



TEXAS

Health and Human Services

Texas Curriculum For Nurse Aides in Long-Term Care Facilities

(Sixth Edition 2018)

HEALTH AND HUMAN SERVICES COMMISSION
REGULATORY SERVICES
NURSE AIDE TRAINING PROGRAM MAIL CODE E-420
PO BOX 149030
AUSTIN, TEXAS 78714-9030
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TABLE OF CONTENTS

Part 1 COURSE OUTLINE

Page

Section I Introduction to Long Term Care (LTC)	1
• Unit 1 – Introduction	5
• Unit 2 – Role of the Nurse Aide in LTC	10
• Unit 3 – Safety Measures	12
• Unit 4 – Emergency Measures	18
• Unit 5 – Infection Control	20
• Unit 6 – Resident Rights and Independence	33
• Unit 7 – Communication and Interpersonal Skills	39
• Unit 8 – Taking Care of Yourself	45
Section II Personal Care Skills	50
• Unit 1 – Body Mechanics, Positioning and Moving Residents	52
• Unit 2 – Care of The Residents Environment	55
• Unit 3 – Assisting Residents with Bathing	57
• Unit 4 – Toileting and Perineal Care	59
• Unit 5 – Skin Care	61
• Unit 6 – Hygiene and Grooming	63
• Unit 7 – Nutrition	66
• Unit 8 – Hydration	69
• Unit 9 – Elimination	71
Section III Basic Nursing Skills	74
• Unit 1 – Promoting a Restraint-Proper Environment	76
• Unit 2 – Vital Signs, Height and Weight	79
• Unit 3 – Observing, Reporting and Charting	82
• Unit 4 – Admission, Transfer and Discharge	87
• Unit 5 – Coping with Death	89
Section IV Restorative Services	91
• Unit 1 – Introduction to Restoration Services	93
• Unit 2 – Role of the Nurse Aide in Restoration Care	96
Section V Mental Health and Social Service Needs	101
• Unit 1 – Psychosocial Needs of Residents	103
• Unit 2 – Culture Change	111
• Unit 3 – Specific Behavior Problems	115
• Unit 4 – Cognitive Impairment	120
Section VI Social Skills	127
• Unit 1 – Conflict Resolution	128
• Unit 2 – Technologies	133

<u>Part 2 Procedural Guidelines</u>	135
Section I Safety and Emergency Procedures	136
1. Fainting and Falls	136
2. Seizures	137
3. Clearing the Obstructed Airway	138
4. Personal Protective Equipment (PPE)	141
5. Body Mechanics for Nurse Aides	143
Section II Infection Control	145
6. Hand Washing	145
7. Isolation Precautions	146
Section III Communication	149
8. Communication and Interpersonal Skills	149
Section IV Nutrition & Hydration	154
9. Assisting with Meals	154
10. Feeding the Dependent Resident	156
Section V Resident's Environment	158
11. Making the Unoccupied Bed	158
12. Making the Occupied Bed	160
Section VI Basic Nursing Skills	162
13. Intake and Output (I&O)	162
14. Temperature (Oral, Axillary and Rectal)	164
15. Manual Pulse and Respiration	165
16. Blood Pressure	166
17. Height and Weight	167
Section VII Personal Care	169
18. Tub or Shower Bath	169
19. Complete Bed Bath	171
20. Perineal Care/Incontinent Care-Female (With or Without Catheter)	173
21. Perineal Care/Incontinent Care-Male (With or Without Catheter)	175
22. Catheter Care	177
23. Brushing the Teeth	179
24. Denture Care	180
25. Special Mouth Care	182
26. Hair Care	183
27. Shampooing the Hair	184
28. Shaving the Resident	185
29. Fingernail Care	187

30. Foot Care	189
31. Dressing and Undressing the Resident	191
32. Applying Knee High Elastic (Compression) Stockings	192
Section VIII Elimination Care	193
33. Bedpan	193
34. Urinal	195
35. Indwelling Urinary Catheter Care	197
36. Urine Specimen Collection	200
37. Stool Specimen Collection	201
Section IX Caring for Resident Death	203
38. Postmortem Care	203
Section X Basic Restoration Services	205
39. Assisting Resident to Transfer to Chair or Wheelchair	205
40. Ambulation and Ambulation Aids	208
41. Passive Range of Motion Exercises (PROM)	210
Section XI Prevention of Pressure Ulcers	212
42. Positioning Residents	212
43. Turning Resident on Side Toward You	214
44. Moving Resident in Bed	216
45. Assisting Resident to Sit Up on Side of Bed	218

Part 3 National Nurse Aide Assessment Program (NNAAP) Skills

Part 4 Appendix

- Appendix A – Guidelines for Using the Texas Curriculum for Nurse Aides in Long-Term Care Facilities
- Appendix B – Nurse Aide Performance Record
- Appendix C – Daily Sign-In Record
- Appendix D – Texas Administrative Code

USDA Food Plate

Glossary of Terms

Reference Page

COURSE OBJECTIVES:

To prepare nurse aides with the knowledge, skills and abilities essential for the provision of basic care to residents in long-term care facilities. After completing this course, participants will be able to:

- provide person-centered basic care to residents of long-term care facilities.
- communicate and interact therapeutically with residents and their families, with sensitivity to the physical, social, and mental needs of residents.
- assist residents in attaining and maintaining maximum functional independence.
- protect, support and promote the rights of residents.
- provide safety and preventive measures in the care of residents.
- demonstrate skill in observing, reporting and documentation.
- function effectively as a member of the health care team.

COURSE CONTENT – SECTION I INTRODUCTION TO LONG-TERM CARE (LTC)

KEY TERMS

Abuse - the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

Airborne Precautions - actions taken to minimize the transmission of infectious agents that remain infectious when suspended in the air.

Alcohol Based Hand Rub or Sanitizer - a 60-90% alcohol containing preparation designed for use on the hands to reduce the number of microorganisms.

Antiseptic Hand Wash - washing hands with water and soap containing an antiseptic agent.

Biohazardous Waste - items that are contaminated with blood, body fluids, feces, or other body substances that may be harmful.

Bloodborne Pathogens - microorganisms that are present in human blood and can cause disease.

Competency Evaluation Program (CEP) - A hands-on skills examination and a written or oral examination approved by HHSC that tests the competency of a nurse aide.

Contaminated - dirty or soiled with microorganisms.

Contact Precautions - measures that are intended to prevent the transmission of infectious agents that are spread by direct or indirect contact with a resident.

Culture Change - the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working with them are considered and respected.

Dementia - Dementia is an umbrella term for a group of signs and symptoms that describe decline in a person's mental ability that is severe enough to interfere with his/her daily life.

Droplet Precautions - actions designed to reduce or prevent the transmission of pathogens spread through close respiratory secretions.

Employee Misconduct Registry (EMR) - a registry maintained by HHSC, in accordance with Texas Health and Safety Code, Chapter 253, to track findings of reportable conduct by an unlicensed employee of a facility. The EMR lists persons who are not employable in a facility.

Hand Hygiene - washing hands with water and soap or soap/detergent containing an antiseptic agent or thoroughly and correctly applying an Alcohol Based Sanitizer.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - a law which protects the privacy of individually identifiable health information and includes; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information, and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze resident safety events and improve resident safety.

Infection - establishment of an infective organism on a suitable host (person), which results in signs and symptoms (such as fever, redness, heat).

Isolation - practices employed to reduce the spread of infectious organisms, usually including the separation of the resident with an easily transmitted disease from other residents.

Long-Term Care (LTC) - services that help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves.

Medical Asepsis: practices used to remove or destroy pathogens and prevent their spread from one person or place to another person or place, also called clean technique.

Microorganism (Germ, Pathogen) - a living organism so small that it can only be seen with the aid of a microscope and that often causes disease.

Minimum Data Set (MDS) – a 52 page assessment document used to record a complete assessment of a nursing facility residents health status and functional capabilities.

Misappropriation of Resident Property – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

Neglect – the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Nurse Aide - An individual providing nursing or nursing-related services to residents in a facility under the supervision of a licensed nurse who has successfully completed a NATCEP approved by the state or has been determined competent by waiver or reciprocity and is listed as active on the Nurse Aide Registry. This definition does not include an individual who is a licensed health professional or a registered dietitian or who volunteers such services without monetary compensation.

Nurse Aide Training and Competency Evaluation Program (NATCEP) - A program approved by HHSC to train and evaluate an individual’s ability to act in the capacity of a nurse aide for the purpose of working in a nursing facility.

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

Occupational Safety and Health Administration (OSHA) - a government agency mandated to protect the employee by establishing and monitoring work place safety requirements.

Parasite - an organism that lives within or upon another organism or host (person or an animal).

Person-Centered Care - care that aims to be resident focused, to promote independence and autonomy, to provide choice and control and to be based on a collaborative team philosophy. It takes into account the resident's needs and views and builds relationships with his/her family members.

Personal Protective Equipment (PPE) - protective items or garments worn alone or in combination to protect the body or clothing from contact with infectious agents. These include but are not limited to gloves, gowns, masks and protective eye wear.

Registry - a state listing of all individuals who have satisfactorily completed a NATCEP or a CEP approved by HHSC or qualified by waiver or reciprocity and are deemed active and employable in a nursing facility. Nurse aides who have a finding entered on the registry of committing an act of abuse, neglect, or misappropriation of resident or consumer property are deemed unemployable in a nursing facility pursuant to 42 Code of Federal Regulation (CFR), §483.156.

Resident - A person accepted for care or residing in a facility.

Standard Precautions - infection prevention practices that apply to all residents regardless of infection status.

Texas Health and Human Services Commission (HHSC) - Department that regulates the nurse aide registry and training programs.

Transmission Based Precautions (Isolation Precautions) – steps taken to prevent the spread of infection by identifying potentially infectious individuals and using airborne, contact, and/or droplet precautions as indicated, in addition to standard precautions

PROCEDURAL GUIDELINES USED IN THIS SECTION:

- Procedural Guideline #1 – Fainting and Falls
- Procedural Guideline #2 – Seizures
- Procedural Guideline #3 – Clearing the Obstructed Airway (HEIMLICHMANEUVER)
- Procedural Guideline #4 – Personal Protective Equipment (PPE)
- Procedural Guideline #6 – Hand Washing
- Procedural Guideline #8 – Communication and Interpersonal Skills

COURSE CONTENT
SECTION I - INTRODUCTION TO LONG-TERM CARE (LTC)

UNIT 1– INTRODUCTION

A. INTRODUCTION TO COURSE

1. History and importance of a nurse aide
2. Course content and student objectives
3. Class and clinical schedules
4. Textbooks/references
5. Course requirements and assignments

B. INTRODUCTION TO PERSON-CENTERED CARE

1. Person-centered care is a care concept that recognizes that individuals have unique values, personal histories and personalities and that each person has an equal right to dignity, respect, and to participate fully in his/her environment.
2. The goal of person-centered care honors the importance of keeping the person at the center of his/her care and decision making process.
3. In person-centered care, those providing the care must actively listen and observe to be able to adapt to each individual's changing needs, regardless of his/her condition or disease process.
4. In long-term care, the person-centered care model is extremely important to ensuring that everyone is treated as an individual with the focus not being placed on his/her illness, abilities, or inabilities.
5. Making sure that people are involved in and central to their care is now recognized as a key component of providing for a high quality of health care.
6. There are many aspects of person-centered care that should be accounted for:
 - a) Respecting one's values and putting them at the center of their care;
 - b) Taking into account someone's preferences and expressed needs;
 - c) Coordinating and integrating care;
 - d) Working together to make sure there is good communication with the individual and that information and education is effectively passed along;
 - e) Making sure people are physically comfortable and safe;
 - f) Providing emotional support;
 - g) Involving the individual's family and friends;
 - h) Making sure there is continuity between and within the services that the person is receiving; and
 - i) Making sure people have access to appropriate care when they need it.

7. Person-centered care is about focusing care on the needs of the person in all areas of care, including:
 - a) Activities of Daily Living (ADLs) by ensuring that the resident is allowed to make choices on what they want to wear, when he/she want to take/receive a shower, and how he/she want to have his/her hair done, just to name a few.
 - b) Dining and Nutrition to ensure that the resident is provided with the food that he/she wants to eat, when to consume each meal, and whether or not to eat in the dining room or his/her personal room.
 - c) Activities to ensure that a resident is provided with meaningful activities that he/she wants to do, when he/she wants to do them, and how he/she wants to do them (to the best of his/her abilities).

C. INTRODUCTION TO OBRA

1. The Omnibus Budget Reconciliation Act (OBRA) of 1987 is a federal law that establishes regulations for nursing facilities and nurse aide training in facilities.
2. The intent of OBRA is to improve the quality of life for residents in nursing facilities.
3. OBRA facility regulations focus on:
 - a) Resident rights, restorative care, psychosocial care and preventive care to maintain maximum physical and mental wellness of residents.
 - b) State inspection of facilities for compliance with regulations with penalties for noncompliance.
4. OBRA nurse aide training regulations include:
 - a) The facility must assure that nurse aides complete an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) and be placed on the Nurse Aide Registry within 4 months of their date of hire by the facility.
 - The first 16 hours of training must be completed prior to any direct contact with a resident.
 - After the first 16 hours, nurse aides can perform only those skills for which they have been trained and found to be proficient by the instructor.
 - b) An approved Nurse Aide Training Program must be at least 100 clock hours in length (including 60 classroom and 40 clinical training hours). The nurse aide must pass the training program to be eligible to take the state test.
 - c) The state test (CEP) includes:
 - A written or oral exam.
 - A skills test consisting of 5 randomly selected skills.The nurse aide must pass the skills and written test before being placed on the registry. The nurse aide has 3 opportunities to pass each test and must meet competency within two years of his or her training completion date.
5. State registry requirements include:
 - a) Each individual listed on the registry must keep the department informed of his or her current address and telephone number.
 - b) Nurse aide certification expires 24 months after being entered into the registry. Nurse aides must submit verification of paid employment prior to the expiration date to continue certification.
 - c) Nurse aides renewing certification after September 1, 2013 must complete 24 hours

- of in-service education every two years.
- d) HHSC does not recertify nurse aides that are listed on the Employee Misconduct Registry (EMR) or have been convicted of a criminal offense listed in Texas Health and Safety Code, §250.006.
- e) A finding of abuse, neglect or misappropriation of resident property may be entered into the registry. If a finding is entered, the nurse aide will not be employable as a nurse aide in LTC facilities.
- f) See Appendix D: Texas Administrative Code, Title 26, Part 1, Section 556.9 and Section 556.12.

D. INTRODUCTION TO RESIDENTS IN LTC FACILITIES

1. Purpose of LTC facilities
 - a) Designed to meet the needs of persons who cannot care for themselves but do not need hospital care.
2. LTC facilities meet the needs of those who may be
 - a) Alert and oriented
 - b) Confused and disoriented
 - c) Needing complete care
 - d) Geriatric
 - e) Disabled
 - Physically
 - Mentally
 - f) Requiring skilled nursing care (short-term care)
 - g) Pediatric
 - h) Needing post-acute care
 - i) Terminally ill needing hospice care
 - j) Other
3. Needs common to residents
 - a) Physical
 - b) Psychosocial
 - c) Privacy
4. Myths and feelings about aging

E. INTRODUCTION TO DEMENTIA IN LONG-TERM CARE

1. Dementia is an umbrella term for a group of signs and symptoms that describe decline in a person's mental ability that is severe enough to interfere with his/her daily life.
2. There are over 100 different types of dementia, with the most common types of dementia being:
 - a) Alzheimer's Disease: the most common type of dementia, accounting for 60%-80% of all cases of dementia. The abnormalities seen in Alzheimer's Disease include: deposits of protein fragment beta-amyloid (plaques); twisted strands of protein tau (tangles); and evidence of nerve cell damage and death in the brain.
 - b) Vascular dementia (also known as multi-infarct): the second most common type of dementia, accounting for approximately 10% of all dementias. This type of dementia shows, in brain imaging that there are blood vessel problems.
 - c) Dementia with Lewy Bodies: the third most common type of dementia that shows Lewy bodies, which are abnormal clumps of the protein alpha-synuclein that

develop in the cortex of the brain.

3. Knowing how the different types of dementia affect the brain will help you to understand why some people with dementia behave in the ways that they do.
4. A resident may present with different signs and symptoms, depending on the area of the brain that is being affected. The different signs and symptoms may include (not all-inclusive):
 - a) Trouble remembering things;
 - b) Impaired communication;
 - c) Poor judgment;
 - d) Disorientation;
 - e) Confusion;
 - f) Behavior changes;
 - g) Problems with planning;
 - h) Sleep disturbances; and
 - i) Difficulty with walking, speaking, and swallowing.
5. As with any disease process that affects the brain, there is the possibility for behavioral issues that may be due to his/her inability to communicate. As his/her condition progresses, the resident may start to display behaviors that may be out of character. These behaviors are often the result of an unmet need such as hunger, thirst, pain, needing to use the bathroom, being comfortable, and many others.
6. The behaviors that may be seen include aggression, agitation, depression, hallucinations, suspicions, repetition in speech or actions, and wandering, to name a few.
7. Understanding these behaviors is the first step in being able to assist someone with the possible unmet needs, which could possibly decrease the behaviors or eliminate them all together.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION I - Required Time = 16 Hrs

UNIT I – INTRODUCTION

NOTES TO INSTRUCTOR:

- *Discuss how today's nurse aide came about, how they are essential to the health care team and how it can be an entry point to a nursing profession.*
- *The first 16 hours of content (Section I "Introduction to LTC") MUST be completed prior to any direct contact with a resident. (see §556.3(i). It should not be used as the orientation to a specific facility.*
- *Distribute a copy of the Texas Nurse Aide Candidate Handbook to each student.*
- *Stress the importance of updating nurse aide certification by submitting employment verification.*

STUDENT OBJECTIVES:

- *Identify 5 of the aspects of Person-Centered Care.*
- *State the intent of OBRA.*
- *Describe the OBRA requirements for nurse aide training and placement on the Texas Registry.*
- *Discuss who can work as a nurse aide in a nursing facility.*
- *Discuss the benefits of this course to residents, nurse aides and LTC facilities.*
- *State the purpose of the LTC facility.*
- *Describe the types of residents in LTC facilities.*
- *Discuss common needs we all share.*
- *Explain the resident's right to privacy of person and condition.*
- *Describe a common belief or feeling about aging and discuss whether it is true.*
- *Define Dementia*
- *List 5 signs/symptoms that may be seen in Dementia*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION I – INTRODUCTION TO LONG-TERM CARE (LTC)

UNIT 2 – ROLE OF THE NURSE AIDE IN LONG-TERM CARE

A. NURSE AIDES

1. The nurse aide may work in various health care settings and is usually the primary “hands on” caregiver.
2. Where they started and possible progress to other health care professions
3. Importance of their job and the skills they provide are essential to improved quality of life for those they provide care to.

B. QUALITIES OF AN EFFECTIVE NURSE AIDE

1. Professional and compassionate attitude
2. Responsible nature
3. Ability to communicate effectively
4. Maintenance of high ethical standards

C. RESPONSIBILITIES OF NURSE AIDES

1. To the resident – job description
2. To the facility – commitment to professionalism
3. To the staff – cooperation, dependability, and conflict resolution

D. RELATIONSHIP OF THE NURSE AIDE TO THE HEALTH CARE TEAM

1. All members of the health care team focus their efforts on a care plan devised to meet the needs of the individual.

E. RELATIONSHIP OF THE NURSE AIDE TO THE RESIDENTS

1. Appropriate professional relationships
2. Inappropriate relationships

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION I – Required Time = 16 Hrs

UNIT 2 – ROLE OF THE NURSE AIDE IN LTC

STUDENT OBJECTIVES:

- *Discuss the history of the nurse aide*
- *Discuss possible career ladder*
- *Discuss the importance of their role in taking care of the residents*
- *State the qualities of an effective nurse aide*
- *List the responsibilities of the nurse aide to the resident, the facility and other staff*
- *Discuss the role of the nurse aide in relation to the other health care team members*
- *What should the nurse aide do if asked to perform a task which is beyond scope?*
- *Discuss examples of how a nurse aide's relationship with a resident would be appropriate or inappropriate*
- *Discuss whether or not it is appropriate for a nurse aide to accept a gift from a resident*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION I – INTRODUCTION TO LONG TERM CARE (LTC)

UNIT 3 – SAFETY MEASURES

A. SAFETY IS EVERYONE’S CONCERN

1. Some older individuals may not realize that some activities may be harmful to them.
2. The most common cause of accidents for LTC residents is falls.
3. Communicate with residents about his/her safety while maintaining his/her right to choices about his/her care and activities.
4. The resident has the right to a safe environment.
5. Think about safety first when you enter an area and last when you leave the area.
6. Safety is integrated throughout this course.

B. POTENTIAL PHYSICAL CHANGES IN THE ELDERLY THAT INCREASE THE RISK OF ACCIDENTS ARE:

1. Decreased vision.
2. Impaired hearing.
3. Tremors or shaking.
4. Dizziness when position is changed from lying to sitting or sitting to standing.
5. Slower reflexes.
6. Mental changes such as forgetfulness or confusion.
7. Weakness due to illness, injury, or shrinking of unused muscles.

C. GUIDELINES FOR PROVIDING A SAFE ENVIRONMENT

1. Recognize and report unsafe conditions that nurse aides are unable to correct.
2. Keep hallways and resident rooms clean, dry, and free of obstacles.
 - a) Keep equipment and supplies on one side of the hallway so that residents have an unobstructed path
 - b) Pick up any objects on the floor
 - c) Wipe spills immediately and place a wet floor sign
3. Keep beds in prescribed position and wheels locked.
4. Follow facility policy for use of siderails.
5. Maintain adequate lighting.
6. Report all equipment not in proper working order and use it according to facility policy and manufacturer’s directions. Unsafe or broken equipment should be identified and removed from service according to facility policy.

7. Properly transport residents according to his/her plan of care. Properly transport equipment according to facility policy and manufacturer's recommendation.
8. Instruct residents to use handrails.
9. Check soiled linen for sharp or misplaced articles.
10. Set brakes on wheelchairs during transfers or when parking the chair.
11. Keep all chemicals in locked area legibly labeled and in their original container. Do not store chemicals in the same area as food products.
12. Keep hazardous materials, sharp objects, and plants away from confused residents.
13. Ensure appropriate footwear is worn by staff and residents.
14. Provide call signals to all residents and remind residents to call for help.
15. Always identify residents before beginning care.
16. Follow recommended safety precautions for all procedures.
17. Report any change in condition, such as loss of appetite.
18. Keep resident's preferred belongings within easy reach.
19. Avoid the use of any clothing that could cause residents to trip.
20. Use shower chairs in showers. Do not transport resident in shower chair or leave unattended in tub or shower.

