBJECTIVE	CONTENT
	1. Restorative Care – 1 hour
Define Restorative Care.	1.1 Restorative care involves the rehabilitation of the individual to the greatest personal, social, economical usefulness and independence of which the resident is capable:
Identify requirements of restorative care.	a. Restorative care requires the development of a fine degree of judgment to know when and when not to intervene. It is important to know how to intervene without the resident feeling he has failed. b. The maintenance of physical, mental and social functional abilities and capabilities require their constant use. The effects of inactivity becomes apparent within a few days and compounds the disabilities that result from injury or illness.
Identify changes in functional abilities associated with aging.	1.2 Residents awareness of changes of functional ability associated with aging: a. Becomes aware of using stair railings. b. Becomes aware of pausing before stepping off a curb. c. Becomes aware of stopping part of the way up a flight of steps. d. Becomes aware of the need for reading glasses or bifocals. e. Becomes aware that a whole day spent with children, friends, or relatives is tiring. f. Becomes aware that behavior that once was accepted is now irritating. g. Adoption to illness, emotional or social crisis become difficult.
Identify approaches to restorative care.	1.3 Approaches to restorative nursing care: a. Efforts directed to assist each resident to – 1) Express how he feels about his illness, himself, his behavior and wants.

Unit IX (contd.)

OBJECTIVE	CONTENT
	2) Become as independent as possible in Activities of Daily Living (ADL). 3) Prevent complications of illness or injury. 4) Learn new skills. 5) Develop a sense of personal accomplishment, usefulness, and pride. 6) Learn to accept the accomplishment of small goals because total rehabilitation may not be possible. 7) Remember skills are acquired.
List approaches to restoring resident's independence.	b. Approaches to restore resident's independence – 1) Be patient and give the resident plenty of time to do for himself. 2) Express confidence in his ability to be independent. 3) Emphasize the progress the resident makes. 4) Offer verbal praise for the resident's efforts to do things for himself. 1.4 Measures of restorative care:
List physical measures of restorative care.	a. Physical measure – 1) Proper body alignment. 2) Bed/Chair positioning. 3) Range of motion exercise. 4) Bowel and Bladder training. 5) Ambulation. 6) Elevation of extremities as indicated.
Name mechanical devices used in restorative care.	b. Mechanical devices – 1) Foot board. 2) Self help devices. 3) Pillows. 4) Hand rolls. 5) Eye glasses. 6) Hearing aid. 7) Dentures.

Unit IX (contd.)

OBJECTIVE	CONTENT
	8) Prosthetic and orthotic devices, use and care of.
State educational and counseling services in restorative care.	c. Educational and counseling services – 1) Prevention of Intellectual regression. 2) Reality Orientation. 3) Remotivation.
	2. Range of Motion (ROM) – 2 hours
Identify the types of ROM exercises.	2.1 Range of motion exercises should permit each of the resident's joints to be exercised. There are three types: a. Active exercise is performed by the resident. b. Passive exercises are performed by someone else when a resident cannot carry out such movement. c. Resistive exercises are performed in response to resistance that is offered by a therapist. 2.2 Rules to follow – Range of motion exercises: a. Do each exercise three times. (Follow the head nurse's or team leader's instructions.) b. Follow a logical sequence so that each joint and muscle is exercised. For instance, start at the head and work your way down to the feet. c. If the patient is able to move parts of the body, encourage him to do as much as he can. d. Be gentle. Never bend or extend a body part further than it can go. e. If a patient complains of unusual pain or discomfort in a particular body part, be sure to report this to your head nurse or team leader. 2.3 Procedure – ROM exercises: (refer to procedure #39 in the Appendix) a. Assemble your equipment – 1) Blanket. 2) Extra lighting, if necessary.

Unit IX (contd.)

OBJECTIVE	CONTENT
	b. Wash your hands. c. Identify the patient by checking the identification bracelet. d. Ask visitors to step out of the room, if this is your hospital's policy. e. Explain to the patient that you are going to help him exercise his muscles and joints while he is in bed. f. Pull the curtain around the bed for privacy. g. Raise the bed to a comfortable working position. h. Place the patient in a supine position (on his back) with his knees extended and his arms at his side. i. Loosen the top sheets, but don't expose the patient. j. Raise the side rail on the far side of the bed. k. Exercise the neck.
List goals of bladder and bowel training.	3. Rehabilitative Care – 2 hours 3.1 Bowel and bladder training: a. Goals of bowel and bladder training – 1) Establish a regular pattern of elimination. 2) Decrease the amount of times a resident is incontinent. 3) Increase a resident's self esteem by attaining control of elimination. 4) Decrease the chance of other problems; e.g. skin breakdown that can occur fro continued incontinence. 5) Preserve the integrity and function of the elimination system. b. Preparation for bowel and bladder training – 1) Explain the reason and the importance of possible positive

Unit IX (contd.)