D. ACCIDENT AND INCIDENTS

1. "Incident" – An occurrence or event that interrupts normal procedures or precipitates a crisis
2. "Accident" – An unexpected, undesirable event
3. Role of the nurse aide in recognizing and reporting incidents and accidents

E. UNSAFE OR BROKEN EQUIPMENT should be "locked out" so that it cannot be used. The person who discovers broken equipment should "tag" is following facility policy.

F. THE HAZARDOUS COMMUNICATION EMPLOYEE RIGHT TO KNOW program is designed to make employees aware of the proper uses and hazards of chemicals in the

Work place.

G. ROLE OF THE NURSE AIDE IN ANSWERING CALL SIGNALS

1. Ensure that all residents have access to a call signal at all times and know how to use it.
2. The call signal may be the resident's only means of getting help in an emergency.
3. Know and follow facility policy for using call signals:
 - a) In general, all staff are responsible for answering call signals, even if it's not his/her assigned resident
 - b) Know the various signals for resident rooms, bathrooms, etc. in your facility.
 - c) Know how to turn call signals off/on
 - d) Know timelines for answering call signals
 - e) Proper responses when answering call signals

H. ROLE OF THE NURSE AIDE IN IDENTIFYING RESIDENTS

1. Resident identification systems:
 - a) Identification bands
 - b) Name on door
 - c) Pictures
 - d) Sensor bracelets for residents that wander
2. Follow facility policy and procedure for identifying residents.

I. ROLE OF NURSE AIDE IN OXYGEN SAFETY

1. Types of oxygen delivery systems and how they are used:
 - a) Cannula
 - b) Mask
2. Know the liter flow ordered by the doctor, monitor liter flow when in the room and notify nurse of incorrect liter flow.
3. Safety precautions when oxygen is used:
 - a) Post oxygen signs on door, over bed and follow facility policy.
 - b) Check with nurse before using electrical equipment such as razors, fans, radios, televisions.
 - c) Never use flammable liquids such as nail polish remover.
 - d) Be sure that the oxygen cylinder is secured on base and/or chained to a carrier or wall.
 - e) Immediately report smoking/smoking materials when oxygen is in use.
 - f) Use only cotton blankets – not wool or synthetic.
 - g) If tank is empty report to nurse.

J. ROLE OF THE NURSE AIDE IN FIRE PREVENTION AND SAFETY

1. Fire Prevention
 - a) Supervise smoking in designated areas/monitor for smoking materials in rooms.
 - b) Allow no open flames near oxygen.
 - c) Report frayed wiring or faulty electrical equipment.
 - d) Report concerns of overloaded electrical outlets.
2. Fire emergency rules

- a) Stay calm and do not panic, run or scream.
- b) Follow the steps of RACE:
 - R= Remove all residents from the immediate vicinity of the fire.
 - A = Activate the alarm system.
 - C = Contain the fire and smoke by closing all doors and windows.
 - E = Extinguish the fire, if it is small enough to contain.

3. Remove combustible supplies and equipment from hallways.

4. Remember that smoke kills. In a smoke-filled area, stay close to the floor because smoke rises.

5. Know facility policy regarding fire emergency rules.

K. ROLE OF THE NURSE AIDE IN OTHER NATURAL DISASTERS INHERENT TO THE AREA

- 1. Tornado
- 2. Hurricane
- 3. Other natural disasters

L. THE SAFE MEDICAL DEVICE ACT OF 1991 requires that the Food and Drug Administration (FDA) be notified of any death or serious injury caused by any type of medical device

M. THE TEXAS CONCEALED HANDGUN LAW prohibits carrying a concealed weapon in a hospital, nursing home or other health care facility.

N. THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) is mandated by the government to protect the employee.

- 1. OSHA inspects LTC facilities for compliance with personal protective equipment, standard precautions, Material Safety Data Sheets (MSDS), and tuberculosis testing and exposure.
- 2. OSHA also requires each facility to have an eyewash station within a reasonable distance of where hazardous chemicals are used and a total body wash station. Facility shower rooms satisfy both requirements.

O. VIDEO RECORDERS MAY BE IN USE – Audio Electronic Monitoring(AEM)

INSTRUCTOR'S NOTES & STUDENT OBJECTIVES
SECTION I – Required Time = 16 Hrs

UNIT 3 – SAFETY MEASURES

NOTES TO INSTRUCTOR:

- *Integrate the principles of safety throughout this course*

STUDENT OBJECTIVES:

- *Discuss the importance of safety in the long-term care facility. Demonstrate/Act out unsafe behaviors and situations*
- *Describe physical changes that may be associated with aging that increase the risk of accidents*
- *Identify physical changes that are beyond the resident's control*
- *Recognize safety hazards and describe how to maintain environmental safety in the long-term care facility*
- *Describe how to lock out unsafe or broken equipment*
- *Describe the procedure to follow for reporting incidents and accidents*
- *Describe the importance of Material Safety Data Sheets (MSDS), where they are located, and how they are used in your facility*
- *Demonstrate proper use response to a resident's call signal following facility policy*
- *Demonstrate correct identification of resident prior to giving care following facility policy and resident's plan of care*
- *Describe different types of oxygen delivery*
- *State safety precautions to take when oxygen is in use*
- *Identify measures to prevent fires according to facility policy*
- *In your facility, locate the emergency fire and disaster plans, emergency exits, alarm system, and fire extinguishers*

- *Report concerns of use of extension cords as pertains to safety.*
- *Describe the role of the nurse aide in one natural disaster inherent to the area according to facility policy*
- *Describe the requirements of:*
 - *The Safe Medical Device Act of 1991*
 - *The Texas Concealed Handgun Law*
 - *OSHA*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION I – INTRODUCTION TO LONG-TERM CARE (LTC)

UNIT 4 – EMERGENCY MEASURES

A. GENERAL MEASURES FOR EMERGENCY CARE

1. Stay with the resident and call for help. Be sure the nurse is notified
2. Do not move the resident unless there is immediate danger
3. Remain calm and reassure the resident
4. Start emergency measures that you are trained to perform while waiting for help to arrive
5. Remain with the resident after help arrives to assist and answer questions as needed
6. Know facility procedure and phone numbers for reporting emergencies
7. Know where emergency equipment and supplies are located

B. FAINTING AND FALLS
(Procedural Guideline # 1)

C. SEIZURES
(Procedural Guideline #2)

D. CLEARING THE OBSTRUCTED AIRWAY (HEIMLICH MANEUVER)
(Procedural Guideline #3)

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION 1 – Required Time = 16 Hrs.

UNIT 4 – EMERGENCY MEASURES

STUDENT OBJECTIVES:

- *State the general procedure to follow in an emergency in your facility*
- *Describe and/or demonstrate laboratory skills in emergency measures for:*
 - *Fainting/syncope*
 - *Falls and suspected fractures*
 - *Seizures*
 - *Vomiting and aspiration*
 - *Clearing the obstructed airway (Heimlich Maneuver)*
 - *NOTE: Do not practice forceful abdominal thrusts on human subjects as part of training*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION I – INTRODUCTION TO LONG-TERM CARE (LTC)

UNIT 5 – INFECTION CONTROL

A. INTRODUCTION: Infections are a significant cause of illness, disease and death for residents that reside in certain living situations including nursing facilities. Residents of long-term care facilities are particularly at risk for infection due to the increased severity of illness experienced by residents being cared for in the facilities. The resident is more at risk because of multiple underlying diseases, medications that reduce resistance to microorganisms, and use of medical devices such as urinary catheters to treat symptoms. Infection control is one of the most important aspects of providing a safe environment for residents. Nurse aides must understand and follow the facility's infection control policies and procedures.

B. MICROORGANISMS (Germs, Pathogens)

1. Only seen with a microscope
2. Found in our everyday environment
 - a. Air
 - b. On our skin
 - c. In our bodies
 - d. In food and in water
 - e. On surfaces
3. Have certain requirements to survive
 - a. Oxygen (aerobic)
 - b. No oxygen (anaerobic)
 - c. Warm temperature
 - d. Moist environment
 - e. Darkness for growth
 - f. Food – dead tissue or live tissue
4. Body defenses
 - a. Beneficial in maintaining balance in our bodies and in our environment
 - b. Microorganisms may cause illness, infection and disease
 - c. External defenses to prevent illness, infection and disease
 - Skin as a barrier
 - Intact mucous membranes
 - Cilia
 - Coughing/Sneezing
 - Acid in the stomach
 - Tears
 - Internal defenses
 - Inflammation
 - Fever
 - Natural Immune Response

C. CHAIN OF INFECTION

1. Must have a causative agent (pathogen)

- a. Bacteria
- b. Viruses
- c. Fungi
- d. Protozoa

2. Must have a reservoir for the pathogen to grow

- a. Humans with diseases
 - Symptomatic
 - Asymptomatic
- b. Animals/insects
- c. Food/water
- d. Environment
- e. Inanimate objects such as clothing, bedding, mops, resident care devices

3. Must have a point of entry

- a. Breaks in the skin
- b. Mucous membranes that are not intact
- c. Respiratory system
- d. Gastrointestinal system
- e. Urinary system
- f. Reproductive system

4. Must have a point of exit

- a. Saliva/other respiratory secretions
- b. Urine
- c. Feces
- d. Drainage from wounds
- e. Reproductive secretions
- f. Blood
- g. Tears (minor risk)

5. Must have a mode of transmission

- a. Contact
 - Direct contact – person to person
 - Indirect contact – inanimate contaminated objects to person
- b. Airborne
 - Inhaling small pathogens that float in the air
- c. Bloodborne
 - Microorganisms that are present in human blood and can cause disease
- d. Droplet
 - Drops of secretions put into the air through sneezing, coughing or talking
- e. Food and fluids
- f. Vectors
 - Mosquitoes, parasites

6. Must have a host individual to harbor the infectious pathogen

D. GENERAL APPROACHES TO PREVENT AND CONTROL INFECTIONS

1. Medical asepsis (Clean Technique)

- a. Practice(s) used to remove or destroy pathogens to prevent spread of infection from one

person/place or object to another person/place or object.

2. Practices to promote medical asepsis

a. Wash hands with soap and water according to the Centers for Disease Control and Prevention (CDC) guidelines (Procedural Guideline #6). This is the single most important practice to prevent the transmission of infection. List of some situations that require hand washing:

- Anytime hands are visibly soiled
- After personal use of the toilet
- Before and after caring for a resident's personal care, assisting to toilet, feeding and procedures
- Before and after eating or handling food
- After coming in contact with a resident's skin, mucous membranes or body fluid
- After contact with any infectious materials
- After removing gloves
- After blowing or wiping nose or covering mouth while coughing
- After handling any soiled materials
- After handling used linens, bedpans or urinals

b. Proper use of gloves (discussed under Standard Precautions)

c. Following CDC recommendations for Respiratory Hygiene/Cough Etiquette

- Combination of measures designed to minimize transmission of pathogens via droplet/airborne routes
- Cover mouth and nose during coughing and sneezing
- Use tissues to contain any respiratory secretions/promptly dispose of tissue
- Wear a mask when coughing to decrease environmental contamination (follow facility policy)
- Turn head away from others when coughing, try to maintain a distance of 3 feet from others

d. Proper use of hand sanitizer (follow facility policy)

e. Wash resident hands before and after meals

f. Clean used equipment and place in approved storage, avoid cross contamination between clean and dirty (follow facility policy)

3. Methods to kill/control pathogens a. Disinfection

- Use of chemical disinfectants to clean equipment b. Sterilization
- Process of killing all microorganisms

4. Caring for supplies and equipment

a. Disposable equipment use once and discard in appropriate container

b. Clean non-disposable equipment (follow facility policy)

- Disinfectants
- Soap and hot water
- Disposable wipes, cloths

5. Other measures of asepsis

a. Keep equipment and supplies, linens, etc. from touching clothing

b. Never shake linen, used or unused

- c. Always clean from cleanest area to the soiled area
 - d. When cleaning, clean away from you to prevent contamination of clothing
 - e. Pour contaminated liquids into appropriate places, designated hoppers, toilets (follow facility policy)
 - f. Clean equipment used on multiple residents between each resident (follow facility policy)
6. Standard Precautions (CDC recommendations/takes the place of Universal Precautions)
- a. Based upon the premise that every person is potentially infected or colonized with an organism that could be transmitted to others in a healthcare setting
 - b. The primary strategy for preventing healthcare associated transmission of infections among residents and healthcare personnel
 - c. The nurse aide must be knowledgeable about and closely follow the facility policies
 - d. Components of Standard Precautions CDC guidelines 2007 (Table Below on page 23)

In all cases, facility policy will be the standard.

Hand Hygiene

- Hands may be washed using friction with soap and warm water for all cases
- Hands are visibly soiled
- Before direct contact with residents
- After contact with blood body fluids or excretions, mucous membranes, non-intact skin, wound dressings
- Immediately after removing gloves
- Between resident contacts
- Between tasks and procedures on the same resident to prevent cross contamination

Personal Protective Equipment (PPE) (Procedural Guideline #4) Gloves

- When touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, contaminated items or contact with resident
- Remove gloves after contact with a resident or surrounding environment including medical devices
- Do not wear the same pair of gloves for the care of more than one resident
- Never wash or reuse gloves

Gown Guidelines

- During procedures/resident care activities when contact of clothing/exposed skin is anticipated from blood, body fluids, secretions and excretions
- Do not reuse gowns
- Place used gowns in appropriate container

Mask, Eye Protection, Face Shield Guidelines

- During procedures/resident care activities likely to generate splashes or sprays of blood, body fluids, secretions
- Multiple Use Resident Care Equipment Guidelines
- Handle in a manner that prevents transfer of pathogens to others or the environment; wear gloves if visibly contaminated
- Always perform hand hygiene after using equipment

Environmental Control Guidelines

- Follow facility procedures for cleaning and disinfecting environmental surfaces and equipment

Textiles and Laundry Guidelines

- Keep linen away from clothing
- Handle in a manner that prevents transfer of pathogens to you, others and the environment
- Place soiled linen in specified containers
- Never mix soiled linen with clean linen

7. Transmission Based Precautions (CDC recommendations/formerly Isolation Precautions)

- a. Used for residents who are known to be or suspected of being infected or colonized with infectious microorganisms that require additional measures to prevent transmission

Airborne Precautions - Use in addition to Standard Precautions; use for residents with known or suspected infection that is spread by microorganisms dispersed by air currents.

- Resident Placement - Private room, keep doors closed at all times, explain to the resident the importance of remaining in the room
- Gowns - Must be worn when entering the room
- Mask and Eye Wear - For known or suspected pulmonary tuberculosis, respirator mask worn by all prior to entering room
- Hand Hygiene - Hands must be washed before gloving and after gloves are removed
- Resident Transport - Limit as possible/place mask on resident
- Resident Care Equipment - Clean and disinfect according to facility policy and manufacturers' recommendations before use on another resident

Droplet Precautions - Use in addition to Standard Precautions; use for residents with known or suspected infection that is spread by droplets generated by coughing, sneezing, talking

- Resident Placement - Private room or with resident with same disease
- Gowns - Must be worn when entering the room
- Mask and Eye Wear - Wear mask when working within 3 feet of resident
- Hand Hygiene - Hands must be washed before gloving and after gloves are removed
- Resident Transport - Limit as possible/place mask on resident
- Resident Care Equipment - Clean and disinfect according to facility policy and manufacturer's recommendations before use on another resident

Contact Precautions - Use in addition to Standard Precautions; use for residents with known or suspected infection that is spread by direct contact with the resident (hand or skin to skin contact that occurs when performing activities that require touching skin or indirect contact with surfaces or items in the resident room)

- Resident Placement - Private room or with resident with same disease
- Gowns - Must be worn when entering the room
- Hand Hygiene - Hands must be washed before gloving and after gloves are removed
- Resident Transport - Limit as possible/place mask on resident
- Resident Care Equipment - Clean and disinfect according to facility policy and manufacturers' recommendations before use on another resident

E. COMMON INFECTIOUS DISEASES

PRECAUTIONS FOR INFECTIOUS DISEASES IN THE LONG-TERM CARE FACILITY

The following is a list of the most common infection diseases that are likely to be found in long-term care facilities. Precautions recommended and the infection period duration have been derived from the current CDC guidelines and recommendations. For more information please go to the CDC website at http://www.cdc.gov/								
Types of Precautions: A-Airborne, C-Contact, D-Droplet, S-Standard When A, C, OR D are specified, also use S								
APPENDIX A1								
TYPE AND DURATION OF PRECAUTIONS RECOMMEND FOR SELECTED INFECTIONS AND CONDITIONS								
Infection or Condition	Precaution							
	Type of Precaution	Private Room	Mask	Gown	Gloves	Infective Material	Duration of illness	Comments
Abscess, draining minor	S	No	No	Yes, if soiling is likely	Yes	Pus	Duration of illness	Dressing adequately contains the pus
Abscess, draining major	C	Yes, if drainage is not contained	No	Yes	Yes	Pus	Duration of illness	Dressing does NOT contain the pus
Acquired Immunodeficiency Syndrome (AIDS)	S	Yes, if residents hygiene is poor	No	Yes, if soiling is likely	Yes, for touching infective material; when handling feces if GI bleeding is likely; if there are open wounds	Blood and body fluids	Duration of illness	Use caution when handling blood and blood soiled articles; avoid needle stick
Amebiasis Dysentery	S	Yes, if resident's hygiene is poor	No	Yes, if soiling is likely	Yes, for touching infective material	Feces	Duration of illness	
Bronchitis, Adult	S	No	No	No	No	Respiratory Secretions		
Candidiasis, all forms	S	No	No	No	No			
Cellulitis	S	No	No	Yes, if soiling is likely	Yes, for touching infective material	Pus	Duration of illness	Dressing covers and adequately contains the pus
Cellulitis, Drainage	C	No	No	Yes, if soiling is likely	Yes, for touching infective material	Pus	Duration of illness	Dressing does not cover and or does not adequately

								contain the pus
Chickenpox (Varicella)	A, C	Yes	Yes	Yes	Yes	Respiratory secretions and lesions	Until all lesions are crusted	Susceptible people should stay out of the room
Chlamydia - Genital	S	No	No	No	Yes, for touching infective material	Genital discharge	Duration of illness	
Chlamydia - Respiratory	S	No	No	No	Yes, for touching infective material	Respiratory Secretions	Duration of illness	
Chlamydia - Trachomatous Conjunctivitis	S	No	No	No	Yes, for touching infective material	Purulent exudate	Duration of illness	
Common Cold	S	No	No	No	No	Respiratory secretions	Duration of illness	
Conjunctivitis:								
Acute Bacterial	S							
Chlamydia	S							
Gonococcal	S							
Acute Viral (acute hemorrhagic)	C	No	No	No	Yes, for touching infective material	Eye secretions	Duration of illness	
Creutzfeldt-Jakob disease	S	No	No	No	Yes, for touching infective material	Blood, brain tissue and spinal fluid	Duration of illness	Use caution when handling blood, brain tissue, or spinal fluid
Decubitus ulcer (major, draining, infected)	C	Yes, if drainage is not contained	No	Yes, if soiling is likely	Yes, for touching infective material	Pus	Duration of illness	Dressing does NOT adequately contain the pus
Decubitus Ulcer (minor, draining, infected)	S	No	No	Yes, if soiling is likely	Yes, for touching Infective material	Pus	Duration of illness	Dressing covers and adequately contains the pus, or infected area is very small.
Diarrhea, acute	S	Yes, if resident's hygiene is poor	No	Yes, if soiling is likely	Yes, for touching infective material	Feces	Duration of illness	PLEASE NOTE: If C-Diff is suspected you must initiate precautions until C-Diff can be ruled

								out.
Diarrhea - Clostridium Difficile (C-Diff)	C	Yes, if not available may Cohort with resident who has C-diff	No	Yes, if soiling is likely	Yes, for touching infective material	Feces	Duration of illness	PLEASE NOTE: If C-Diff is suspected (lab test' ordered to r/o), you must initiate contact precautions immediately and continue until test results rule out or for duration of illness.
Diphtheria (cutaneous)	C	Yes, if not available may cohort	No	Yes, if soiling is likely	Yes, for touching infective material	Lesion secretions	Until 2 cultures from the skin lesions taken at least 24 hours apart after the cessation of antimicrobial therapy are negative for Corynebacterium Diphtheria	
Diphtheria (pharyngeal)	D	Yes, if not available may cohort	Yes	Yes, if soiling is likely	Yes, for touching infective material	Respiratory Secretions	Until 2 cultures from both nose and throat, taken at least 24 hours after the cessation of antimicrobial therapy are negative	
Enterocolitis	S	Yes, if resident's hygiene is poor	No	Yes, if soiling is likely	Yes, for touching infective material	Feces	Duration of Illness	For C-Diff see Diarrhea- C-Diff
Fever of Unknown Origin	S	No	No	No	No			
Gastroenteritis, all types Except C-Diff	S	Yes, if resident's hygiene is poor	No	Yes, if soiling is likely	Yes, for touching infective material	Feces	Duration of illness	
German Measles (Rubella)	D	Yes	Yes, for those close to the resident	Yes, for close contact with the resident	Yes, for touching infective material	Respiratory secretions	For 7 days after the onset of the rash	Pregnant women should have NO contact with resident
Hepatitis, Viral - Type A	S							
Hepatitis, Viral - Type A, Diapered	C						One week after onset of symptoms	

or incontinent resident								
Hepatitis, Viral - Type B	S							
Hepatitis, Viral - Type C	S							
Herpes Simplex, recurrent (skin, oral, genital)	S	No	No	No	Yes for touching infective material	Lesion secretions from infected site	Until all lesions are crusted	
Herpes Zoster (varicella-zoster) (Shingles): localized in immunocompromised-disseminated	A, C	Yes, if airborne precautions	Yes	Yes	Yes, for touching infective material	Lesion secretions and possible respiratory secretions	Duration of illness	Exposed susceptible residents should be on isolation precautions beginning at 10 days after exposure and continuing until 21 days after last exposure
Herpes Zoster (varicella-zoster) (Shingles): localized in normal resident	S	Yes, if resident's hygiene is poor	No	No	Yes, for touching infective material	Lesion secretions	Until all lesions are crusted	Person susceptible to chickenpox should stay out of the room.
Influenza, adults	D	Yes, if available or may cohort	Yes, for those close to the resident	Yes, for close contact with the resident	Yes, for touching infective material	Respiratory secretions		If private room or cohorting is not an option keep a distance between the infected resident, roommate, and visitors of approximately 3 feet. Mask resident when transporting out of room.
Legionnaires' Disease	S	No	No	No	No	Respiratory secretions		Not transmitted person to person

Head Lice	C	No	No	Yes, when initial contact is made	Yes, when initial contact is made	Hairbrushes, caps, scarfs, coats	Until 24 hours after initiation of effective therapy	Residents should remain in room during the treatment period. Wash all clothing and bedding separately from other facility linen/laundry, washing at temperature of 160° or greater for 5-10 minutes. Disinfect combs / hairbrushes with medicated shampoo. Store non-washable items in a sealed plastic bag for 10-14 days.
Body Lice	S	No	No	Yes, when initial contact is made	Yes, when initial contact is made			Transmitted person to person through infested clothing; bag and wash cloths according to CDC guidance above
Pubic Lice	S	No	No					Transmitted person to person through sexual contact.
Measles (Rubeola)	A	Yes	Yes, for those close to the resident	No	No	Respiratory secretions	For 4 days after the start of the rash	Person susceptible to measles should stay out of the room.
Multiple Resistant organisms: MRSA; VRE; other bacteria								

resistant to penicillin								
Colonized or Contained	S	No	No	Yes, if soiling is likely	Yes, for touching infective material	Respiratory secretions, urine, and possibly feces*	Until antimicrobials culture is negative*	In outbreaks, cohorting of infected or colonized residents may be indicated if private rooms are not available
Infected or Not Contained	C	Yes, may cohort				Infected area, pus, secretions, and possible feces**	Until antimicrobials culture is negative, colonized, or contained**	
Pneumonia (bacteria)	S	No	No	No	No	Respiratory secretions		
Pneumonia (Haemophilus influenzae)	S	No	No	No	No	Respiratory secretions		
Pneumonia (S. aureus)	S	No	Yes	Yes, if soiling is likely	Yes, for touching infective material	Respiratory secretions	For 48 hours after start of therapy	
Pneumonia (viral)	S	No	No	No	No	Respiratory secretions		
Ringworm	S	No	No	No	No			
Scabies	C	Yes, if resident's hygiene is poor	No	Yes, wear long sleeve gowns for close contact	Yes, wear gloves pulled up over the wrist area of the gown's sleeve.	Skin, bed linens and clothing.	Until 24 hours after start of effective therapy	
Shistosomiasis	S	No	No	No	No			
Staphylococcal dis. (minor)	S	No	No	Yes, if soiling is likely	Yes, for touching infective material	Pus	Duration of illness	Dressing adequately contains the pus
Staphylococcal dis. (skin wound, major)	C	Yes, if drainage is not contained	No	Yes, if soiling is likely	Yes, for touching infective material	Pus	Duration of illness	Dressing does not adequately contain the pus
Syphilis (latent w/o lesions)	No	No	No	No				
Tapeworm	S	No	No	No	No	Feces (maybe)		
Tetanus	S							
Trench Mouth	S	No	No	No	No			

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION I – REQUIRED TIME = 16 Hrs

UNIT 5 – INFECTION CONTROL

NOTES TO INSTRUCTOR:

Refer to most current CDC recommendations regarding Infection Control. These may be found at:

<http://www.cdc.gov>

STUDENT OBJECTIVES:

- *Define:*
 - *Microorganisms*
 - *Pathogens*
 - *Infections*
 - *Medical asepsis*
 - *Infection*
- *Describe why residents in a long-term care facility are more at risk for infection.*
- *Name 3 places where microorganisms are found.*
- *Name 3 things that are required for a microorganism to survive.*
- *Name 3 external defenses in our bodies to prevent illness from microorganisms.*
- *Name 2 internal defenses in our bodies to control illness from microorganisms.*
- *Identify how diseases are transmitted.*
- *List the 6 components of the chain of infection.*
- *Define medical asepsis.*
- *Identify practices the nurse aide can use to promote medical asepsis in the work setting.*
- *Discuss the methods used to kill or control microorganisms.*
- *Discuss aseptic measures to control the spread of infection.*
- *Identify the single most important practice to prevent the transmission of infection.*
- *Demonstrate understanding of the principles of Standard Precautions.*
- *Discuss examples of cross-contamination, “clean” and “dirty.”*
- *State the time that hands should be lathered during handwashing.*

- *Demonstrate the proper procedure for handwashing.*
- *Identify the correct personal protective equipment for specific resident care activities.*
- *Demonstrate proper application and removal of gloves, gown and mask.*
- *Describe the proper procedure for handling biohazardous waste in your facility.*
- *Demonstrate understanding of the principles of Transmission Based Precautions.*
- *State the 3 types of Transmission Based Precautions recommended by the CDC.*
- *Describe what TB is and how it is spread.*
- *Identify 2 drug-resistant organisms and how they are spread.*
- *Describe the type of precautions used for drug-resistant organisms.*
- *Describe how to identify head lice and how they are spread.*
- *Describe what you would report to the nurse if you suspect a resident has lice.*
- *Describe the infection control measures for lice.*
- *Describe what scabies is and how it is transmitted.*
- *Describe what you would report to the nurse if you suspect a resident has scabies.*
- *Name 2 blood-borne pathogens.*
- *Describe the precautions to follow to prevent exposure to blood-borne pathogens.*

REFERENCES:

Department of Health and Human Services

Centers for Medicare and Medicaid Services

Center for Medicaid and State Operations/Survey and Certification Group

CMS Manual System

Pub. 100-07

“Interpretive Guidelines for Long-Term Care Facilities F tag F441”

Siegel, JD, Rhinehart E, Jackson, M, Chiarello, L, and the Healthcare Infection Control

Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing

Transmission of Infectious Agents in Healthcare Settings, June 2007

<http://www.cdc.gov/ncidod/dhgp/pdf/isolation2007.pdf>

Department of Health and Human Services Centers for Disease Control and Prevention

Division of Viral Hepatitis <http://www.cdc.gov/hepatitis>

ADDITIONAL NOTES:

COURSE CONTENT
SECTION I – INTRODUCTION TO LONG-TERM CARE (LTC)

UNIT 6 – RESIDENT RIGHTS AND INDEPENDENCE

A. CONSIDERATIONS FOR CARE

1. Effects of aging and institutionalization on resident rights and independence.
2. Effects of cognitive impairment on resident rights and independence.
3. Empathy and how we all value our rights
4. Respect resident rights and promote resident independence in all aspects of the care you give

B. THE RESIDENT’S CARE PLAN

1. The resident’s care plan is a working document that details all of the nursing care that the resident should receive.
2. The information that is in the resident’s care plan comes from a comprehensive assessment that the Registered Nurse must complete within a specific timeframe from admission.
3. The care plan is designed to assist all those who are caring for the resident to provide the highest level of care and consistency possible.
4. All members of the care team, including the Nurse Aide, should be a part of the care planning process; as all members bring crucial information about the resident that will be considered in providing a high quality of care.
5. The Nurse Aide is required to provide all care to the resident that is listed on the care plan.
6. Depending on the resident, the care plan may include:
 - a. What kind of personal or health care services are needed;
 - b. What type of staff should provide the services needed;
 - c. How often the services are needed;
 - d. What kind of equipment or supplies may be needed to provide the services;
 - e. The diet that the resident is prescribed (if there is a special one) or the resident’s food preferences;
 - f. The resident’s health and personal goals; and
 - g. How the care plan will help the resident reach his/her goals.

C. RIGHTS OF RESIDENTS

1. As citizens
2. Resident rights as stated in the Nursing Facility Requirements for Licensure and Medicaid

Certification, 40 TAC §19.401 - §19.423.

D. SEXUALITY AND INTIMACY

1. Intimacy and physical sexual expression is a basic human right and need throughout the lifespan.
2. Intimacy is defined as an expression of the natural desire of human persons for connection; a state of reciprocated physical closeness to, and emotional honesty with another.
3. Sexual Activity includes sexual contact and other activities intended to cause sexual arousal.
4. There are many myths that are associated with the sexuality and the older adult. These include:
 - a. Older people do not have any sexual desires or healthy sexual relationships;
 - b. Older people are unable to engage in sexual activities;
 - c. Any sexual activity among the elderly is perverse and embarrassing;
 - d. Older people are fragile physically and might harm themselves;
 - e. Older people are grateful for sexual contact;
 - f. Elderly people who claim to be sexually active are fantasizing; and
 - g. Sex is only for the young.
5. The reality is older adults may still enjoy and be able to engage in sexual activity.
6. In order to respect the rights of the resident, residents that have the capacity must be allowed to have intimate relationships/engage in sexual activity.

E. ROLE OF THE NURSE AIDE IN RESPECTING AND PROMOTING RESIDENT RIGHTS AND INDEPENDENCE.

1. Ensure person-centered care is provided in all instances.
2. Provide privacy.
3. Maintain confidentiality.
4. Communicate appropriately and allow resident to have personal choice whenever possible.
5. Accommodate individual needs and preferences.
6. Encourage residents to participate in care as much as possible.
7. Provide care and security of residents' personal possessions.
8. Maintain safety.
9. Report residents' complaints of grievances and disputes to nurse.

10. Proper use of technical devices.
11. Assist residents to vote.
12. Assist residents to attend and participate in activities they are interested in within and outside of the facility.
13. Support the resident's right to participate in a group of his/her choosing.
14. Provide care that is free from abuse, neglect, and misappropriation of resident property.
15. Attempt a variety of alternatives to avoid the use of restraints. All attempts must be documented along with the resident's response.

F. ABUSE, NEGLECT, AND MISAPPROPRIATION OF RESIDENT PROPERTY (EXPLOITATION)

1. Definitions (from 26 TAC Chapter 556)
 - a. "Abuse – the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish."
 - i. Physical Abuse: non-accidental force against an individual that results in physical pain, injury, or impairment.
 - ii. Emotional Abuse: speaking to an individual in ways that cause emotional pain or distress
 - iii. Sexual Abuse: engaging in sexual contact with an individual without his/her consent.
 - b. "Neglect – the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."
 - c. "Misappropriation of Resident Property – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."
2. Recognizing potential signs of abuse:
 - a. Unexplained bruising, swellings, pain or other unexplained injuries.
 - b. Sudden changes in resident's personality or behavior.
 - c. Fear and anxiety.

G. ROLE OF THE NURSE AIDE IN PROTECTING RESIDENTS FROM ABUSE, NEGLECT, AND MISAPPROPRIATION OF RESIDENT PROPERTY

1. Avoiding abuse, neglect and/or misappropriation of resident property.
2. Recognize the different risk factors that may increase the risk of abuse, neglect, or misappropriation of resident property.
 - a. Resident characteristics
 - b. Facility Risk Factors
 - c. Staff Risk Factors

3. Reporting abuse, neglect, or misappropriation of resident property:
 - a. As members of the health team, nurse aides are legally and ethically responsible for reporting actual or suspected abuse, neglect, or misappropriation or resident property.
 - b. Report suspected findings to the nurse and provide factual information requested for filing reports.
 - c. The Complaint Hotline at HHSC is (800) 458-9858.

H. ROLE OF THE NURSE AIDE IN UTILIZING ABUSE PREVENTION STRATEGIES IN RESPONSE TO ABUSIVE BEHAVIOR DIRECTED TOWARD STAFF BY RESIDENTS AND FAMILIES.

1. Demonstrate personal restraint and control when dealing with an abusive resident or family member.
2. Recognize the underlying reason for the behavior as well as potential triggers.
3. Implement guidelines for dealing with angry residents and families.
4. Implement guidelines for dealing with combative residents.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION I – REQUIRED TIME = 16 Hrs

UNIT 6 – RESIDENTS RIGHTS AND INDEPENDENCE

NOTES TO INSTRUCTOR:

- *Stress the concept of resident rights and independence throughout this course.*

STUDENT OBJECTIVES:

- *Discuss the effects of aging and institutionalization on resident rights and independence.*
- *Discuss the effects of cognitive impairment on resident rights and independence.*
- *List 5 of the components of the resident care plan.*
- *Identify the myths associated with sexuality and the Older Adult.*
- *Describe the rights of residents in nursing facilities.*
- *Describe an example of a behavior in each area that:*
 - *Promotes resident rights.*
 - *Violates resident rights.*
- *Demonstrate respect for the rights of residents in your facility.*
- *Define and describe one example of each term:*
 - *Abuse or “harming a resident.”*
 - *Neglect or “failing to provide care to a resident.”*
 - *Misappropriation or “stealing from a resident.”*
- *Discuss how you would act to avoid abuse, neglect and misappropriation of resident property. Describe technique and role play.*
- *List 3 signs that might indicate that a resident has been abused.*
- *Discuss ways in which the physical environment may increase the risk of abuse, neglect, or misappropriation of resident property.*
- *Describe the responsibility of the nurse aide for reporting suspected abuse, neglect or misappropriation of resident property.*
- *Locate the HHSC Hotline number posted in your facility.*
- *List 3 ways that a nurse aide would deal with an angry resident or family member.*

- *List 5 strategies for responding to combative behaviors directed to staff by a resident to prevent abuse.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION I – INTRODUCTION TO LONG-TERM CARE (LTC)

UNIT 7 – COMMUNICATION AND INTERPERSONAL SKILLS

A. “COMMUNICATION” is the way we exchange information with others. Thus, it is the basis of our interpersonal relations.

B. EFFECTIVE COMMUNICATION

1. Sender – the person who wants to communicate information.
2. Message – the information the person needs to send.
3. Channel – the method of sending information.
 - a. Verbal – spoken or written words
 - b. Non-verbal – facial expressions, posture, hand/body movements, and appearance
4. Receiver – person to whom the message is sent.
 - a. Effective listening
 - b. Reading body language
 - c. Written – Communication boards, care plan
5. Confirmation – the way the receiver lets the sender know that the message has been received.
6. Recognizing differences in communication styles:
 - a. Generation differences
 - b. Use of technology
 - c. Use of acronyms and slang

C. IMPORTANCE OF COMMUNICATION

1. Communications and interpersonal relations are the most important part of life for most people.
2. The nurse aide may be the primary person that the resident communicates with on a regular basis.
3. Communication is an important part of the care that you give. Effective communication can improve your relationships with residents, make your job easier and save wasted time.
4. Communication is also an important part of your personal life. Effective communication can improve your relationships with your family, friends and co-workers.
5. Communicating with other members of the health care team.
6. INTERACT STOP AND WATCH – The nurse aide may identify important changes while caring for a resident. Please report any changes to the nurse immediately.

D. COMMUNICATING WITH FAMILY AND FRIENDS OF RESIDENTS

1. Remember that you are representing yourself and the facility to others.
2. Maintain an open, friendly and supportive relationship with residents' families and friends.
3. Protect resident privacy and confidentiality as required under the HIPAA Privacy Rule.
4. When asked, tell family and friends something about the resident's activities such as "He ate a good breakfast" or "She played Bingo last night."
5. Escort visitors to the supervisor for problems, complaints or reports on a resident's condition.

E. ANSWERING THE TELEPHONE IN A LONG-TERM CARE FACILITY

- a. Speak clearly and courteously.
- b. Identify the facility and your location per facility policy.
- c. Identify yourself by name and title.
- d. Politely ask who is calling and get contact information.
- e. Determine what is requested and transfer call to the appropriate person or take a clear message and relay it to the appropriate person as allowed under HIPAA.
- f. Thank the person for calling.

F. CHANGES DUE TO AGING THAT AFFECT COMMUNICATIONS

1. Communication with residents who have sensory losses.
2. Communication with residents who have memory losses.
3. Communicating with residents who have vision loss.
4. Communicating with residents who have hearing loss.
5. Communicating with residents who have problems with speaking.
6. Communicating with residents who have problems with understanding.

G. COMMUNICATION STYLES AND GOALS

1. Communication should be goal-oriented. Think about what you are trying to accomplish and set your goal.
2. Select your communication style based on your goal.
 - a. Social conversation – goal is to create a comfortable, relaxing atmosphere.
 - b. Interviewing – goal is to conduct a question and answer period to determine resident

- needs.
- c. Teaching – goal is for the resident to learn and understand.
- d. Reporting – goal is to accurately communicate the facts.
- e. Problem solving – goal is to help meet resident’s needs.
- f. Therapeutic communication – goal is to encourage resident to discuss feelings.

H. TECHNIQUES FOR EFFECTIVE (GOAL-ORIENTED) COMMUNICATION

1. Use every contact with resident as an opportunity to communicate.
 - a. Talk courteously with residents during care, listening and responding appropriately.
 - b. Smile and speak when you pass in the hall.
 - c. Set aside time just to communicate with residents.
 - d. Continue to communicate with residents who are unresponsive as they may still understand and benefit from your communication.
2. Assure that your verbal and nonverbal communication match and send the same message.
 - a. Nonverbal messages tend to reflect your true feelings and are thought to be more powerful than what you say.
 - b. If there is a difference between the verbal and nonverbal messages, people will likely believe the nonverbal message.
3. Plan your message ahead of time as needed to assure it is clear and correct:
 - a. Arrange main points in logical order.
 - b. Omit unrelated and non-essential information.
 - c. Get feedback to determine if message is understood.
4. Select the most appropriate method for sending the message:
 - a. Verbal – most commonly used.
 - b. Nonverbal – more powerful than verbal.
 - c. Written – may be useful for residents with hearing loss or memory loss. Also important in communication with health care team.
 - d. Interpreter – may be required to communicate with a resident in a foreign language.
 - e. Communication assistive devices – (e.g. picture boards, word boards) may be useful for residents with sensory loss.
5. Individualize your communications to the needs of the resident. The same communication techniques do not work for all residents or all nurse aides.
 - a. Be aware of what you are saying (verbally and non-verbally) and of the care you are giving.
 - b. Observe and evaluate the resident’s response to what you are saying and doing.
 - c. Adjust your approach if you are not getting the desired response.
 - d. Then re-evaluate and re-adjust your approach as needed.
 - e. Report and discuss your observations and problems with communication to the nurse.

I. TECHNIQUES FOR IMPLEMENTING THERAPEUTIC COMMUNICATION

1. Definitions –
 - a. Therapeutic Communication: the face-to-face process of interacting that focuses on advancing the physical and emotional well-being of a resident. Therapeutic

communication is the basis of interactive relationships and affords the nurse aide the opportunity to establish rapport, understand the resident's experiences, formulate individualized or resident-centered interventions and optimize the care they provide to the residents.

- b. Active Listening – Being attentive to what the resident is saying, verbally and non- verbally. Sit facing the resident, open posture, lean toward the resident, make eye contact, and relax.
- c. Silence – Time for the aide and resident to observe one another, sort out feelings, think of how to say things, and consider what has been verbally communicated. The aide should allow the resident to break the silence
- d. Providing Information – Relevant information is important to make decisions, experience less anxiety, and feel safe and secure.
- e. Clarifying – To check whether understanding is accurate, or to better understand, the nurse restates an unclear or ambiguous message to clarify the sender's meaning. "I'm not sure I understand what you mean by 'sicker than usual', what is different now?"
- f. Summarizing – Pulls together information for documentation. Gives the resident a sense you understand. It is a concise review of key aspects of your interaction.

J. COMMUNICATION AND INTERPERSONAL SKILLS (Procedural Guideline #8)

1. Guidelines for Starting a Conversation.
2. Guidelines for Talking and Listening.
3. Guidelines for Encouraging Residents to Express Feelings.
4. Guidelines for Avoiding Barriers to Communication.
5. Guidelines for Effective Interpersonal Relations.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION I – REQUIRED TIME = 16 Hrs

UNIT 7 – COMMUNICATION AND INTERPERSONAL SKILLS

NOTES TO INSTRUCTOR:

- *Integrate communication skills throughout this course.*

STUDENT OBJECTIVES:

- *Define verbal and nonverbal communication*
- *State two ways to send messages*
- *State two ways to receive messages*
- *Discuss the inappropriate use of technology, acronyms and slang*
- *Imagine a day or a lifetime without communication*
- *Describe a situation where you wasted much time and effort because of miscommunication*
- *Describe a situation where effective communication resulted in a positive outcome*
- *Describe how to communicate with your peers and report to your supervisors*
- *Describe how to communicate with residents' families and friends.*
- *Discuss how it is inappropriate to share resident's personal information with friends and family. The HIPAA Privacy Rule can be found at: www.hhs.gov/ocr/privacy/*
- *Describe how to answer the telephone in a long-term care facility.*
- *Give examples of age-related changes that may affect communication.*
- *State one style of communication and identify the goal associated with it.*
- *Give an example of how you plan to use one style of communication to reach a specific goal.*
- *Discuss or role-play a situation in which the verbal and nonverbal message is different. Describe how this made you feel.*
- *Discuss how you plan to individualize your communications by observing, evaluating, and*

adjusting. Try out your plan with classmates or friends.

- *Demonstrate skill in communication with residents:*
 - *Starting a conversation*
 - *Talking and listening*
 - *Encouraging resident to express feeling/concerns*
 - *Avoiding barriers to communication*
 - *Ending a conversation*
 - *Vision loss*
 - *Hearing loss*
 - *Problems with speech*
 - *Problems with understanding*
- *Describe the techniques for therapeutic communication with a resident*
- *Demonstrate skill in promoting effective interpersonal relationships*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION I – INTRODUCTION TO LONG-TERM CARE (LTC)

UNIT 8 – TAKING CARE OF YOURSELF

A. MANAGING PHYSICAL ILLNESS

1. Preventing physical illness is very important.
2. Use the Standard Precautions and infection control practices taught in this class to help protect yourself, as well as the residents, from infections and communicable diseases.

B. PREVENTING AND MANAGING INJURIES

1. The safety practices taught in this class will protect both the nurse aide and the resident from injury.
2. The most common causes of employee injury in long-term care facilities are:
 - a. Slips and falls.
 - b. Back injuries caused by improper body mechanics.
3. Use equipment according to manufacturing guidelines and facility policy.
4. Reporting injuries.
 - a. Know and follow the facility policies for reporting injuries and emergencies of residents and staff.
 - b. All injuries should be reported and incident reports completed following facility policy.

C. MANAGING YOUR TIME

1. Report for duty on time.
2. Listen to report and read the resident's care plans.
3. Set priorities to make the best use of your time.
 - a. Rate each task in order of importance.
 - b. Anything that must be done at a specific time is a high priority.
 - c. Things that must be done by the end of the shift are next.
 - d. Sometimes priorities change because of resident illness or new admissions. Be flexible.
4. The better organized you are, the more easily you will complete your tasks. Good organization also reduces stress.
5. Plan your work for efficient use of your time.
 - a. Estimate the time that each task will take.
 - b. Identify tasks that you can group together, e.g., while the resident is in bathroom, you can make the bed.
 - c. Plan your schedule around meal times.
 - d. Plan ahead for tasks in which you will need an assistant or special equipment.
 - e. Check on your residents before you begin your assignment.
 - f. Take care of resident's immediate needs as this reassures them and makes them less anxious
 - g. Check the activities calendar for events that the resident may enjoy

6. Anticipate and gather needed items before you go into a resident's room to avoid unnecessary trips.
7. Work while you are on duty. You are employed and paid to work the entire shift.
8. Take assigned breaks and return in a timely manner.
9. Try to improve your performance.