OBJECTIVE	CONTENT
	benefits of bowel and bladder training. 2) Encourage involvement of the family members. 3) The resident's past elimination pattern is reviewed, as well as the total resident history. 4) A routine for elimination is established by the nurse and written on the nursing care plan. It is resident's personal plan of elimination is carried out by the entire staff. 5) Each long-term care facility will have a specific program that is followed by the staff. These may be different from facility to facility but the basic goal is the same.
Identify steps in bladder training.	c. Steps involved in bladder training – 1) Provide privacy. 2) Adequate fluid intake. 3) Bedside commode or toilet other than bedpan. 4) Use any technique to stimulate voiding. 5) Adhere to the time schedule as outlined in the care plan of the resident. 6) Regularity is the key to successful program. 7) Requires cooperation of shifts. 8) Increase the time interval as possible. 9) Positive reinforcement. 10) Record output and success or non-success each time for evaluation and planning.

Unit IX (contd.)

OBJECTIVE	CONTENT
Identify steps in bowel training.	d. Steps involved in bowel training – 1) Provide privacy. 2) Encourage resident to eat prescribed diet. 3) Assist resident to bathroom facilities immediately after morning meal. 4) Encourage exercise. 5) Positive encouragement. 6) Encourage fluids. 7) Record success or non-success for evaluation and planning.

PART III

CLASSROOM & CLINICAL TRAINING – 15 HOURS

(Theory, Classroom Lab and Clinical)

NOTE: Effective July 1, 2006, all nursing assistant training programs must include Part III in their program. This is required in addition to the 75 hour training program, making the total of 90 clock hours of training.

BARBARA BROYLES ALZHEIMER AND DEMENTIA TRAINING PROGRAM FOR NURSING ASSISTANTS

Do not ask me to remember.
Don't try to make me understand.
Let me rest and know you're with me.
Kiss my cheek and hold my hand.

I'm confused beyond your concept.
I am sad and sick and lost.
All I know is that I need you.
To be with me at all cost.

Do not lose your patience with me.
Do not scold or curse or cry.
I can't help the way I'm acting.
Can't be different though I try.

Just remember that I need you.
That the best of me is gone.
Please don't fail to stand beside me.
Love me 'til my life is done.

Author unknown

The Office of Long Term Care wishes to extend sincere appreciation to University of Arkansas Athletic Director Frank Broyles, Representative Sandra Prater, Senator Mary Ann Salmon, Representative Shirley Borhauer, Dr. Cornelia Beck, and Gwynn Davis.

Representative Prater with assistance and encouragement from Representative Borhauer spent numerous hours creating and sponsoring the legislation that made possible the training provided by way of this curriculum, including the requisite funding. Without her initial impetus and unwavering efforts, Arkansas would still lack this necessary element of CNA training. Senator Salmon, recognizing the value of this necessary training, co-sponsored the legislation and helped shepherd it through the Arkansas Senate.

During the legislative session, Coach Broyles provided dramatic and very personal testimony of the struggles that he and his family faced while his wife, Barbara, battled with this terrible disease. In doing so, Coach Broyles gave a face and feelings to what can oft times be a purely theoretical discussion. His unselfish act of revealing these personal and intimate moments were instrumental in the swift and virtually unanimous approval of the law.

Dr. Cornelia Beck and Gwynn Davis, both of UAMS, proved to be invaluable in the actual content and creation of the curriculum. Without their expertise and efforts, not only would this manual have been significantly delayed, the quality would have suffered greatly.

This Alzheimer's/Dementia curriculum was developed to encompass provisions set forth in Act 1184 of 2005 and will be incorporated into the Arkansas' Office of Long Term Care regulations for Nursing Assistant Training Curriculum. The committee developing the Barbara Broyles Alzheimer's and Dementia Curriculum included the following persons:

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Arkansas Department of Health and Human Services
Office of Long Term Care

Barbara Broyles Alzheimer's and Dementia Training Program

Objective: The Trainee shall understand: Alzheimer's disease and dementia terminology, signs of disease progression, care at specific stages; demonstrate communication skills; discuss principles of nutrition and hydration as related to Alzheimer's disease; discuss common behaviors and interventions associated with Alzheimer's and dementia; and discuss burnout and burnout prevention.

Required Videos: Bathing Without a Battle; Look at Me
Required: Documentation of completion of Bathing Without a Battle