D. PROTECTING YOURSELF LEGALLY

1. Follow all facility policies to protect your job and assure that you are functioning within the limits of the law. Check facility policy and procedure manuals if you are unsure of how to perform a procedure.
2. Do things the way you were taught.
3. Do not perform skills for which you have not been trained. Inform your supervisor if you don't know how to perform a procedure or are unable to get it done.
4. Protect residents' rights and meet residents' needs in a timely manner. These are both legal obligations and ethical standards (things that are morally right). Follow HIPAA Privacy Rules.

E. YOUR EMOTIONAL HEALTH

1. "Stress" is mental and physical tension or strain.
 - a. Working in a LTC facility and dealing with sickness and death can be stressful.
 - b. Your job may be physically and emotionally demanding.
 - c. Stress is unavoidable as you help others with their problems.
 - d. Stress can leave you feeling overwhelmed and out of control.
 - e. Your personal/family problems may also contribute to your stress.
 - f. If you are not physically or mentally in good health, stress may seem to worsen.
2. "Burn-out" is total mental, emotional, and sometimes, physical fatigue which can often times cause you to become so overwhelmed with the job routine that other aspects of your life begin to be neglected, such as your family.
3. Understand the signs of burnout.
 - a. Chronic fatigue
 - b. Insomnia
 - c. Forgetfulness/impaired concentration and attention
 - d. Physically feeling sick
 - e. Increased irritability
 - f. Feeling of dread when you have to go to work
 - g. Not as engaged when you are at work
 - h. Becoming insensitive to the residents
4. Learn ways to decrease burnout.
 - a. Monitor extra shifts you are working
 - b. Start saying no (to extra work)
 - c. Invest in your own health
 - d. Discuss concerns of burnout with your supervisor

- e. Identify where things could go wrong
 - f. Request assistance as necessary to prevent or resolve burnout.
 - g. Make time for downtime
5. Use stress-reducing techniques to cope with stress or sadness.
 - a. Take your assigned breaks
 - b. Whenever possible, participate in relaxation activities that work for you.
 - c. Increase social interactions
 - d. Avoid unnecessary stress
 - e. Alter the situation if possible
 - f. Adapt to what is causing the stress
 - g. Make time for fun
 6. It is your responsibility to understand your feelings, what may make you angry and how you behave.
 - a. A sign of emotional intelligence is the ability to control your emotions.
 - b. Ask yourself, “How will my actions affect my residents, my co-workers, my employer, and me?”
 - c. Find acceptable ways of coping with these feelings – do not direct your anger towards residents.
 - d. Do not take negative resident behavior or remarks personally.
 - e. Try to understand why the resident is acting or behaving this way. If the behavior is out of the ordinary for this resident, notify the nurse of the changes you are observing.
 - f. Regardless of how the resident reacts towards you, you must respond professionally with courtesy and respect.

I. PERSONAL AND VOCATIONAL ADJUSTMENTS

1. Health care rules and directives from supervisors should be followed in a timely manner even if you do not agree with them. (See D. 1 – 4 of this unit).
2. Nurse aide actions contribute to complete care of resident and function of the facility.
3. “Dependability” is one of the most important qualities of a nurse aide.
 - a. Be dependable with your attendance by reporting for duty on time and when scheduled.
 - b. Keep absences to a minimum. Residents depend on you to be at work when you are scheduled.
 - c. If you are unable to come to work, always notify the facility as far in advance as possible.
4. Complete your assignment.
5. Respect your co-workers and try to get along with them.
 - a. Be available to help others and accept help if you need it.
 - b. Treat other staff members with the same courtesy and dignity that you would residents.
 - c. Care is best delivered when everyone works as a team.
6. Practice empathy, patience, courtesy, cooperation and emotional control.
 - a. Everyone has a right to his/her own feelings. Don’t judge other people’s feelings as right or wrong.
7. A good attitude is a very important trait that you bring to your job.

- a. Attitude is developed throughout your lifetime and is a reflection of your experiences.
 - b. Attitude is an outer reflection of your inner feelings.
 - c. Others can see your attitude through your behavior.
 - d. Your tone of voice and body language can change the message that you are trying to convey.
 - e. Be positive about your job, your contribution to resident care and believe that you will succeed.
8. “Tact” is the ability to do or say things without offending or upsetting other people.
9. Continue to learn and grow.
- a. Health care is always changing as new information and technology become available. Your nurse aide class is just the beginning.
 - b. You may learn much from nurses and other nurse aides.
 - c. Attend 12 hours of in-service training per year that is offered by your facility. Attend other continuing education classes as possible.
 - d. Read health-related books, journals.
 - e. Review policy and procedure manuals if you are not sure about how to perform a procedure.
 - f. Be flexible and be able to adjust to many new situations.
10. Your appearance sends a message to others that says you have pride in yourself and your work. Follow your facility’s dress code.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION I – REQUIRED TIME = 16 Hrs

UNIT 8 – TAKING CARE OF YOURSELF

NOTES TO INSTRUCTOR:

- *Integrate the principles of care of self throughout this course*

STUDENT OBJECTIVES:

- *Describe how to prevent physical illness.*
- *Describe three ways to prevent work-related injuries.*
- *Describe how to manage your time and organize your work routine.*
- *Discuss ways to protect yourself legally.*
- *Describe ways to stay emotionally healthy.*
- *Describe methods for reducing stress.*
- *Describe the signs of burnout.*
- *List ways burnout can be decreased.*
- *Provide examples and discuss actions of personal well-being.*
- *Describe personal and vocational adjustments that the nurse aide must make.*
- *Discuss how nurse aide can be the beginning step to a career in the healthcare field.*

ADDITIONAL NOTES:

COURSE CONTENT – SECTION II PERSONAL CARE SKILLS

KEY TERMS

A.M. – morning, before noon

Ambulation – the ability to walk from place to place independently with or without an assistive device

Elimination – the act of discharging or excreting waste products from the body

Environment – the conditions and elements that make up the surroundings and influence each individual's sense of well-being

Hydration – supplying with ample fluid or moisture

Hygiene – conditions or practices (as of cleanliness) that are aids to good health

Nutrition – the process of eating the right kind of food so you can grow properly and be healthy

P.M. – evening, afternoon or night

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

PROCEDURAL GUIDELINES USED IN THIS SECTION:

- Procedural Guideline #5 – Body Mechanics for Nurse Aides
- Procedural Guideline # 9 – Assisting with Meals
- Procedural Guideline #10 – Feeding the Dependent Resident
- Procedural Guideline #11 – Making the Unoccupied Bed
- Procedural Guideline #12 – Making the Occupied Bed
- Procedural Guideline #13 – Intake and Output(I&O)
- Procedural Guideline #18 – Tub or Shower Bath
- Procedural Guideline #19 – Complete Bed Bath
- Procedural Guideline #20 – Perineal Care/Incontinent Care-Female (With or Without Catheter)
- Procedural Guideline #21 – Perineal Care/Incontinent Care-Male (With or Without Catheter)
- Procedural Guideline #22 – Catheter Care
- Procedural Guideline #23– Brushing the Teeth
- Procedural Guideline #24 – Denture Care
- Procedural Guideline #25 – Special Mouth Care
- Procedural Guideline #26 – Hair Care
- Procedural Guideline #27 – Shampooing the Hair
- Procedural Guideline #28 – Shaving the Resident
- Procedural Guideline #29 – Fingernail Care
- Procedural Guideline #30 – Foot Care
- Procedural Guideline #31 – Dressing and Undressing the Resident
- Procedural Guideline #32 – Applying Knee High Elastic (Compression) Stockings
- Procedural Guideline #33 – Bedpan
- Procedural Guideline #34 – Urinal
- Procedural Guideline #35 – Indwelling Urinary Catheter Care
- Procedural Guideline #36 – Urine Specimen Collection
- Procedural Guideline #37 – Stool Specimen Collection
- Procedural Guideline #39 – Assisting Resident to Transfer to Chair or Wheelchair
- Procedural Guideline #40 – Ambulation and Ambulation Aides
- Procedural Guideline #42 – Positioning Residents
- Procedural Guideline #43 – Turning Resident on Side Toward You
- Procedural Guideline #44 – Moving Resident in Bed
- Procedural Guideline #45 – Assisting Resident to Sit Up on Side of Bed

COURSE CONTENT
SECTION II - PERSONAL CARE SKILLS

UNIT 1 - BODY MECHANICS, POSITIONING AND MOVING RESIDENTS

A. BODY MECHANICS AND BODY ALIGNMENT

1. Principles
2. Importance to nurse aides/residents
3. Body Mechanics for Nurse Aides (Procedural Guideline #5)

B. POSITIONING RESIDENTS IN PROPER BODY ALIGNMENT

1. Positioning and protective devices
 - a. Pillows
 - b. Foam wedges - bolster
 - c. Handrolls/trochanter rolls
 - d. Foot cradles/footboards
 - e. Trapeze
 - f. Specialized beds and mattresses
 - g. Specialized equipment for heels and feet
2. Positioning Residents (Procedural Guideline #42)
 - a. Fowlers
 - b. Supine
 - c. Semi-supine
 - d. Prone
 - e. Semi-prone
 - f. Lateral
3. Beginning and Closing Steps
 - a. Note the beginning and closing steps that appear at the beginning of Part 2 – Procedural Guideline.
 - b. These standard steps are repeated in most procedural guidelines that are done at the bedside.
 - c. Follow the beginning and closing steps as appropriate.
 - d. Start with the beginning steps and end with the closing steps for each applicable procedure.
 - e. Review the steps with each procedural guideline, as slight differences occur mainly in the sub-points.

C. MOVING AND LIFTING RESIDENTS/BED MOBILITY

1. Guidelines and precautions for all moving and lifting procedures
2. Turning Resident on Side Toward You (Procedural Guideline #43)
3. Moving Resident in Bed (Procedural Guideline #44)
4. Assisting Resident to Sit Up on Side of Bed (Procedural Guideline #45)

5. Assisting Resident to Transfer to Chair or Wheelchair (Procedural Guideline #39)

6. Discuss the use of the mechanical lift if applicable according to facility policy

D. AMBULATION AND AMBULATION AIDS (Procedural Guideline #40)

1. Guidelines and Precautions for Ambulation

2. Gait Belts

3. Canes

4. Walkers

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION II

UNIT 1-BODY MECHANICS, POSITIONING AND MOVING RESIDENTS

STUDENT OBJECTIVES:

- *State the benefits of using proper body mechanics and alignment:*
 - *To the nurse aide*
 - *To the resident*
- *Demonstrate proper body mechanics in moving and lifting.*
- *Demonstrate skill in positioning and supporting residents in proper body alignment in bed, chair and wheelchair.*
- *Demonstrate ability to elevate head of bed to a 45° angle.*
- *State the standard beginning and closing steps.*
- *Demonstrate skill in performing the standard beginning and closing steps of the procedural guidelines.*
- *State the guidelines and precautions for all of the moving and lifting procedures. Stress the significance of following precautions and to ensure safety of resident while moving or lifting.*
- *Demonstrate skill in:*
 - *Turning resident on side toward you*
 - *Moving resident in bed*
 - *Assisting resident to sit up on side of bed*
 - *Assisting resident to transfer to chair or wheelchair*
- *Demonstrate skill in assisting resident with ambulation using:*
 - *Gait belt*
 - *Cane*
 - *Walker*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II PERSONAL CARE SKILLS

UNIT 2 - CARE OF THE RESIDENT'S ENVIRONMENT

A. CONSIDERATIONS FOR CARE

1. Respect resident's room as private space
2. Respect resident's preferences and privacy
3. Respect resident's personal belongings as irreplaceable
4. Maintain a safe environment

B. ROLE OF THE NURSE AIDE IN USE AND CARE OF EQUIPMENT AND SUPPLIES IN RESIDENT'S ROOM

1. Bed
2. Side rails
3. Call signal
4. Privacy curtains/screens
5. Window curtains if applicable
6. Resident's belongings
7. Other items

C. ROLE OF THE NURSE AIDE IN ENVIRONMENTAL CONTROL

1. Respect resident's private environment. Share in the role of a homelike environment that is safe and clean.
 - a. Cleanliness—team effort
 - b. Control of odors
 - c. Safety
 - d. Comfort and convenience

D. ROLE OF THE NURSE AIDE IN BEDMAKING

1. Making the Unoccupied Bed (Procedural Guideline #11)
2. Making the Occupied Bed (Procedural Guideline #12)

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION II

UNIT 2 – CARE OF THE RESIDENT’S ENVIRONMENT

STUDENT OBJECTIVES:

- *Discuss why the resident’s personal belongings may be so important to the resident.*
- *Demonstrate respect for the resident’s room, privacy and belongings.*
- *Discuss and/or demonstrate skill in maintaining a safe and comfortable environment for the resident while respecting the resident’s personal preference.*
- *Discuss alternative use of side rails according to facility policy.*
- *Demonstrate skill in the proper use and care of equipment and supplies in the resident’s room.*
- *Discuss and give examples of a home-like environment.*
- *Demonstrate skill in correct handling of clean and dirty linen.*
- *Demonstrate skill in bed making:*
 - *Unoccupied bed*
 - *Occupied bed*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II PERSONAL CARE SKILLS

UNIT 3 - ASSISTING RESIDENTS WITH BATHING

A. CONSIDERATIONS FOR CARE

1. Promote residents' rights, privacy, independence and preferences in personal care.
2. Use bath time to give all personal care and to communicate with residents and to make observations. Tell the resident what you are going to do step by step.
3. Observations, reporting and documentation associated with bathing.
4. Respect the resident's right to refuse bathing. Inquire as to why the refusal and offer alternatives such as a bed-bath on a different day or at a different time. Allow the resident to select his/her preferred schedule.

B. ROLE OF THE NURSE AIDE IN ASSISTING RESIDENTS WITH BATHING

1. Tub or Shower Bath (Procedural Guideline #18)

1. Complete Bed Bath (Procedural Guideline #19)

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION II

UNIT 3 - ASSISTING RESIDENTS WITH BATHING

STUDENT OBJECTIVES:

- *Discuss how difficult it would be to depend on someone else to perform your personal hygiene, and what would make it less difficult.*
- *Describe the important role of the nurse aide in assisting residents with personal care on a daily basis.*
- *Discuss how the nurse aide can use bath time to identify and meet the residents' needs.*
- *Discuss how the nurse aide can respect and protect residents' rights while assisting with personal care.*
- *Demonstrate skill in safely assisting resident into and out of tub or shower.*
- *Demonstrate skill in assisting residents with:*
 - *Tub bath*
 - *Shower bath*
 - *Complete bed bath*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II – PERSONAL CARE SKILLS

UNIT 4 - TOILETING AND PERINEAL CARE

A. ASSISTING RESIDENT WITH TOILETING

1. Bathroom
2. Bedside commode
3. Assists with Use of Bedpan (Procedural Guideline #33) and Urinal (Procedural Guideline #34)

B. ASSISTING WITH PERINEAL CARE/INCONTINENT CARE

1. Perineal Care/Incontinent Care-Female (With or Without Catheter - Procedural Guideline #20)
2. Perineal Care/Incontinent Care-Male (With or Without Catheter - Procedural Guideline #21)
3. Catheter Care (Procedural Guideline #22)

**\INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION II**

UNIT 4 – TOILETING AND PERINEAL CARE

STUDENT OBJECTIVES:

- *Discuss ways to promote privacy while assisting a resident with toileting.*

- *Demonstrate skill in assisting residents with:*
 - *Bathroom or bedside commode*
 - *Bedpan and urinal*

- *Describe the importance of perineal care/incontinent care.*

- *Demonstrate skill in giving perineal care/incontinent care:*
 - *Female*
 - *Male*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II – PERSONAL CARE SKILLS

UNIT 5 - SKIN CARE

A. CONSIDERATIONS FOR CARE

1. Skin changes associated with aging, certain medical conditions and other chronic illnesses
2. Importance of skin care for residents with particular medical conditions
3. Common sites of pressure areas and skin breakdown
4. Early recognition of pressure areas and skin breakdown

B. ROLE OF THE NURSE AIDE IN PREVENTING SKIN BREAKDOWN

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

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION II

UNIT 5- SKIN CARE

STUDENT OBJECTIVES:

- *State changes in the skin, hair and nails associated with aging.*
- *Identify common sites of skin breakdown.*
- *Describe and/or demonstrate skill in observing, recognizing and reporting early signs of pressure areas and skin breakdown.*
- *Describe and/or demonstrate skill in giving skin care for the prevention of pressure ulcers.*
- *Define “friction” and “shearing” and describe measures for prevention.*
- *State normal daily fluid requirements.*
- *Describe how good nutrition affects the skin.*
- *Describe the skin changes you would report to nurse.*
- *Describe the care of resident with skin redness or breakdown.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II – PERSONAL CARE SKILLS

UNIT 6 - HYGIENE AND GROOMING

A. ASSISTING WITH ORAL CARE

1. Importance to residents
2. General Guidelines and Precautions
3. Brushing the Teeth (Procedural Guideline #23)
4. Denture Care (Procedural Guideline #24)
5. Special Mouth Care (Procedural Guideline #25)

B. HAIR CARE (Procedural Guideline #26)

C. SHAMPOOING THE HAIR (Procedural Guideline #27)

D. SHAVING THE RESIDENT (Procedural Guideline #28)

E. FINGERNAIL CARE (Procedural Guideline #29) and FOOT CARE (Procedural Guideline #30)

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

F. DRESSING AND UNDRESSING THE RESIDENT (PROCEDURAL GUIDELINE#31)

G. APPLYING KNEE HIGH ELASTIC (compression) STOCKINGS (PROCEDURAL GUIDELINE #32)

- H. ENCOURAGING AND ASSISTING RESIDENT WITH HANDWASHING
- I. OTHER GROOMING SUCH AS COSMETICS

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION II

UNIT 6 – HYGIENE AND GROOMING

STUDENT OBJECTIVES:

- *Demonstrate skill in assisting with oral care:*
 - *Brushing the teeth*
 - *Denture care*
 - *Special mouth care*
- *Instruct students to encourage self-flossing for residents who are self-care.*
- *Identify one precaution that should be followed when assisting with oral care.*
- *Demonstrate skill in assisting residents with:*
 - *Hair care*
 - *Shampooing the hair*
 - *Shaving the resident*
 - *Hand, foot and nail care*
 - *Dressing and undressing the resident*
 - *Knee high stocking*
- *Read and describe the policy for hand, foot and nail care in your facility.*
- *Identify one precaution that should be followed when cutting resident's toenails.*
- *Discuss ways to promote residents' independence and participation in personal grooming.*
- *Explain why promoting independence is important to self-esteem*
- *Describe the tasks required in performing A.M. and P.M. care.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II – PERSONAL CARE SKILLS

UNIT 7 – NUTRITION

A. CONSIDERATIONS FOR CARE

1. Basic nutritional needs
 - a. Nutrients
 - b. USDA Food Plate
2. Importance of food to residents
 - a. Nutritional
 - b. Psychosocial
3. Changes in nutrition due to aging
4. Common problems related to nutrition
 - a. Problems with appetite
 - b. Mechanical problems in putting food into mouth, chewing and swallowing
 - c. Diabetes

B. ASSISTING RESIDENTS WITH NUTRITION

1. Setting the stage for pleasant mealtimes
2. Guidelines and Precautions in feeding residents
3. Assisting with Meals (Procedural Guideline #9)
 - a. Preparing the eating area
 - b. Preparing residents prior to mealtime
 - c. Serving (passing) trays
 - d. Assisting residents with eating
 - e. Monitoring mealtime
 - f. Removing trays
 - g. Assisting residents after meals
 - h. Observing, reporting and documentation
4. Use of assistive feeding devices to maintain independence in eating
 - a. Non-slip plate holders
 - b. Utensils with built-up handles and other modifications
 - c. Plate guards
5. Importance of resident receiving and eating special therapeutic diets ordered by a physician as treatments:
 - a. Liquid, soft or easy-to-chew diets
 - b. High calorie or high protein diets
 - c. Low salt, fat or calorie diets

- d. Diabetic diets
 - e. Pureed
6. Feeding the Dependent Resident (Procedural Guideline #10)

INSTRUCTOR NOTES & STUDENTS NOTES
SECTION II

UNIT 7 – NUTRITION

STUDENT OBJECTIVES:

- *Define the six groups of foods in the food plate.*
- *Select a well-balanced diet for one day using the food plate as a guide.*
- *List two changes associated with aging that affect eating and drinking.*
- *Discuss the importance of eating to residents.*
- *Discuss one way a nurse aide could assist residents with each of the common eating problems.*
- *Demonstrate skill in assisting residents with meals.*
- *Discuss the importance of the nurse aide in assisting residents with therapeutic diets and diet supplements.*
- *Practice spoon feeding and being fed by a classmate and think about how the resident feels.*
- *Demonstrate skill in feeding the dependent resident.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II – PERSONAL CARE SKILLS

UNIT 8 – HYDRATION

A. CONSIDERATIONS FOR CARE

1. Amount of fluids needed by body

2. Normal daily range of I & O
 - a. Fluid intake = 2000 to 2500 cc
 - b. Urine output = 1500 to 2000 cc

3. Importance of fluid balance

4. Problems with hydration due to aging or illness

5. How to recognize dehydration and fluid retention

B. ASSISTING RESIDENTS WITH HYDRATION

1. Role of nurse aide in offering and encouraging fluid intake

2. Measures to increase fluid intake

3. Thicken liquid according to manufactures guidelines and facility policies

4. Measuring Intake and Output (I & O) (Procedural Guideline #13)

5. Follow fluid restrictions according to facility policy

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION II

UNIT 8 – HYDRATION

STUDENT OBJECTIVES:

- *State the range of normal fluid intake and output.*
- *Describe one observation you could make to recognize:*
 - *Insufficient fluid intake*
 - *Fluid retention*
- *Discuss or demonstrate measures the nurse aide could use to increase fluid intake.*
- *Describe and/or demonstrate skill in serving fresh water to residents using proper infection control practices.*
- *Describe and/or demonstrate skill in measuring and recording I & O, using the fluid containers in your facility.*
- *Discuss the nurse aide's responsibilities when fluids are restricted.*
- *Discuss situations where fluid restrictions are required.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION II – PERSONAL CARE SKILLS

UNIT 9 – ELIMINATION

A. URINARY ELIMINATION

1. Normal function of urinary system
2. Changes in urinary function associated with aging
3. Common problems of the urinary system
 - a. Urinary retention
 - b. Urinary incontinence
 - c. Urinary infection
 - d. Kidney failure
4. Role of the nurse aide in preventing urinary problems
 - a. Encourage fluid intake.
 - b. Assist with toileting frequently, promptly and regularly as needed.
 - c. Provide privacy
5. Indwelling Urinary Catheter Care (Procedural Guideline #35)
 - a. Catheters must be ordered by physician.
 - b. Catheters must be inserted by licensed personnel.
 - c. Catheters must never be used for convenience of staff.
 - d. Catheters should always be secured with tape or leg strap.
 - e. Provide privacy bags
6. Observing and reporting urinary elimination

B. BOWEL ELIMINATION

1. Normal bowel function
2. Changes in bowel function associated with aging
3. Common problems of bowel elimination
 - a. Constipation
 - b. Diarrhea
 - c. Incontinence
4. Role of the nurse aide in preventing constipation
 - a. Encouraging fluid intake
 - b. Encouraging high fiber foods
 - c. Encouraging exercise and activity
 - d. Assisting with toileting promptly and at regular times

e. Providing privacy

5. Role of nurse aide in identifying fecal impaction

6. Role of nurse aide in managing diarrhea

7. Observing and reporting bowel elimination

C. BLADDER AND/OR BOWEL INCONTINENCE

1. Definition and causes

2. Avoiding incontinence

a. Incontinence is not a normal part of aging.

b. Regular and prompt toileting is an important measure in avoiding incontinence for all residents, including confused residents.

3. Respect the resident's right to privacy when discussing the use of briefs or toileting.

4. Use of appropriate size of incontinent pads and briefs

5. Use of external catheters for males

6. Incontinent care (review Procedural Guidelines 20 & 21 as needed)

7. Bowel and bladder toileting

a. Description

b. Role of the nurse aide in bowel and/or bladder retraining program

D. COLLECTING SPECIMENS

1. Urine Specimen Collection (Procedural Guideline #36)

2. Stool Specimen Collection (Procedural Guideline #37)

INSTRUCTOR NOTES & STUDENT OBJECTIVES SECTION II

UNIT 9 - ELIMINATION

STUDENT OBJECTIVES:

- *Describe the changes in urinary function associated with aging.*
- *Describe and/or demonstrate skill in the care of indwelling urinary catheters.*
- *State observations about urinary elimination that should be reported to the charge nurse.*
- *Describe noticeable symptoms such as color of urine.*
- *Describe the changes in bowel function associated with aging.*
- *Discuss measures to help prevent constipation.*
- *Discuss ways to identify fecal impaction.*
- *State observations about bowel elimination that should be reported to the nurse.*
- *Discuss ways to prevent the spreading of bacteria when resident has diarrhea.*
- *Discuss the important role of the nurse aide in regular and prompt toileting of residents.*
- *Discuss the important role of the nurse aide in the bowel and/or bladder toileting program in your facility.*
- *Describe and/or demonstrate skill in collecting:*
 - *Routine or clean-catch urine specimens*
 - *Routine stool specimens*

ADDITIONAL NOTES:

COURSE CONTENT – SECTION III BASIC NURSING SKILLS

KEY TERMS

ADLs – activities of daily living

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

Document – to record information in a file or chart

Environment – the conditions and elements that make up the surroundings

Fahrenheit (F) – relating to a temperature scale

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

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

Observing – to take notice

Pulse (P) – the rate of the heartbeat

Reporting – to give an account of

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

Respiration (R) – breathing

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

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

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

PROCEDURAL GUIDELINES USED IN THIS SECTION:

- Procedural Guideline #8 – Communication and Interpersonal Skills
- Procedural Guideline #14 – Temperature (Oral, Axillary and Rectal)
- Procedural Guideline #15 – Manual Pulse and Respiration
- Procedural Guideline #16 – Blood Pressure
- Procedural Guideline #17 – Height and Weight
- Procedural Guideline #38 – Postmortem Care

COURSE CONTENT
SECTION III BASIC NURSING SKILLS

UNIT 1 – PROMOTING A RESTRAINT-PROPER ENVIRONMENT

A. CONSIDERATIONS FOR CARE

1. OBRA defines “physical restraints” as any method or equipment used on or near the resident’s body that the resident cannot remove easily and which restricts freedom of movement or normal access to one’s body.
2. OBRA states that residents have the right to be free from restraints which are unnecessary, inappropriate or not required to treat the resident’s medical symptoms.

B. REQUIREMENTS FOR USING RESTRAINTS

1. Restraints require written doctor’s order and consent that specifies the reason for the restraint.
2. Restraints may be used only to treat or protect the resident—not for discipline or staff convenience.
3. The least restrictive type of restraint must be used for the least amount of time.
4. All person-centered approaches must be attempted/implemented prior to the use of restraints, except in the case of emergency restraints.
5. Restraints must be used only as a last resort when all other methods have failed.

C. DANGERS OF USING RESTRAINTS

1. Physical effects such as skin damage, circulatory impairment, incontinence, nerve/muscle injury, pneumonia, serious injury and death.
2. Emotional effects such as depression, frustration, anger, agitation, disorientation and loss of self-esteem.

D. ROLE OF THE NURSE AIDE IN AVOIDING THE NEED FOR RESTRAINTS

1. General measures
 - a) Keep environment calm, restful.
 - b) Eliminate multiple stimuli.
 - c) Speak in a calm, gentle manner.
 - d) Provide kind, respectful care.
 - e) Practice person-centered care principles.
 - f) Meet residents’ needs, e.g. elimination, positioning, activity.
 - g) Frequent observation.
 - h) Adjust staff and environment to resident’s individual needs—not vice versa.
2. Observation and problem-solving

- a) Make careful observations of resident to identify what:
 - Causes the problem behavior.
 - Calms or distracts the resident.
- b) Report your objective observations to the nurse to assist the nurse in care planning.
- c) Provide care (that you are trained to provide) following the instructions of the nurse, care plan, and person-centered principles to:
 - Eliminate cause of behavior.
 - Calm or distract resident.
- e) Continue to report observations to the nurse to assist the nurse with evaluating the plan of care.

E. ROLE OF THE NURSE AIDE IN THE CARE OF RESIDENTS WHEN RESTRAINTS ARE NEEDED

1. Soft restraints (Mitt)
 - a) Precautions
 - b) Applying soft restraints (Mitt)
 - c) Care of the restrained resident
 - d) Observing and reporting
2. Geri chair
3. Pommel chair
4. Scoop mattress
5. Seat belt, lap buddy
6. Side rail

**INSTRUCTOR NOTES AND STUDENT OBJECTIVES
SECTION III**

UNIT 1 – PROMOTING A RESTRAINT-PROPER ENVIRONMENT

STUDENT OBJECTIVES:

- *Define physical restraints and list 2 types of restraints.*
- *Describe how you would feel if you were restrained in your chair, geri chair, side rail, secure unit or used a merry walker.*
- *List the reason, the meaning and importance of using restraints only as a last resort.*
- *List 2 advantages of not using restraints:*
 - *To the resident*
 - *To the staff*
- *List 3 general measures you could use to help avoid the need for restraints.*
- *Describe the observation and problem-solving measures you could use to help maintain a proper restraint free environment.*
- *Discuss the important role of the nurse aide in avoiding restraints.*
- *Demonstrate laboratory skill in applying mitt or lap buddy restraint.*
- *Describe the care that must be given to a restrained resident every 2 hours.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION III BASIC NURSING SKILLS

UNIT 2 – VITAL SIGNS, HEIGHT AND WEIGHT

C. TEMPERATURE (“T”)

1. Definition: “Temperature” is the amount of heat in the body.
2. Normal “T” and range to be reported
 - a) Report below 96°F and above 99°F
3. Factors that affect temperature.
4. Importance of accurate measurements.
5. Temperature (Procedural Guideline #14)
 - a) Oral Temperature
 - b) Axillary Temperature

D. PULSE (P)

1. Definition: The “pulse” is the rate of the heartbeat.
2. Normal rate and range to be reported
 - a) Normal rate – about 76/minute
 - b) Report P <60 & >100/minute
 - c) Normal rhythm – regular
3. Pulse points
4. Factors that affect pulse rate and rhythm
5. Importance of accurate rate and description of pulse (irregular, bounding, weak, thready)
6. Pulse (Procedural Guideline #15)

E. RESPIRATION (R)

1. Definition—respiration is inspiration (breathing in) and expiration (breathing out).
2. Normal rate and range to be reported
 - a) Normal rate – about 16/minute
 - b) Report R <12 & >22/minute
3. Factors that affect respiratory rate, rhythm and character
4. Importance of accurate rate and description (deep, shallow, noisy)
5. Respiration (Procedural Guideline #15)

F. BLOOD PRESSURE (BP)

1. Definition—blood pressure is the force of the blood against the artery walls as the heartbeats.
2. Normal BP and range to be reported
 - a) Recorded as systolic/diastolic
 - b) Normal – about 120/80 mmHg
 - c) Report <100/60 & >140/90 mmHg
3. Factors that affect blood pressure
 - a) Recheck a blood pressure no more than 3 times and wait at least 1 to 2 minutes before repeating the BP measurement on the same arm.
 - b) Report to the charge nurse for assistance if you cannot hear the BP or are unsure of what you are hearing after 3 tries. Don't guess at the BP reading.
4. Importance of accurate BP readings
5. Blood Pressure (Procedural Guideline #16)

G. HEIGHT AND WEIGHT

1. Definition
2. Importance of accurate measurements
3. Height and Weight (Procedural Guideline #17)
 - a) Ambulatory Residents
 - b) Non-ambulatory Residents
 - c) Contractures

**INSTRUCTOR NOTES AND STUDENT OBJECTIVES
SECTION III**

UNIT 2 – VITAL SIGNS, HEIGHT AND WEIGHT

INSTRUCTOR NOTES:

- *You must teach the temperature procedures using all types of devices. Then you may also teach other methods e.g. digital or aural temperatures following facility policy.*
- *Describe factors that may affect pulse including a Pacemaker.*

STUDENT OBJECTIVES:

- *State the normal temperature and the range to be reported for:*
 - *Oral Temperature*
 - *Axillary Temperature (Ax)*
 - *Aural Temperature*
- *State the normal rate and the range to be reported for*
 - *Pulse*
 - *Respiration*
- *Discuss and/or demonstrate skill in recognizing and reporting irregular pulse and respiratory rates. Patients with pacemaker have same pulse.*
- *State the normal blood pressure and the range to be reported.*
- *Describe the importance of accurate measurement and reporting of TPR and BP.*
- *Demonstrate skill in taking and recording blood pressure.*
- *Demonstrate skill in taking and recording height and weight.*
- *Review facility policy regarding the use of BP cuffs.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION III – BASIC NURSING SKILLS

UNIT 3 – OBSERVING, REPORTING AND DOCUMENTING

A. IMPORTANCE OF OBSERVING, REPORTING AND DOCUMENTING IN LTC

B. IMPORTANCE OF THE NURSE AIDE IN OBSERVING AND REPORTING

C. MINIMUM DATA SET – The MDS is a 52 page resident assessment document

1. Purpose

- a) Drives care
- b) Sets reimbursement
- c) Regulatory document
- d) Justifies staffing

2. CNA Impact

a) Documents ADLs

- Transfer
- Toileting
- Eating
- Bed mobility
- Behaviors
- Restorative

b) Reflects amount of assistance required in Self Performance (what resident does):

- Independence
- Supervision
- Limited
- Extensive
- Total
- Activity did not occur

c) Reflects amount of assistance required in Support (what staff does):

- No set-up upon assistance
- Set-up only
- 1 person physical assist
- 2 person physical assist
- ADL did not occur

D. TYPES OF OBSERVATIONS

1. Objective observations

2. Subjective observations

E. GUIDELINES FOR EFFECTIVE OBSERVATIONS

1. Develop the habit of making systematic observations as you work. Go from head to toe or use

your own system.

2. Use your senses (sight, touch, hearing, smell).
3. Learn the usual/normal condition for resident, keeping in mind person-centered care principles (both physical and mental).
4. Then note any changes from the usual condition for that resident, such as: if a resident's usual BP is 170/100, then a "normal" BP of 120/80 may be unusual for that resident.
5. Document your observations on-the-spot and use for reporting.

F. HOW TO REPORT

1. General reporting guidelines
2. Follow facility policy for reporting.
 - a) Urgent reporting
 - b) Routine reporting

G. DOCUMENTATION

1. What is documentation
 - a. Factual information about the resident
 - b. Includes the needs and conditions of the resident and the care that is provided by the CNA
 - c. Occurs on an on-going basis
 - d. Firsthand record of any and all observations made by the care staff
2. Why document
 - a. Documentation allows caregivers to communicate with one another
 - b. It is used to ensure that services that were paid for, for each individual resident, are delivered
 - c. Provides a picture of the resident's condition
 - d. Details how the resident is responding to treatment
 - e. It is a legal record of care that can be used in a court of law
3. When should you document
 - a. Documentation should occur as soon as possible after the care and/or services are provided to the resident
 - b. It is **NEVER** okay to document that care/services were provided prior to being delivered to the resident
 - c. Each nursing facility will have its own policies and procedures related to documentation, which may include documentation by exception.
4. What is documentation by exception
 - a. This is the implication that all standards have been met with a normal or expected response unless otherwise documented.
 - b. Well-defined guidelines and standards for each resident must be in place

- c. If 'normal limits' are used to indicate the need to document or not, then these normal limits must be clearly defined
 - d. When in doubt, it is better to be safe and document, as inadequate documentation can result in harm to the resident and possible legal consequences.
5. What should be documented
- a. CNAs are responsible for documenting activities of daily living (ADLs) that are outlined in each resident's care plan
 - b. Any other activities in which assistance is provided
 - c. Useful information that the family provides about the resident
 - d. Any refusal of assistance by the resident
 - e. Observations that are made regarding the resident

H. HOW TO DOCUMENT

1. General documenting guidelines
 - a) Accurate and complete information must be provided
 - b) Documentation must be done on time
 - c) Done in a legal manner, ensuring that all information provided is factual, without any opinions
 - d) Professional (words spelled correctly and writing is legible)
2. Follow facility policy for documenting
 - a) On worksheets/flow sheets
 - b) In charts
 - c) Electronic systems

I. CONSEQUENCES OF INCOMPLETE/IMPROPER DOCUMENTATION

1. When documentation is not completed properly, there can be serious consequences
 - a. Legal consequences such as litigation, loss of job, and loss of licensure
 - b. Changes in the resident's condition may be overlooked
 - c. Resident's quality of care can suffer, potentially leading to injury, hospitalization, and even death
 - d. The nursing facility may be subject to survey citations which may lead to fines or other penalties

J. OBSERVING AND REPORTING SUMMARY

1. Review and summarize guidelines for observing and reporting.
2. Signs of Infections
 - a. Temperature elevation
 - b. Chilling and sweating
 - c. Skin hot or cold, color flushed or blue
 - d. Inflammation (heat, pain, redness, swelling)
3. Respiratory Problems
 - a. Noisy, labored, difficult respiration (dyspnea) shortness of breath (SOB), wheezing
 - b. Coughing - dry or productive. If productive, describe sputum
 - c. Change in color of lips or nails, usually blue

4. Cardiovascular Problems

- a. Chest pain
- b. Headache, dizziness, vomiting, weakness, paralysis
- c. Cold, blue, numb or painful feet or hands

5. Skin Problems

- a. Skin changes such as rash, redness, irritation, bruising, discoloration, swelling, skin breakdown, drainage, foul odors
- b. Skin complaints such as burning, itching, tingling, numbness, pain
- c. Skin infections d. Pressure areas
- d. Skin growths (benign and malignant)

6. Bowel or Abdominal Problems

- a. Unusual appearance of stool. Presence of unusual substances such as blood, mucus
- b. Bowel complaints such as pain, constipation, diarrhea, bleeding
- c. Indigestion
- d. Nausea and vomiting
- e. Abdominal pain
- f. Abdominal bleeding (digested blood causes vomitus and stool to look like "coffee-grounds")

7. Urinary Problems

- a. Unusual appearance of urine -- such as dark, red, cloudy instead of yellow or straw colored. Presence of unusual substances such as solid particles, blood, odor
- b. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain
- c. Changes in mental status

8. Fluid Balance Problems

- a. Signs of dehydration such as low fluid intake, low output of dark urine with strong odor, weight loss, dry skin, dry mucous membrane (lips, tongue, eyes), drowsiness, confusion
- b. Signs of fluid retention such as edema, weight gain, respiratory difficulties
- c. Changes in mental status

9. Mental status changes

- a. Changes in level of consciousness/alertness
- b. Changes in behavior or communication
- c. Changes in mood or emotional status
- d. Changes in memory or confusion
- e. Threats of suicide or threats of harm to others

INSTRUCTOR NOTES AND STUDENT OBJECTIVES SECTION III

UNIT 3 – OBSERVING, REPORTING AND DOCUMENTING

STUDENT OBJECTIVES:

- *Explain the importance of recognizing and reporting changes in resident's condition.*
- *Give two examples of how accurate observations and reporting by the nurse aide can lead to better care of residents.*
- *Discuss the MDS – resident assessment document.*
- *Discuss observations that you would report immediately to the nurse and observations that you would report at the end of your shift.*
- *Describe the principles of documentation*
- *Demonstrate skill in reporting and recording the care you give and/or observations you make.*
- *Review and discuss what you would observe for and report to the nurse related to:*
 - *Vital sign changes*
 - *Infections*
 - *Respiratory problems*
 - *Cardiovascular problems*
 - *Skin problems*
 - *Bowel or abdominal problems*
 - *Urinary problems*
 - *Fluid balance problems*
 - *Nutritional problems*
 - *Mental status changes*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION III – BASIC NURSING SKILLS

UNIT 4 – ADMISSION, TRANSFER AND DISCHARGE

- A. TYPES OF ADMISSIONS/DISCHARGES/TRANSFERS
- B. EFFECTS OF ADMISSIONS/DISCHARGES/TRANSFERS ON RESIDENTS
- C. ROLE OF THE NURSE AIDE IN ADMITTING, DISCHARGING AND TRANSFERRING RESIDENTS
 1. Follow the policies and procedures of your facility, as variations exist in methods, roles and responsibilities.
 2. Request and follow instructions from charge nurse.
 3. Set aside adequate time for the procedure and have the room and needed supplies available.
 4. Transport the resident following facility policy.
 5. Use effective Communication and Interpersonal Skills (Procedural Guideline #8). Be a good listener and develop supportive relationships with residents.
 6. Provide person-centered assistance and support to reduce the resident's stress and anxiety. Even under the best circumstances, these procedures represent changes that may result in increased stress and anxiety for the resident.
 7. Take baseline TPR, BP, Height and Weight following facility policy and Procedural Guideline #14 thru #17.
 8. Care for the resident's valuables and personal belongings following facility policy.
 9. For a newly admitted resident, make the resident feel welcome and ask how the resident prefers to be addressed.

**INSTRUCTOR NOTES AND STUDENT OBJECTIVES
SECTION III**

UNIT 4 – ADMISSION, TRANSFER AND DISCHARGE

STUDENT OBJECTIVES:

- *Describe the role of the nurse aide in admission, transfer and discharge of residents.*
- *Discuss ways the nurse aide can help a new resident adjust to changes in surroundings and residents' psychosocial needs.*
- *Discuss signs of physical and mental behavior and when to report to nurse.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION III – BASIC NURSING SKILLS

UNIT 5 – COPING WITH DEATH

- A. ACCEPTING ONE’S OWN MORTALITY IS A DEVELOPMENTAL STAGE OF LIFE
- B. WAYS RESIDENTS COPE WITH IMPENDING DEATH
 - 1. Denial
 - 2. Anger
 - 3. Bargaining
 - 4. Depression
 - 5. Acceptance
- C. SIGNS OF APPROACHING DEATH
- D. ROLE OF THE NURSE AIDE IN MEETING THE PHYSICAL NEEDS OF THE DYING RESIDENT
 - 1. Personal care
 - 2. Comfort
- E. ROLE OF THE NURSE AIDE IN MEETING THE EMOTIONAL NEEDS OF THE DYING RESIDENT
 - 1. Preserving dignity
 - 2. Providing privacy
 - 3. Spiritual and cultural needs
- F. ROLE OF THE NURSE AIDE IN PROVIDING SUPPORT TO
 - 1. Resident
 - 2. Family and friends
 - 3. Other concerned residents
- G. ROLE OF HOSPICE
- H. POSTMORTEM CARE (Procedural Guideline #38)

**INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION III**

UNIT 5 – COPING WITH DEATH

STUDENT OBJECTIVES:

- *Discuss ways residents cope with death.*
- *List signs of approaching death, including loss of senses and body functions.*
- *Describe how you will manage your own feelings about death and how you can get support for yourself.*
- *Discuss spiritual and cultural needs of the dying resident.*
- *Describe and/or demonstrate the role of the nurse aide in giving physical and emotional support to the dying resident.*
- *Discuss how the nurse aide should respond to other residents' questions about a dying resident.*
- *Discuss how hospice care is a partner in care.*
- *Discuss and/or demonstrate the procedure for postmortem care.*

ADDITIONAL NOTES:

COURSE CONTENT – SECTION IV RESTORATIVE SERVICES

KEY TERMS

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

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

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

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

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

PROCEDURAL GUIDELINES USED IN THIS SECTION:

- Procedural Guideline #41 – Passive Range of Motion (PROM) Exercises

COURSE CONTENT
SECTION IV – RESTORATIVE SERVICES

UNIT 1 – INTRODUCTION TO RESTORATIVE SERVICES

A. CONSIDERATION FOR CARE

1. Restoration is the care given to attain and maintain the highest possible level of independence and functional ability (physical and psychosocial).
2. OBRA focused on restoration to improve the quality of life for LTC facility residents by:
 - a. Working as an interdisciplinary team to provide restorative care.
 - b. Addressing risk factors in advance to prevent deterioration or declines in residents' conditions. Note that declines in condition are not normally due to the aging process alone.
3. The concept of restorative care is that optimal independence and function leads to optimal self-esteem and quality of life.
4. Use a restorative approach in all aspects of care.

B. THE INTERDISCIPLINARY RESTORATIVE TEAM

C. THE IMPORTANCE OF THE NURSE AIDE IN RESTORATIVE CARE

D. GUIDELINES FOR RESTORATION

Restoration is a resident's right.

Restoration is a team effort.

Restoration should be based on the resident's specific needs, following person-centered principles

Promote optimal physical and psychosocial wellness.

Prevent complication through proper care.

Maximize self-care within limitations.

Provide support, empathy, patience, encouragement, enthusiasm, and praise.

Acknowledge success, however small.

Emphasize strengths and abilities—not weakness and disabilities.

Emphasize independence—not helplessness.

Convey a positive attitude of hope.

See the resident as a whole, complex person—a unique individual, implementing person-centered care principles. Realize that problems in one area of life may affect other areas or overall functioning.

**INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION IV**

UNIT 1 – INTRODUCTION TO RESTORATION

INSTRUCTOR NOTES:

- *Restorative skills are integrated throughout this course.*

STUDENT OBJECTIVES:

- *Define restoration.*
- *Discuss how highest practicable = what resident can do for themselves.*
- *Discuss how restoration can improve self-esteem and the quality of life.*
- *Discuss the importance of the nurse aide in restorative care.*
- *Identify three guidelines for restorative care.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION IV – RESTORATIVE SERVICES

UNIT 2 – ROLE OF THE NURSE AIDE IN RESTORATION CARE

A. REVIEW OF GENERAL RESTORATIVE MEASURES

1. Restorative measures related to the activities of daily living (ADL's):
 - a. Hygiene and grooming
 - b. Activity
 - c. Nutrition and hydration
 - d. Elimination
 - e. Communication
 - f. Mobility and bed mobility

2. Role of the nurse aide in applying general restorative measures and promoting self-care
 - a. Use a restorative approach in the care of all residents, with a focus on independence and the quality of life.
 - b. Prevent complications and promote wellness by:
 - i. Encouraging activity, exercise and good alignment
 - ii. Offering adequate food and fluids
 - iii. Providing proper skin care
 - iv. Practicing safety and infection control
 - c. Explain procedure and encourage resident's participation to his/her level of ability. (standard beginning steps of Procedural Guidelines).
 - d. Allow adequate time for residents to complete self-care tasks.
 - e. Always replace call signal and needed items within resident's reach (standard closing step of Procedural Guidelines).
 - f. Encourage resident to use strengths to overcome weaknesses. Look for things the resident can do and build on the abilities.
 - g. Encourage residents to function as independently as possible—but not beyond his/her capabilities.
 - i. Independence can be physical such as walking or mental such as decision-making.
 - ii. Seek help from nurse in understanding residents' abilities and disabilities.
 - iii. Find the right balance for each resident.
 - iv. Generally stop short of resident becoming frustrated, discouraged or giving up.
 - h. Make careful observations to prevent complications and to monitor the resident's progress.
 - i. Be sensitive to residents' needs and responses.
 - ii. Identify what works and what doesn't work for residents.
 - iii. Report your observations to the nurse (standard closing step of Procedural Guidelines).

B. SPECIFIC RESTORATIVE PROGRAMS

1. Restorative care planning begins on the day of admission and is:
 - a. Based on needs of individual residents
 - b. Developed and implemented by the restorative team

- c. Written in the resident care plan
2. Specific restorative programs
 - a. Hygiene and grooming program
 - b. Exercise program
 - c. Ambulation program
 - d. PROM program
 - e. Pressure sore prevention program
 - f. Dining program
 - g. Bowel/bladder program
 - h. "Alternatives to Restraints" program
 - i. Communication program
 - j. Behavior management program
 3. Role of the nurse aide in assisting with specific restorative programs
 - a. Make careful observations of residents' problems and/or restorative needs.
 - b. Report your objective observations to assist the nurse in assessing, planning care and the document programs.
 - c. Review and become familiar with the specific restorative plan of care.
 - d. Understand exactly what your role and responsibilities are.
 - e. Request information and assistance from the nurse.
 - f. Follow the restorative care plan and instructions of the nurse, keeping in mind the principles of person-centered care.
 - g. Report changes in improvement or decline to the nurse.
 - h. Work with the restorative team as appropriate. Your participation can be valuable to the success of the program and can be a valuable learning experience for you.

C. ASSISTING RESIDENT WITH ADAPTIVE OR ASSISTIVE DEVICES

1. Grooming devices
2. Ambulation devices
3. Feeding devices
4. Communication devices

D. ASSISTING RESIDENTS WITH PROSTHETIC DEVICES

1. Eye glasses
2. Hearing aids
3. Artificial eyes
4. Artificial limbs
5. Braces and splints
6. Dental devices

E. MAINTAINING PROM

1. Range of motion refers to the distance a joint will comfortably move.
2. Types of PROM
 - a. Active
 - b. Passive
 - c. Assisted
3. Use of PROM during personal care
 - a. Check with the nurse to find out which joints should be exercised and the type of exercise needed.
 - b. Plan PROM exercise as part of self-care or ADLs after discussing the exercise with the resident to ensure his/her participation
4. Passive Range of Motion (PROM) Exercises (Procedural Guideline #41)

INSTRUCTOR NOTES & STUDENT OBJECTIVES SECTION IV

UNIT 2 – ROLE OF THE NURSE AIDE IN RESTORATION CARE

INSTRUCTOR NOTES:

- *This unit is a time to review the restorative skills already taught, stress the importance of restoration, and add new knowledge and skill in restorative care.*

STUDENT OBJECTIVES:

- *Discuss ways to incorporate restorative care into daily activities.*
- *Describe how the nurse aide could “encourage the resident’s participation” in a procedure.*
- *Discuss how “replacing the call signal and needed items within the resident’s reach” can be a restorative measure.*
- *Discuss task segmentation for a dementia patient.*
- *Discuss how your observations relate to restorative measures.*
- *Describe and/or demonstrate skill in applying general restorative measures in the care of all residents.*
- *State 3 types of specific restorative programs.*
- *Describe or demonstrate the role of the nurse aide in specific restorative programs.*
- *Discuss how restorative services are related to reimbursement.*
- *Discuss and/or demonstrate skill in assisting residents with adaptive or assistive devices for:*
 - *Grooming*
 - *Ambulation*
 - *Feeding*
 - *Communication*
- *Discuss and/or demonstrate skills in assisting with:*
 - *Eye glasses*
 - *Hearing aids*
 - *Artificial eyes*
 - *Artificial limbs*
 - *Braces and splints*

- *Dental devices*
- *State the precautions and rules for PROM.*
- *Demonstrate skill in performing PROM exercises.*
- *Do not become discouraged if PROM is limited and/or progress is slow.*

ADDITIONAL NOTES:

COURSE CONTENT - SECTION V MENTAL HEALTH AND SOCIAL SERVICE NEEDS

KEY TERMS

Alzheimer's Disease (AD) – a brain disease of later life that is characterized by changes in brain tissue with gradual loss of memory and mental abilities

Behavior – the way in which one conducts oneself

Cognitive – of, relating to, being, or involving conscious intellectual activity (as thinking, reasoning, or remembering)

Impairment – a medical condition that leads to a disability

Psychosocial – relates to one's psychological development in, and interaction with, a social environment

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

PROCEDURAL GUIDELINE USED IN THIS SECTION:

- Procedural Guideline #8 – Communication and Interpersonal Skills

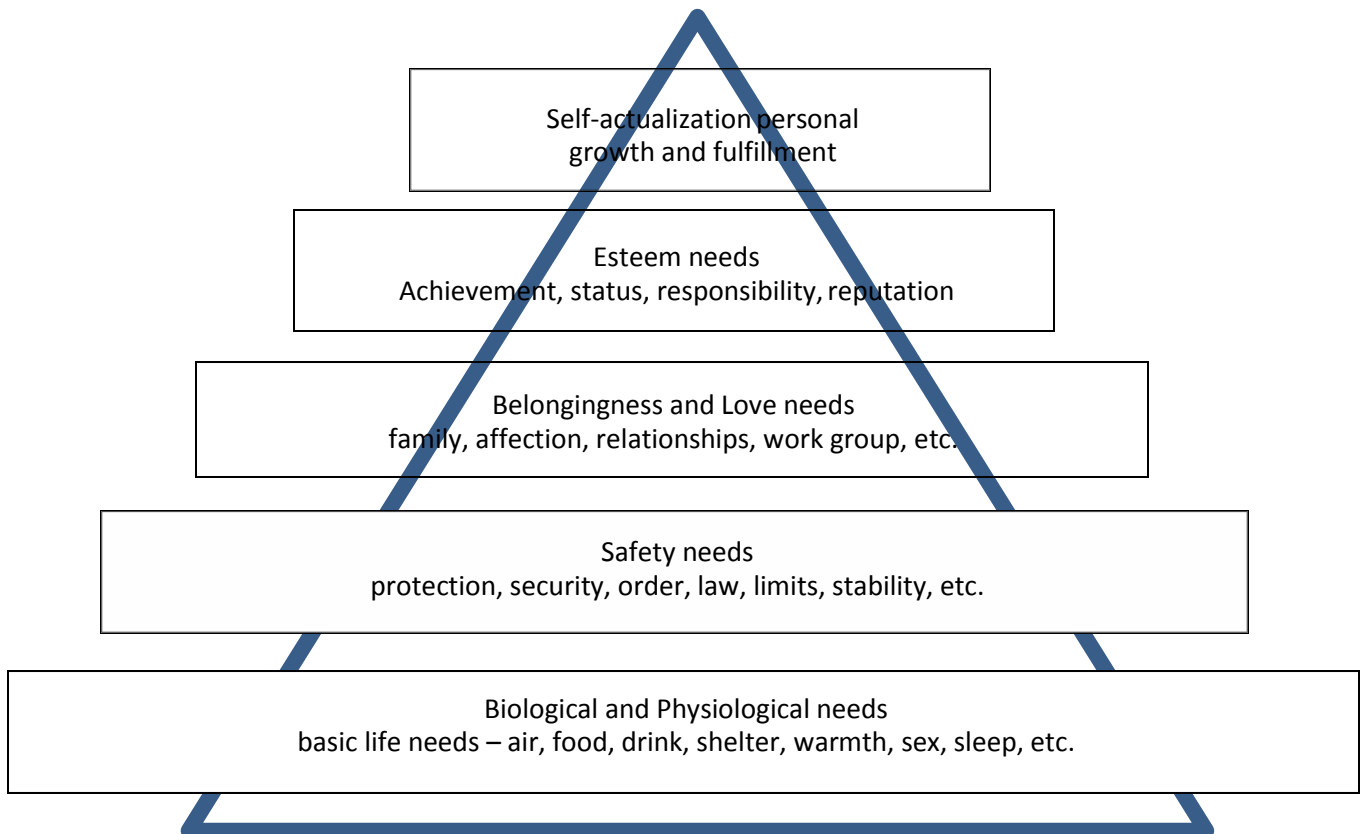
COURSE CONTENT
SECTION V – MENTAL HEALTH AND SOCIAL SERVICE NEEDS

UNIT 1 – PSYCHOSOCIAL NEEDS OF RESIDENTS

A. Hierarchy of Needs

1. Abraham Maslow, a psychologist, studied the basic human needs that motivate people.
 - a) He identified 5 basic human needs and arranged them in a pyramid to show their order from the most basic to the highest level needs. (See pyramid below)
 - b) Maslow's theory is that people strive to meet their unmet needs, but the most basic needs must be met before the person is free to meet the needs at the next higher level.
 - c) Individuals move up and down the pyramid of needs on an on-going basis, often meeting many needs with one activity.
 - d) The needs are interactive, that is, changes in one's needs will cause changes in other needs.

Maslow's Hierarchy of Needs
(Original five-stage model)



2. The resident is a person with basic human needs. Use effective Communication and Interpersonal Skills (Procedural Guideline #8). Be a good listener and develop supportive relationships with residents. Be constantly aware of how the resident is responding, and adjust your approach and methods to achieve the desired results. Request help from the nurse as needed to assist in meeting psychosocial needs.
3. Physical or physiological needs of residents are the most basic needs related to body function.
 - a) Meeting the physical needs of residents is covered in Sections I thru IV of this course.
 - b) If physical needs are not met, the higher needs cannot be met.
4. Security needs of residents are both physical and psychosocial.
 - a) The physical aspects are related to the resident receiving care in a safe manner. Provide safe care to residents (covered throughout this course). Perform care in an organized, consistent and confident manner. Answer call signals promptly and be available to help residents who need help.
 - b) The psychosocial aspects are related to the resident trusting the caregiver and “feeling” safe and secure. Develop trusting relationships with residents. Check in on residents and offer assistance even before they ask for help. Follow-through on commitments you make to the resident.
5. Sexual needs of residents are both physical and psychosocial in nature.
 - a) Sexuality includes physical sex, as well as sensual pleasures related to physical appearance, touch, intimacy, caring and love. Use praise and touch as appropriate to help meet needs for love and caring. Assist residents to feel good about his/her physical appearance by:
 - (1) Providing care that includes occasional extras such as a new hairstyle.
 - (2) Complimenting resident on appearance emphasizing his/her best features.
 - b) Sexual needs and practices are highly individual.
 - c) Sexual behavior of older adults
 - (1) Myths
 - (2) Facts
 - d) Managing sexual behavior of residents
 - (1) Appropriate sexual behavior. Provide privacy for appropriate sexual behavior of residents such as closing doors and knocking before entering.
 - (2) Inappropriate sexual behavior. Manage inappropriate sexual behavior by calmly directing resident to a private place and notify a nurse. Follow instructions given by the nurse and as included in the care plan.
6. Love or social needs of residents are met through interpersonal relations that result in a sense of belonging, acceptance, and affection. For some residents, you may be the major social contact and/or the major source of assistance in making social contacts with others.
 - a) Listen carefully and express genuine interest in residents/activities.

- b) Encourage and assist residents to maintain relationships with family/friends.
- c) Assist residents to prepare for visits or outings with family/friends.
- d) Help family/friends feel welcome at the facility and encourage visits.
- e) Work with the nurse to refer the resident to a social worker, activity director and/restorative team to meet social needs.
- f) Support and assist residents with unplanned social contacts such as:
 - (1) Introducing the resident to other people.
 - (2) Arranging the environment to promote socialization and avoid conflicts between residents.
 - (3) Informing residents of social activities that they may enjoy.
 - (4) Assisting residents to prepare for and arrive on time for social activities.
 - (5) Respecting resident wishes regarding participation in activities.

7. Self-esteem or status needs of residents are the psychological and emotional need to feel good about one's self.

- a) Respect each resident as a unique individual.
- b) Identify each resident's strengths and reward independence with positive feedback.
- c) Use rewards appropriate to the residents' preference such as positive feedback, praise, compliments, congratulations, a handshake, a pat on the back, or a hug.

8. Self-actualization is the highest level psychosocial need that can only be met if all of the other needs are met.

- a) It is the need to fulfill one's own unique potential.
- b) Being "the best that you can be" at whatever you strive to be is a self-actualizing experience. There are limitations to assisting another with self-actualization, as this process is highly personal, internal and unique to each individual.
- c) Assure that basic needs are met and encourage and support residents in achieving goals and independence.

9. Spiritual needs are psychosocial in nature.

- a) Self-actualization is often attained through spiritual or religious activities.
- b) Know and respect the spiritual beliefs of each resident and handle with care and respect.
- c) Spiritual needs include:
 - (1) Personal values - Encourage residents to discuss spiritual beliefs and personal values.
 - (2) Religious beliefs - Inform residents of available spiritual/religious activities. Assist residents to participate in spiritual activities of his/her choice. Provide privacy for religious visits and practices as requested. If a resident asks to see a clergy, report request to nurse promptly.

B. MAJOR LOSSES AND CHANGES ASSOCIATED WITH AGING.

1. Most older adults suffer at least some of these losses/changes. They may occur in rapid succession over a short period of time following a change in condition. The losses and changes (like the basic human needs) are interactive, that is one loss will be intensified by another loss.

- a) Loss of health and fitness may occur through the onset of sensory impairments, short-term memory loss and chronic disease.
- b) Loss of economic security may occur through loss of job, income, home, belongings and other losses.
- c) Loss of relationships may occur through death or loss of spouse, family, friends, and pets.
- d) Loss of independence and control over own life may occur as a result of other losses.
 - (1) Admission to a nursing facility or other health care institution maybe necessary due to one or more losses.
 - (2) Relocating to an unfamiliar environment and giving up an established lifestyle represents the ultimate loss of independence to many.

2. Effects of losses and changes on basic human needs.

- a) The loss of health may decrease the person's ability to meet own needs.
- b) The loss of health may increase the complexity of physical care, medical care and the need for assistance. This will affect physical as well as self-esteem and independence needs.
- c) The loss of a spouse or other family and friends may occur, leaving the person alone (without a support system) to deal with health, as well as security problems. This will affect the need for security, love, self-esteem and independence.
- d) If these events require relocation to a nursing facility, the resident's ability to adjust may be overwhelmed. This will affect all of the basic human needs (including independence) and the way in which all of the needs will be met.
- e) Respect the resident's individuality and dignity by encouraging independence, decision-making, and promoting resident rights and self-esteem.
- f) Assist residents to establish and maintain a daily schedule of activities as similar as possible to his/her prior life style.
- g) Encourage residents who are sad or grieving to express feelings. Allow them to cry to express his/her feelings. Avoid saying "Don't cry".
- h) Listen to residents who feel helpless, useless, or hopeless; try to involve them in useful activities of his/her choosing such as helping someone or reading.
- i) If a resident verbalizes fear and anxiety report to a nurse and follow guidelines given by the nurse and in the care plan.
- j) Allow residents who are frustrated or angry to talk about his/her anger. Don't take the behavior personally.

C. DEVELOPMENTAL TASKS ASSOCIATED WITH AGING

1. Erik Erikson, another psychologist, studied the "developmental tasks" or tasks to be accomplished at the different stages of the life cycle. A brief summary of these developmental tasks follows:

- a) Infant – Develops basic trust (security). Receives care.
- b) Toddler – Develops autonomy (self-identity). Learns self-control.
- c) Preschool – Develops initiative (ambition/drive). Explores world.
- d) School Age – Develops industry (work). Gains skills.
- e) Teenage – Develops identity (individuality and sexuality).
- f) Young Adult – Develops intimacy (close relationships). Starts family.

- g) Middle Adult – Develops generativity (productivity). Pursues career.
- h) Older Adult – Develops ego integrity (mature identity). Reviews own life and accepts own mortality.

2. The developmental task of older adults (age 65 and above) represents a major change in focus.

Like self-actualization, there are limitations to assisting with this developmental task, as the process is highly personal, internal and unique to each individual.

Developmental tasks may include:

- a) Adjusting to the many losses and changes associated with aging
- b) Reviewing own life experiences (reminiscing)
- c) Accepting being old
- d) Resolving remaining life conflicts
- e) Realizing the continuity of life beyond own mortality
- f) Integrating life experiences into a meaningful whole
- g) Becoming comfortable with own life and own self
- h) Accepting own life and inevitable death (mortality) without despair or fear
- i) Allow resident time to recall and review life experiences as desired.
- j) Listen carefully and point out resident's strengths, successes and positive experiences. Validate where they are – discuss *Validation Therapy developed by Naomi Feil*.
- k) Assist resident to contact and interact with family/friends as desired.
- l) Encourage and assist resident to review family pictures, records and other items.

D. NORMAL RESPONSES TO LOSSES AND CHANGES ASSOCIATED WITHAGING.

1. Psychological responses of residents to losses/changes. These are normal responses commonly used by people adjusting to loss/change.

- a) Sadness and grief are normal and even psychologically necessary responses to losses and changes—not only loss of family/friends, but also losses such as mobility/independence/health.
- b) Fear and anxiety are normal responses that can become generalized as a result of past losses, fear of future losses and the feeling of vulnerability.
- c) Helplessness, uselessness, and hopelessness are normal responses that occur with the realization that past losses can't be reversed, and future losses can't be avoided.
- d) Frustration and anger are also normal responses. Anger may be internalized, but it is difficult to maintain self-esteem and be angry at one's self. Anger may be directed outward at family, friends or caregivers. This misplaced anger is difficult to deal with, but it is a better solution for the resident's mental health.

2. Coping or defense mechanisms used by residents adjusting to loss/change. These are normal methods commonly used by people to cope with stress and protect self-esteem. How a person copes with loss/change is largely determined by how well the person has mastered the developmental tasks.

- a) "Compensation" is using a strength to hide a weakness, e.g. a person with hearing loss may attend a discussion group and do all of the talking to hide his/her inability to hear.
- b) "Rationalization" is providing an acceptable but untrue reason for one's own

behavior, e.g. "I'm too sick to go to the discussion"

c) "Projection" is placing the blame for one's own problem on someone or something else, e.g. "I can't hear you because you mumble."

d) "Denial" is refusing to admit that a problem exists, e.g. "I do not need a hearing aide"

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION V

UNIT 1 – PSYCHOSOCIAL NEEDS OF RESIDENTS

INSTRUCTOR NOTES:

- *Mental health and social service needs have been integrated throughout this course.*

STUDENT OBJECTIVES:

- *State the 5 basic human needs.*
- *Think about how you meet your own basic human needs.*
- *Discuss how the needs of residents are like our own.*
- *Describe an example of an appropriate and inappropriate sexual behavior of residents and how you would respond.*
- *Discuss Professional Boundary Guide - National Council of State Boards of Nursing (NCSBN)*
<https://www.ncsbn.org/ProfessionalBoundariesbrochure.pdf>
- *State a specific religious activity or cultural practice and describe how the nurse aide could assist a resident to participate in the activity.*
- *Describe the major losses/changes associated with aging.*
- *Discuss how you might respond to these losses/changes.*
- *Discuss the interactive effects of losses and changes on basic human needs.*
- *Describe the developmental tasks of older adults.*
- *Describe 2 normal psychological responses to losses/changes.*
- *Describe 2 normal defense mechanisms and give an example.*
- *Describe and/or demonstrate skill in assisting residents with psychosocial needs:*
 - *Utilizing resident's family and friends for support*
 - *Security needs*
 - *Sexual needs*
 - *Love or social needs*
 - *Self-esteem or status needs*

- *Self-actualization*
- *Spiritual needs*
- *Cultural practices*

ADDITIONAL NOTES:

REFERENCES:

Maslow's Hierarchy of Needs
(Original five-stage model)

http://www.abraham-maslow.com/m_motivation/Hierarchy_of_Needs.asp

COURSE CONTENT
SECTION V – MENTAL HEALTH AND SOCIAL SERVICE NEEDS

UNIT 2 – CULTURE CHANGE

A. What is culture change? - The purpose of culture change philosophy is to promote a new way of thinking relating to people living in nursing facilities. The "old" culture was task-oriented and schedule driven and the new culture is focused on the person living in the facility and building relationships between that person and the people working in the facility. It is a change of perspective from viewing the nursing home as a work site controlled by nursing facility employees to viewing it as the residence of people with disabilities, regardless of age, living in his/her own home.

B. Cultural influence on residents' needs:

1. Culture is the customs, beliefs, social practices, and traits of a racial, religious or social group.
2. Culture is not a basic human need but has a strong influence on needs.
3. Know and respect the cultural background of residents.
4. Talk to residents and/or family about his/her cultural background and practices and support the resident as appropriate.
5. Report special needs verbalized by the resident to the nurse so they can be included in the care plan.

C. Major characteristics of culture change include:

1. An environment of home and community within long-term care facilities;
2. A vision of leadership committed to cultivating living environments that nurture, inspire and create a home-like setting and ambiance for the people who live there;
3. A paradigm of person-centered and person-directed care practices;
4. Emphasis on the dignity and worth of an individual's preferences related to routine tasks (e.g., bathing times, set bed-time hours, flexible dining choices);
5. Consideration of the voices of people with disabilities regardless of age, medical condition or limitations; and
6. The empowerment and support of direct care workers.

D. Purpose of culture change (changing routines and organizational approaches in an effort to individualize and de-institutionalize care)

1. Person-directed care

- a) Care is directed by and centered on the person receiving care
- b) Meaningful relationships for those who live and work in the facility as well as involving families and friends to create a community

2. Person-directed care values:

- a) Dignity
 - b) Respect
 - c) Purposeful living, self-determination
 - d) Freedom to make informed choices about daily life and health care)
- Meaningful relationships for those who live and work in the facility

3. Residents control his/her schedule for:

- a) Waking
- b) Bathing
- c) Going to bed
- d) Eating – what and when they want to eat

4. Residents can create living spaces that are more private, comfortable and personalized

5. Residents have a say about the environment of common areas in the facility.

6. Meaningful involvement of the residents' family, friends and the greater community outside the facility walls.

7. Quality of life and quality of care are equally important.

E. Long-term care and culture change

1. The same staff takes care of the same residents
2. Good relationships develop between staff and the residents
 - a) Motivates staff to provide better quality of care
 - b) The resident feels more secure, content and happy
3. Lower staff turnover
4. Formation of “neighborhoods”
 - a) Smaller groups of residents
 - b) Consistent staff assignment

F. Language

1. Patronizing language
 - a) What is it?
 - b) The words we use and how they affect the relationship
 - c) How elderly people react to patronizing language
 - d) How the elderly regard those who use it

2. Language that bothers some people

- a) High pitched voice
- b) Loud voice c) Slow talk
- d) One-sided conversation
- e) Calling someone “dear”, “sweety”, etc.
- f) Using first name
- g) Saying, “it’s time for our”
 - Using “we” or “our” when speaking to an older person
 - It confuses the difference between you and me and implies that the person cannot make independent decisions.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION V

UNIT 2 – CULTURE CHANGE

INSTRUCTOR NOTES:

- *Discuss different aspects of culture change and how they benefit not only the resident but the nursing facility as well.*
- *Discuss how to talk to the residents as not to appear patronizing.*

STUDENT OBJECTIVES:

- *Discuss the purpose of culture change.*
- *List the person-directed care values.*
- *List advantages of person-directed care for the resident.*
- *List advantages of person-directed care for the nurse aide.*
- *Discuss the proper way to address and speak to a resident so as not to appear patronizing.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION V – MENTAL HEALTH AND SOCIAL SERVICE NEEDS

UNIT 3 – SPECIFIC BEHAVIOR PROBLEMS

A. CONSIDERATIONS FOR CARE

1. All behavior has a meaning.
2. Many experts believe that the purpose of behavior is to satisfy unmet needs.
3. Patterns of behavior are developed throughout a lifetime based on heredity and environment (life experiences).
4. Most older adults continue to use the same behavioral responses that they learned throughout his/her life.

B. CAUSES OF BEHAVIORAL PROBLEMS

1. Remember that a resident's behavior may be a response to an unmet need.
 - a) In an alert, orientated resident the unmet need is usually psychosocial.
 - b) In a confused resident, the unmet need is usually physical.
2. Behavioral problems occur when the stresses associated with aging exceed the resident's ability to cope with stress.
3. Behavioral problems vary widely. Those included here are some of the more common behavior problems seen in nursing facilities.

C. BEHAVIOR MANAGEMENT

1. ABCs of behavior management
 - a) A is the Antecedent (cause) of the behavior. b) B is the Behavior.
 - c) C is the Consequences (effect or results) of the behavior.
2. Three steps of behavior management
 - a) Step 1 – determine the cause of the behavior.
 - b) Step 2 – eliminate the cause of the behavior. If the cause is eliminated, the behavior should stop or change.
 - c) Step 3 – sometimes the consequences of the behavior may also have to be eliminated in order to eliminate the behavior, especially if the behavior has been rewarded over a period of time.

D. ROLE OF THE NURSE AIDE IN ASSISTING WITH SPECIFIC BEHAVIOR MANAGEMENT PLANS. BEHAVIOR MANAGEMENT IS RESTORATIVE CARE.

1. Know and understand the residents in your care. Know at least one effective measure to comfort and/or distract each resident such as:
 - a) Objects such as a favorite pillow, doll, or something new and interesting.

b) Activities such as a favorite topic, music, TV, rocking chair, holding hands. c) A favorite caregiver who is effective in calming the resident.

2. Report your objective observations to assist the nurse in assessing and planning care.
3. Review and become familiar with the specific behavior management plan.
4. Understand exactly what your role and responsibilities are.
5. Request information and assistance from the nurse.
6. Continue careful observations and objective reporting to assist the nurse in evaluating the plan of care. Share your observations of comfort measures and the resident likes and dislikes with the nurse to assist others in working with the resident.
7. Increase the resident's appropriate behavior by reinforcement (rewards) as specified in the care plan. Rewards must be acceptable to the resident and sincere.
 - a) Verbal reinforcement may include positive feedback such as approval, praise, compliments, congratulations.
 - b) Nonverbal reinforcement may include touch that is acceptable to the resident such as a pat, hug, handshake, or other rewards (a smile, snack, public recognition).
8. Reduce the resident's inappropriate behavior by:
 - a) Ignoring it, if you can safely do so
 - b) Continuing to reinforce appropriate behavior
 - c) Other non-punitive responses as specified in the plan of care
9. Share your experiences with the resident, with the nurse and the behavior management team as appropriate. Your participation can be valuable to the success of the program and can be a valuable learning experience for you.

E. THE BEHAVIOR MANAGEMENT PLAN MAY REQUIRE THAT YOU MODIFY YOUR BEHAVIOR IN RESPONSE TO A RESIDENT'S BEHAVIOR.

F. SPECIFIC BEHAVIOR PROBLEMS:

1. Assisting Residents with Sleep Problems

- a) If resident has difficulty falling asleep at night:
 - Promote sleep by offering P.M. care, controlling noise, dimming lights and other measures.
 - Allow resident to remain up and provide appropriate activity that won't disturb others. Don't set a specific bedtime.
- b) If resident wakes up in middle of the night:
 - If resident is frightened, provide reassurance and comfort measures.
 - If resident is confused, provide orientation to time, place and person.

- If resident wants to get out of bed, assist to location close to nurse's station and provide diversional activities as appropriate.

c) Follow guidelines provided by the nurse and in the care plan to decrease environmental problems, anxiety, fear, pain, too much sleep or caffeine, too little exercise and unmet needs, such as elimination of fluids.

d) Provide care to eliminate cause(s) of the behavior as instructed by the nurse and behavior management plan.

2. Assisting Residents who have Depression

a) Depression is a mental disorder

- It may occur following stress or losses such as death of a spouse, or as a natural consequence of aging.
- Signs and symptoms include sadness, fatigue, decreased concentration, memory loss, sleep/eating disorders, crying, lack of interest, low self-esteem.

b) Develop an honest, caring and supportive relationship with the resident.

c) Listen and encourage the resident to express feelings. Use open-ended statements like "Tell me why you are sad?"

d) Do not interrupt or change the subject. Follow communication guidelines. Do not use phrases like "cheer up," "stop crying" or "things could be worse."

e) Encourage physical activity as tolerated.

f) Encourage resident to participate in meaningful activities.

g) Encourage family/friends to provide support and activities.

h) Promptly report changes in behavior (both increased and decreased sadness) and threats of suicide to the nurse immediately.

i) Follow instructions of the nurse and behavior management plan as appropriate.

3. Assisting Residents Who Are Complaining or Demanding

a) Talk with the resident to determine the nature of the complaint/demand and report objective observations to the nurse.

b) Correct or meet justified complaints or demands as instructed by the nurse.

c) If complaint/demand is not met, tell the resident that you are reporting it to the nurse.

- Listen and provide support.
- If complaints are related to the care, do not take it personally. Do not become defensive, take sides or argue with the resident.

- Give the resident as much control as possible over daily life and routines.
- Try to distract the resident with a favorite object or activity as appropriate.
- Assist the nurse in identifying the cause of unjustified complaints such as boredom; need for attention, anger, long standing behavior patterns, or unmet needs.

d) Follow the instructions of the nurse and behavior management plan as appropriate.

4. Assisting Residents Who Are Yelling or Screaming

- a) Try to distract the resident.
- b) Listen to what the resident is saying and provide care as indicated to alleviate the cause of anger.
- c) Report the behavior to the nurse immediately.
- d) Follow the instructions of the nurse and behavior management plan as appropriate.

5. Assisting Residents Who Are Verbally or Physically Aggressive

- a) Verbal aggression is arguing, threatening or accusing, usually in a loud and angry voice. Physical aggression or combative behavior includes hitting or kicking or other physical gestures.
- b) Remain calm, reassuring and use non-threatening body language.
- c) Do not become defensive, argue or try to reason with the resident.
- d) Move the resident into a private space, or move other residents to safety.
 - If the attack is directed at you, leave if you can safely do so, or call for assistance of a caregiver to help calm the resident and control the behavior.
 - If the attack is directed at another resident, request assistance and remove both residents to separate areas.
- e) For physical aggression, use the following safety precautions:
 - Notify the nurse promptly, and obtain needed assistance.
 - Protect yourself following facility policy.
 - Take threats seriously and keep your distance.
 - Do not try to touch or turn your back on the combative resident.
 - Don't back the resident into a corner.
- f) Try distraction or have the resident's favorite caregiver assist in calming the resident.
- g) Report behavior immediately to the nurse.
- h) Follow the instructions of the nurse and behavior management plan as appropriate.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION V

UNIT 3 – SPECIFIC BEHAVIOR PROBLEMS

STUDENT OBJECTIVES:

- *Describe how an unmet need might cause you to behave in a certain way.*
- *Describe the unmet basic human needs that are most likely to cause behavioral problems in:*
 - *An alert, orientated resident*
 - *A confused resident*
- *Psychosis, dementia and combative residents*
- *State the steps of behavior management.*
- *Discuss how the nurse aide functions with the health care team for behavior management.*
- *Describe 1 step for increasing appropriate behavior and 1 step for reducing inappropriate behavior.*
- *Discuss NCSBN Professional Boundaries_*
<https://www.ncsbn.org/ProfessionalBoundariesbrochure.pdf>
- *Have students participate in role play to learn how to react to different situations. For additional information see the HHSC website below regarding Behavioral & Environmental Interventions: <http://qmweb.HHSC.state.tx.us/BehaviorMgm.asp>*
- *Give 2 examples of a verbal and nonverbal reinforcer.*
- *Describe and/or demonstrate skill in assisting residents with specific behavior problems*
 - *Sleep problems*
 - *Depression*
 - *Complaining or demanding*
 - *Yelling or screaming*
 - *Verbal or physical aggression*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION V – MENTAL HEALTH AND SOCIAL SERVICE NEEDS

UNIT 4 – COGNITIVE IMPAIRMENT

A. DEFINITIONS

1. Cognitive impairment means impaired or damaged thinking.
 - a) The main symptoms are memory loss and confusion.
 - b) Cognitive impairment is not a normal part of aging.

2. Dementia is an umbrella term for a group of symptoms that describe a decline in a person's mental ability that is severe enough to interfere with his/her daily life. In addition to dementia, there are a significant number of other diagnoses that can cause the same symptoms. It is important that you understand the difference in how the symptoms present themselves in the resident.
 - a) Delirium (known as acute dementia): is a medical condition that results in confusion and other disruptions in thinking and behavior, including changes in perception, attention, mood and activity level. These symptoms may mirror those of Dementia; however, the cause of the delirium is often treatable and reversible. In residents with delirium, there is an abrupt confusion, emerging over days or weeks, and represents a sudden change from the person's behavior or level of functioning.
 - b) Chronic dementia: a medical condition, caused by any number of different disease processes that causes a progressive, subtle decline in memory and at least one other cognitive area in a resident who was previously alert. Dementia is an incurable disease process that will ultimately result in death.

B. THE DIFFERENT TYPES OF DEMENTIA:

1. There are over 100 different types of dementia. The following are the most common types of Dementia, including:
 - a) Alzheimer's Disease (AD) is the most common type of dementia which accounts for approximately 60-80% of all cases. AD is a chronic, progressive brain disease with damage most commonly seen in the hippocampus and its connected structures. In addition, the cortex of the brain becomes thinner with damage also noted to the left hemisphere as well as the temporal lobe and potentially the right parietal lobe. The symptoms noted in AD include: having trouble remembering things (including conversations, names, familiar objects, etc.); impaired communication; poor judgment; disorientation; confusion; behavior changes; and difficulty speaking, walking and swallowing.

 - b) Vascular Dementia (also known as multi-infarct): a less common form of dementia, accounting for 10% of the dementia cases. In Vascular Dementia, the damage is caused by diseases of the blood supply to the brain. Often this form of Dementia occurs after a resident suffers from a stroke, due to the brain dying when the blood supply is suddenly cut off. Residents with Vascular Dementia often experience symptoms such as impaired judgment and problems with planning, concentrating, and thinking.

c) Dementia with Lewy Bodies: a far less common form of dementia, accounting for approximately only 4% of cases. In Dementia with Lewy Bodies, there is often less shrinkage of the brain; however, tiny deposits of protein (Lewy Bodies) are seen in several areas of the brain, such as the cerebral cortex, the limbic system, and the brain stem. For those residents who suffer from this form of dementia, they may have symptoms such as memory loss, thinking problems, sleep disturbances, visual hallucinations, and muscle rigidity.

C. THE DEVELOPMENTAL STAGES OF ALZHEIMER'S DISEASE:

1. Early: In the early stages of Alzheimer's, a resident may function independently. He or she may still be able to drive, work and be part of social activities. Despite this, the resident may feel as if he or she is having memory lapses, such as forgetting familiar words or the location of everyday objects.

2. Middle: You may notice the resident with Alzheimer's confusing words, getting frustrated or angry, or acting in unexpected ways, such as refusing to bathe. Damage to nerve cells in the brain can make it difficult to express thoughts and perform routine tasks

3. Late: In the final stage of this disease, residents lose the ability to respond to his/her environment, to carry on a conversation and, eventually, to control movement. They may still say words or phrases, but communicating pain becomes difficult. As memory and cognitive skills continue to worsen, personality changes may take place and residents need extensive help with daily activities.

D. EFFECTS OF ALZHEIMER'S DISEASE

1. Progressive deterioration of behavior and personality
2. Impaired learning
3. Impaired thinking
4. Impaired judgment
5. Impaired memory
6. Impaired impulse control

D. ABILITIES THAT ARE SPARED (NOT LOST) IN ALZHEIMER'S DISEASE

1. Emotions and feelings
2. Physical strength
3. Senses such as vision, hearing, taste, smell and touch

4. Habits such as piano playing and cycling

E. SOME BEHAVIORAL RESPONSES TO COGNITIVE IMPAIRMENT

1. Memory loss

2. Confusion and disorientation

3. Lack of self-control

F. DIFFERENT BEHAVIORS NOTED IN DEMENTIA

1. There are many different behaviors that may be seen in an individual with dementia. It is important to understand that these behaviors are a result of the disease process and not an intentional act by the resident. These behaviors include:

a) Aggression and Anger: Aggressive behaviors may be verbal or physical. They can occur suddenly, with no apparent reason, or result from a frustrating situation. The cause of the aggression or anger may be due to physical discomfort such as pain, being tired, or the result of medication side effects. In addition, there may be environmental factors that are causing the behaviors. These environmental factors include: overstimulated by loud noises, an overactive environment or physical clutter.

b) Anxiety and Agitation: A resident with dementia may feel anxious or agitated. He or she may become restless, creating a need to move around or pace, or become upset in certain places or when focused on specific details. The possible cause of these behaviors include moving to a new residence or nursing home; changes in environment, such as travel, hospitalization or the presence of houseguests; changes in caregiver arrangements; misperceived threats; fear and fatigue resulting from trying to make sense out of a confusing world.

c) Hallucinations: When a resident with dementia experiences hallucinations, he or she may see, hear, smell, taste, or feel something that isn't there. These hallucinations are the result of changes within the brain resulting from the dementia and usually occur in the later stages of the disease.

d) Repetition: As with many of the behaviors noted in dementia, the underlying cause is due to the deterioration of the brain cells that cause the resident to not be able to make sense of the world around them. In the case of repetition, a resident may not remember that he or she has just asked a question or completed a task.

e) Sleep Issues and Sundowning: Sleep changes in residents with dementia are somehow the result of the impact of dementia on the brain, often causing residents to have problems sleeping or an increase in behaviors that begin at dusk and last into the night. The factors that may contribute to these behaviors include: end-of-day exhaustion (both mental and physical); an upset in the "internal body clock," causing a biological mix-up between day and night; reduced lighting and increased shadows causing residents with dementia to misinterpret what they see, and become confused and afraid; reactions to nonverbal cues of frustration from caregivers who are exhausted from his/her day; disorientation due to the inability to separate dreams from reality when sleeping; less need for sleep, which is common among older adults.

G. SPECIAL NEEDS OF COGNITIVELY IMPAIRED RESIDENTS

1. Physical care

- a) Provide for the resident's physical needs.
- b) Establish a routine for care and try to adhere. Be flexible if needed.
- c) Provide direction and encourage the resident to assist with care as much as possible.
- d) Ask resident if they have pain and report to nurse.

2. Safety needs

- a) Provide a safe environment to avoid risks as directed by the nurse and according to the care plan.

3. Supportive needs

- a) Always approach in a calm, respectful manner.
- b) Recognize when the resident is becoming frustrated and offer assistance.
- c) Limit decision making based on the resident's ability according to direction from the nurse and according to the care plan.
- d) Do not attempt to force the resident to think or remember.
- e) Orient the resident to name, place and day and time.
- f) Use calendars, clocks and other devices to assist the resident.

4. Communication needs

- a) Use positive body language as it may be the only message the resident can receive.
- b) Watch the resident's body language as it may be the only message the resident can send.
- c) Speak slowly and calmly.
- d) Greet by preferred name making eye contact.
- e) Identify yourself by name and title. Always explain what you are going to do.
- f) Give simple easy to follow instructions.
- g) Ask only simple questions and wait for a response. Repeat if necessary. h) Avoid using "NO" and "DON'T".

5. Behavior management

- a) Reorient resident to name, place, day and time.
- b) Do not validate false thinking which may result in increased confusion.
- c) Do not correct resident with a negative message that may result in withdrawal or anger.

H. GUIDELINES FOR ASSISTING RESIDENTS WHO WANDER

1. Allow the resident to wander if it is not harmful to resident or others.
2. Ensure that the resident who wanders wears appropriate identification.
3. Ensure that appropriate doors and windows are locked and alarms are turned on.

4. Try to distract the resident with an interesting object or favorite activity.
5. Look for the cause(s) of wandering, which may include seeking an exit, restlessness, stress, boredom, or unmet needs.
6. Follow instructions of the nurse and behavior management plan as appropriate.

I. GUIDELINES FOR ASSISTING RESIDENTS WHO RESIST CARE

1. Remember the principles of person-centered care, even when providing care to someone who resists it.
2. Keep care simple and routine. Give care in a calm, patient manner. Don't rush.
3. Resisting care often occurs when the caregiver activities require skills that the cognitively impaired resident no longer has.
4. Match the demands of the care to the resident's abilities.
5. Observe for signs of anxiety and body language that indicate early resistance to care such as restlessness, shifting position, clenching fists, wringing hands, or moaning.
6. At the first sign of distress, stop the care as soon as you can safely do so.
7. Report the behavior to a nurse. The caregiver (who has to get the job done) may be expecting too much of the resident, rushing the resident, communicating his/her own anxiety or impatience to the resident, or sending mixed messages.
8. Provide care following the person-centered instructions from the nurse and according to the care plan to eliminate the cause such as meet unmet needs. Delay care until the resident is no longer exhibiting signs of distress. Simplify the task, provide additional assistance, slow down, and adjust your approach.
9. Follow instructions of the nurse and the resident's person-centered behavior management plan as appropriate.

J. GUIDELINES FOR ASSISTING RESIDENTS WITH SELF-CONTROL PROBLEMS

1. Allow the resident to do as much as possible, but assist as requested before anxiety and frustration occurs (help, but don't do).
2. Know and avoid situations that lead to loss of self-control for the resident.
3. Redirect the resident's thoughts and/or activities before they become agitated.
4. Use measures to comfort or distract the resident.

5. Remove the resident to a private space before self-control is lost, keeping in mind person- centered care.
6. Provide care as indicated to eliminate the cause(s) of the behavior.
7. Follow instructions of the nurse and the resident's behavior management plan as appropriate.

K. GUIDELINES FOR ASSISTING RESIDENT WITH ACATASTROPHIC REACTION

1. A catastrophic reaction is an emotional outburst, which may include crying, screaming, agitation, or fighting that is out of the control of the resident.
2. Try to avoid stressful situations and multiple distractions or overstimulation.
3. Approach the resident in a calm, reassuring manner.
4. Guide the resident to a quiet place or remove distractions.
5. Give person-centered verbal and non-verbal support. Do not scold, argue, teach or reason.
6. Try to comfort/distract the resident with a favorite object, activity or caregiver.
7. Leave the resident alone to calm down if you can safely do so.
8. Provide person-centered care that may assist in controlling the behavior.
9. Follow the person-centered instructions of the nurse and behavior management plan as appropriate.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION V

UNIT 4 – COGNITIVE IMPAIRMENT

STUDENT OBJECTIVES:

- *Define cognitive impairment, dementia and Alzheimer's Disease.*
- *State the major difference between acute and chronic dementia.*
- *Describe the three main types of Dementia*
- *Explain the three stages of Alzheimer's Disease*
- *Describe the effects of Alzheimer's Disease.*
- *Describe the behavioral responses to cognitive impairment.*
- *List the different behaviors that may be seen in Dementia.*
- *Discuss the special needs of cognitively impaired residents (e.g., as in early, middle and late stages of Alzheimer's Disease).*
- *Discuss the importance of using verbal and non-verbal communication in working with cognitively impaired residents.*
- *Discuss pitfalls to avoid.*
- *Describe and/or demonstrate skill in assisting cognitively impaired residents:*
 - *By using communication*
 - *With memory loss/confusion*
 - *By using reality orientation*
 - *By using validation therapy*
 - *With wandering*
 - *With resistance to care*
 - *With self-control*
 - *With catastrophic reactions*

ADDITIONAL NOTES:

COURSE CONTENT – SECTION VI
SOCIAL SKILLS

KEY TERMS

Communicate – to share or exchange information

Conflict -- a serious disagreement or argument

Resolution -- a firm decision to do or not to do something, to reach a decision

COURSE CONTENT

SECTION VI – SOCIAL SKILLS

UNIT 1 – CONFLICT RESOLUTION

Conflict Resolution for CNAs

Whenever people spend day after day together, conflict cannot be avoided completely. Conflict in the work place happens to everyone at some point in his or her career. As a Certified Nurse Aide, you have to deal with supervisors, co-workers, residents and even his/her family members, all of whom have his/her own opinions that may lead to conflict. Recognizing the potential for conflict is the first step in prevention. First, do your best at your job every day. Avoid jumping to conclusions, be willing to compromise, learn to listen, and do not use hostile language or engage in gossip.

Conflicts with Co-workers

The start of a dispute between people usually begins with a disagreement. When you and a co-worker disagree, you have one opinion and your co-worker has another. Usually disagreements consist of only words and they do not affect how people interact with each other. A full-blown conflict can begin with different opinions, but it grows into something much larger. Most people have experienced the fury of an unprofessional co-worker or angry resident. Sometimes it can be hard to respond in a rational manner. In almost all conflicts, the problem is not the initial disagreement, but the way in which it is handled. Here are some tips:

- Do not respond in like manner. If the other person is rude, sarcastic or hostile, try hard not to lose your composure.
- Before talking to a supervisor about the problem sit down with the other person and patiently communicate your feelings to the best of your ability.
- Be kind, and try to understand that the other person is genuinely upset. “Be kind, for everyone you meet is fighting a hard battle.” – Plato
- Offer your help.
- Remain patient.
- If you are being physically threatened, move out of the way. Get help immediately.

Conflict with a Supervisor

Resolving problems with a boss can be very uncomfortable, especially if that person has the power to make your job difficult or to end your job. Here are some tips for getting along with your supervisor:

- Review expectations. You will never live up to your supervisor’s expectations if you don’t know what they are.
- Remain professional. As a professional, your goal is to get the job done and carry out your supervisor’s instructions. Your job is to provide care to your residents.

- Don't expect to change others. If you work for a difficult supervisor, there is probably nothing you can do to change his or her behavior. The only thing you can control is your own attitude about that person.
- Take a look at yourself. If a supervisor criticizes your performance, look at the situation objectively. Remember that constructive criticism gives you an opportunity to learn and grow professionally.
- Do not complain about your supervisor to your co-workers. You may end up being labeled as a chronic complainer instead of a team player.

Conflicts with Residents

Residents are all individuals with their own personalities, likes and dislikes, personal habits and ways of communicating, and their own set of problems. Since you spend so much time with your residents, their negative behaviors may be directed at you. Try hard not to take their comments or behaviors personally. If you encounter argumentative residents, try to:

- Speak slowly and calmly.
- Listen to what they are saying.
- Don't crowd them
- Avoid touching angry residents.

In addition, follow these tips for handling conflicts with residents:

1. Tell your supervisor if the stress of working with a particular resident is getting to you.
2. Be sure to share your observations about your residents with your supervisor so that it can be shared with appropriate caregivers. For example, if a resident gets agitated or hostile every time someone mentions her son, you should report that.
3. Consider using a "buddy system" when caring for residents who have a history of being combative.

Summary Tips

- Pick your battles. When you disagree with someone, make sure the issue is really important to you. You don't want to damage your professional reputation or relationships over something trivial.
- Separate personality from behavior. You don't have to like everyone to get along with them.
- Always be respectful. Keep in mind that you are in your workplace and you need to remain calm and professional at all times.
- Don't take it personally. Try to think of the disagreement as a mutual attempt to solve a problem.
- This attitude shows your professionalism and your willingness to work things out.
- Stay out of other people's disagreements.
- Listen first, talk second. People communicate better when they have been understood. When a person feels heard, they are more likely to listen.
- Look for a solution.
- Remember that a workplace conflict affects more than just the people who are directly involved.

- An ongoing workplace feud causes tension for everyone at work.

There are five main approaches or methods that people use when in conflict with one another. Each has an advantage and is appropriate at times, but each also has disadvantages for particular situations. You must learn how and when to use each approach.

1. **Avoidance:** After seeing you and a supervisor chatting, your co-worker snaps, "I can't believe how much you brown nose around here!" While her comment is hurtful and angering, in response you ignore it and go on with the day as if it did not happen. This is useful if the matter is less important or if there is nothing gained by entering into the conflict. However, if there is a more serious problem between two people, avoiding it resolves nothing - and the problem can even worsen.
2. **Accommodation:** This is when people give up their own views in favor of another's. The accommodator is likely to take on the ideas of the other person just to avoid sparking a confrontation. Using the illustration above, the accommodator might say, "Well, I want a good work evaluation this month," even though you don't feel that way at all. Generally, this method won't solve a problem, but it might stop a conflict in its tracks.
3. **Competition:** Unlike people who use avoidance or accommodation techniques, people with a competitive attitude take a firm stand and try to get what they want. Using our example: after your co-worker accuses you of brown nosing, you snap back, "I can't believe you are listening to a private conversation! Mind your own business!" When both people believe they are right and are willing to fight over it, they are demonstrating a competitive attitude. This method will likely escalate a disagreement into a conflict.
4. **Collaboration:** This is when people try to come to a solution that pleases everybody. It takes time because it means that each person gets to present a view and help come up with a solution that incorporates that view. In the example, you might collaborate with your co-worker to understand each other's view point and find a new way to interact with each other. While collaboration is a great method, it is generally too time consuming to be used for every workplace conflict. Example: If there is conflict in individual working styles or too many leaders within the group it may be hard to collaborate.
5. **Compromise:** The goal of compromise is to have people who disagree "meet in the middle." Each person has to give up something, but in doing so, gains something in return. Back to the example, you might say, "I don't feel I deserved that comment. First, I don't think it was brown nosing; I like talking to her. Maybe next time we have a conversation you could join us?" By reacting with a spirit of compromise, you are expressing your feelings in a respectful way. However, by inviting her to join you, you have also "given up" having a private conversation with your supervisor in the future.

Resolving a Workplace Conflict

Conflicts should be resolved on an individual level, between the affected parties if at all possible. Sometimes it is better to ask your supervisor or human resources department to

intervene. If the conflict involves a client, the supervisor should always be included in any resolution. Some simple steps to resolving conflict are:

1. Identify the problem. Before any further process of resolution can continue, both people have to agree on the issue that is causing the argument. People see things through the lens of their own personality, values, goals and prejudices. The goal of this step is to get to a consensus about the problem, not to force one another to see things the same way. Usually, both sides have to agree that at least one problem they share is a lack of communication.
2. Realize there's a solution. Both parties involved in the dispute need to come to the realization that the problem must be discussed. They must agree that the conflict needs to come to an end.
3. Exchange viewpoints. This is perhaps the most important part of the entire process. This is where one side speaks and the other listens, so that the necessary points of view are understood. One person should talk first while the second listens and does not interrupt. When the first person finishes, they should switch. This is important for both parties to remain open-minded, to speak clearly and to identify the issues, making sure everything needed to be shared is discussed.
4. Create solutions. Be fair. Both parties should remain open to each other's ideas and really try a new solution.
5. Agree on the solution. The goal of this final step is to ensure that both parties have agreed on a solution. Both must have a hand in creating the solution.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION VI

UNIT 1 – CONFLICT RESOLUTION

INSTRUCTOR NOTES:

- *Communication plays a big part in conflict resolution.*

STUDENT OBJECTIVES:

- *Give examples of conflict resolution.*
- *Discuss why conflict resolution can be positive.*
- *Discuss and role-play each type of conflict resolution listed in this unit.*

ADDITIONAL NOTES:

COURSE CONTENT
SECTION VI – SOCIAL SKILLS

UNIT 2 – TECHNOLOGIES

A. Information Technology in the Nursing Home

1. Use of Technology in Resident Care

2. Benefits

B. Guidelines for Using Personal or Facility Technology

1. Social Media

a. Do not share confidential or proprietary information about your facility/company.

b. Be respectful and professional to fellow team members, business partners, competitors, residents and family members.

c. Be aware and comply with employer policies regarding use of employer- owned computers, cameras and other electronic devices, and use of personal devices in the workplace.

d. Improper use of social media by staff may violate state and federal laws established to protect patient privacy and confidentiality.

2. Cell Phones

a. Cell phones may not be used in resident areas, including texting.

b. Cameras and/or video recording on the cell phone may never be used to take pictures or video of a resident.

INSTRUCTOR NOTES & STUDENT OBJECTIVES
SECTION VI

UNIT 2 – TECHNOLOGIES

INSTRUCTOR NOTES:

- *Talk about electronic health records and electronic documentation and the different programs/applications which use them that the nurse aide may come across. If possible have the students practice so they can become familiar and comfortable using the technology available.*
- *Talk about how each work place will have their own policies on the use of electronics and social media and how the student should make themselves familiar with their employer's policies.*
- *Make sure work commitments take priority over blogging and social networking.*
- *Additional reference material regarding the use of social media can be found at:*
 - https://www.ncsbn.org/NCSBN_SocialMedia.pdf

STUDENT OBJECTIVES:

- *Describe different technology programs used with resident care.*
- *Discuss benefits of using technology in the nursing home.*
- *Discuss, give examples and role play inappropriate use of social media in the workplace*
- *Describe ways that social media can benefit healthcare.*
- *Discuss consequences of inappropriate use of social media.*

ADDITIONAL NOTES:

PART 2 - PROCEDURAL GUIDELINES

Use the following Beginning, Closing and Observation steps for each Procedural Guideline unless specified.

BEGINNING STEPS

- a. Gather needed supplies such as positioning devices, linen.
- b. Knock on door and identify self by name and title.
- c. Greet resident by preferred name and identify resident per facility policy.
- d. Approach the resident in a calm and courteous manner.
- e. Explain procedure and encourage resident's participation as appropriate.
- f. Lock wheels of bed and lower head as tolerated.
- g. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.
- h. Provide privacy as appropriate such as closing door/curtains, and draping resident.
- i. Provide safety as appropriate such as using good body mechanics, and adjusting the bed to proper working height.
- j. If side rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from the bedside.

CLOSING STEPS

- a. Clean and store reusable items and discard disposables per facility policy.
- b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
- c. Provide for resident's comfort and safety before leaving as appropriate such as clothing/bedding, adjusting bed/side-rails.
- d. Always replace call signal and needed items within resident's reach and lower bed to a safe level.
- e. Inform resident when finished and ask if anything is needed before you go.

OBSERVE FOR, REPORT AND DOCUMENT TO NURSE

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

Section I - SAFETY AND EMERGENCY

PROCEDURES PROCEDURAL GUIDELINE #1 – FAINTING AND FALLS

A. Purpose

1. To prevent further injury.

B. Emergency Guidelines

1. Stay with resident and call for help. Be sure nurse is notified.
2. Lower the resident's head to increase blood supply to brain:
 - a. If resident is standing, assist to lie down or to sit in chair.
 - b. If resident is sitting, assist to lie down or assist to bend forward and put head down between knees if able.

C. How to Assist a Resident After Fainting/Falling

1. Stay with resident and call for help. Be sure nurse is notified.
2. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.
3. Keep the resident as quiet as possible. Do not attempt to move the resident or to straighten the injured area.
4. Do not attempt to move the resident until the nurse examines the resident, assesses the risk of fracture, and gives instructions.
 - a. Then, follow the directions of the nurse for moving the resident.
 - b. Check vital signs and provide other care as requested by nurse.
5. Do not leave the resident alone. Wait until the nurse arrives.

D. Observe For and Report to Nurse:

1. Time of the fall.
2. Cause of the fall such as wet floors, ill-fitting shoes or condition of resident. (Do not speculate on the cause of the fall. Report only what you know to be a fact).
3. Measures taken to break the fall and assist the resident.
4. Any witnesses to the fall.
5. Additional information needed by the nurse to complete the incident report.
6. Other significant observations.
 - a. Examples: side rails, alarms, signal/call light, bed low

PROCEDURAL GUIDELINE #2 – SEIZURES

A. Purpose: To prevent injury due to seizures.

B. Emergency Guidelines

1. Stay with the resident and call for help; note the time. Be sure the nurse is notified.
2. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.
3. If the resident is in bed, raise side rails if present, turn head to side or place in side-lying position and remove pillow.
4. If the resident is out of bed, gently lower the resident to floor, turn head to side or place in side-lying position to open airway and promote drainage of secretions, and protect head with pillow, padding or hold head in your lap.
5. Move hard objects out of the way as appropriate, or pad around the bed and/or objects that might cause injury during seizure.
6. Provide privacy by asking onlookers to leave and closing doors and/or curtains.
7. Do not attempt to restrain the resident.
8. Do not attempt to place any object into the resident's mouth during seizure.
9. When the seizure passes, leave the resident in a position of comfort and safety with call signal within easy reach and lower bed.
10. If used, remove and discard gloves following facility policy. Wash hands.

C. Observe For and Report to Nurse:

1. Changes in the resident before seizure such as visual or auditory aura, confusion, staggering or behavioral changes.
2. Time the seizure started and stopped and duration of the seizure.
3. Description of body parts involved and severity of convulsive movements.
4. Presence of an aura, incontinence, unconsciousness, eyes rolled upward, frothing of the mouth, biting of the tongue or injuries due to seizures.
5. Condition of the resident after seizure such as disorientation or sleepiness.
6. Other significant observations.

PROCEDURAL GUIDELINE #3 – CLEARING THE OBSTRUCTED AIRWAY

A. Purpose: To clear the obstructed airway of adults using the Heimlich Maneuver.

B. Guidelines and Precautions

1. Choking is a true life-threatening emergency that requires immediate action.
2. Choking is the sign of airway obstruction. The universal distress signal for choking is clutching the throat.
3. Choking usually occurs when eating large and poorly chewed pieces of meat or other foods. Associated factors are wearing dentures, laughing and talking while eating. The airway can also be obstructed by blood, vomitus, foreign bodies, or the tongue.
4. Measures to help prevent choking:
 - a. Assure that meat and other foods are cut into small pieces.
 - b. Encourage residents to chew foods slowly and adequately.
 - c. Discourage laughing and talking while chewing and swallowing.
 - d. Assure residents receive correct diets that contain only allowed foods. Peanut butter, nuts, popcorn and beans can cause choking in some residents.
5. This procedure is limited to use of the Heimlich Maneuver on adults. Specialized and advanced procedures and training are available from the American Red Cross and the American Heart Association.
6. Do not practice forceful abdominal thrusts on human subjects as part of training.

C. Determine if resident can cough, breathe or speak.

1. Stay with the resident and call for help. Be sure the nurse is notified immediately.
2. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluid is likely.
3. Observe the resident for coughing, breathing and speech. Ask the resident "Are you choking?"
 - a. If the resident is able to cough, breathe or speak (Partial Airway Obstruction), stand by and encourage coughing to clear the airway.
 - b. If the resident is unable or becomes unable to cough, breathe or speak (Complete Airway Obstruction), perform the Heimlich Maneuver following step D below as appropriate.

D. Perform the Heimlich Maneuver (Abdominal Thrusts)

1. With resident standing or sitting:
 - a. Stand behind the resident.
 - b. Wrap your arms around the resident's waist.
 - c. Make a fist and place the thumb-side of the fist at the midline of the abdomen, just above the navel and well below the breastbone.

d. Grasp fist with free hand and press inward with a quick upward thrust. Avoid pressure on the ribs and breastbone.

2. With resident lying down:

a. Place the resident in the supine position on the floor.

b. Kneel down and straddle the residents' hips.

c. Position the heel of one hand at the midline of abdomen, just above the navel and well below the breastbone.

d. Place your free hand over the other hand and press inward with a quick upward thrust. Avoid pressure on the ribs and breastbone.

3. Repeat abdominal thrusts (as separate and distinct movements) until the airway is cleared (usually 5 to 10 thrusts).

4. Assist the nurse and/or EMS as appropriate.

5. If used, remove and discard gloves following facility policy. Wash hands.

E. Observe For and Report to Nurse:

1. Exact time choking and unconsciousness started and stopped.

2. Procedures done and time procedure started and stopped.

3. Response to procedures.

4. Factors related to cause of choking.

5. Other significant observations.

F. Measures to be followed for any Resident who has vomiting, bleeding near the mouth, excess secretions or is unable to swallow:

1. Notify the nurse immediately if:

a. Resident is choking or is not able to swallow.

b. Resident is not able to spit out vomitus, secretions or blood.

2. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.

3. Keep the resident's head elevated as allowed.

4. Keep the resident turned on his/her side or with head turned well to one side, if possible, to allow fluids to drain out of mouth.

5. Provide emesis basin for the resident who is vomiting.

6. Nurse may provide suctioning and/or notify the physician.

7. Leave the resident in a position of comfort and safety with the call signal within easy reach.

If used, remove and discard gloves following facility policy. Wash hands.

G. Observe For and Report to Nurse:

1. Immediately report difficulty swallowing, bleeding, vomiting, and choking or aspiration.

2. Do not discard vomitus or blood until it is seen by the nurse and a specimen is obtained if needed.

3. Other significant observations.

PROCEDURAL GUIDELINE #4 – PERSONAL PROTECTIVE EQUIPMENT (PPE)

A. Purpose: To protect the health care worker from occupational exposure to pathogens

B. Guidelines

1. Use PPE as required by Standard Precautions, Transmission-based Precautions and facility policy:
 - a. Mask, gown and gloves are worn once and discarded after use.
 - b. PPE is generally put on outside of the isolation room and taken off inside of the isolation room.
 - c. Do not wear PPE outside of the isolation area unless allowed by facility policy.
2. Use other PPE (such as goggles, face shields) as required following facility policy. Note that a mask can be worn without eye protection, but eye protection should NEVER be worn without a mask.
3. Use of PPE is based on the separation of "clean" and "dirty."
4. When using PPE, hands should be washed:
 - a. Before putting on PPE and entering the room.
 - b. After removing gloves because they may develop holes too small to be seen.
 - c. After removing PPE and leaving the room.

C. Putting on Disposable Isolation Mask, Gown and/or Gloves

1. Wash hands first before putting on mask, gown and/or gloves.
2. Put on gown next if required (hands are clean and gown is clean).
 - a. Hold clean gown in front and let it unfold.
 - b. Put your arm through the sleeves.
 - c. Fasten secure at back of neck, waist and back to cover your uniform.
3. Put on mask next if required (hands are clean and mask is clean).
 - a. Remove clean mask from container.
 - b. Put on mask and adjust to cover both nose and mouth.
4. Put on goggles/face shield.
 - a. Adjust to cover eyes.
 - b. Wear prescription eyewear under goggles.
5. Put on gloves last if required (hands are clean and gloves are clean).
 - a. Put on clean gloves.
 - b. Adjust fingers for comfort.
 - c. Cuffs of gloves overlap cuffs of gown.
 - d. Note: gloves should be changed if torn or punctured.

D. Taking Off Disposable Isolation Gloves, Gown and/or Mask.

1. If gown is worn, untie waist ties of gown now (waist ties and gloves are considered dirty).
2. Take off gloves next if worn (used gloves are considered clean on inside and dirty on outside).
 - a. Grasp outside of one glove below cuff and pull off with the clean side out. Continue to hold the removed glove in your gloved hand.
 - b. Place fingers of ungloved hand inside cuff on gloved hand and pull off, turning glove inside out over the other glove (clean to clean).
 - c. Discard gloves as biohazardous waste following facility policy.
3. Remove eye protection if used and dispose of per facility policy.
4. Take off gown next if worn (neck ties and inside of used gown are considered clean; waist ties and outside of gown dirty).
 - a. Note that waist ties were untied at step D 1 (before removing gloves).
 - b. Untie clean neck ties of gown with clean hands.
 - c. Grasp neck ties at back of neck and pull gown off shoulders.
 - d. Slip gown down arms and over hands touching only the clean inside.
 - e. Roll the gown away from you with the clean side out.
 - f. Discard gown as biohazardous waste following facility policy.
5. Take off mask next if worn (ties on used mask are considered clean and mask is dirty).
 - a. Remove mask folding inside out and dispose of per facility policy.
 - b. Do not let outside of mask touch your face or hands.
 - c. Discard mask per facility policy.
6. Wash hands.

PROCEDURAL GUIDELINE #5 – BODY MECHANICS FOR NURSE AIDES

A. Purpose

1. To avoid injury to the nurse aide and the resident.

B. General Guidelines and Precautions for Lifting or Moving

1. Wear loose clothing and low-heeled, comfortable, non-skid shoes to allow good body mechanics.
2. Always get help from co-workers when needed before lifting heavy objects or residents who are unable to stand.
 - a. Follow OSHA or facility policy regarding weight limits.
 - b. Plan the lift ahead of time.
 - c. Lift on pre-arranged signal such as "on the count of three."
3. Elevate the bed to comfortable working height when working at the bedside. Remember to return the bed to the lowest horizontal position when finished for resident safety.
4. Maintain good posture and good body alignment while lifting as indicated below:
 - a. Keep your back straight.
 - b. Keep your knees bent.
 - c. Keep your weight evenly distributed on both feet.
 - d. Keep your feet at shoulder width (about 12 inches apart) to provide a broad base of support.
5. Use the strongest and largest muscles to do the job. Leg and arm muscles are the strongest. Back and abdominal muscles are the weakest.
6. Bend from the hip and knees--not waist--when lifting objects.
7. Always squat down to lift heavy objects from the floor.
8. Keep objects close to your body when lifting and carrying.
9. Use both hands when lifting or moving heavy objects.
10. Slide, push or pull heavy objects rather than lifting them, when possible.
11. Use the weight of your body to help push or pull objects.
12. Work with smooth, even movements--not quick, jerky motions.
13. Face your work and avoid twisting your body.
14. To change the direction of your work, take short steps and turn your whole body without twisting your back and neck.

15. Avoid unnecessary bending and reaching.
16. Do not lift objects higher than your shoulders.

Section II – INFECTION CONTROL

PROCEDURAL GUIDELINE #6 – HAND WASHING

- A. Purpose: To remove germs from hands and prevent the spread of infection.
- B. Guidelines and Precautions
1. Hand-washing is the single most important method in the prevention and control of infection.
 2. Hand-washing should be done at the following times:
 - a. When coming on and going off duty.
 - b. Before and after caring for each resident.
 - c. Before applying gloves and after removing gloves.
 - d. Before and after eating, drinking, smoking, using lip balm, touching contact lenses, wiping nose, using toilet.
 - e. After contact with blood, body fluids and contaminated items (Procedural Guideline #7).
 - f. Whenever hands are obviously soiled.
 3. Precautions
 - a. Always keep your fingertips pointed down while washing your hands.
 - b. Avoid leaning against sink or splashing uniform during Hand-washing.
 - c. Do not touch the inside of sink or faucet handles with clean hands.
 - d. Note where paper towels are located.
- C. Procedural Guidelines
1. Turn on warm water.
 2. Wet hands and wrists.
 3. Apply soap or skin cleanser to hands to produce lather.
 4. Vigorously rub hands together in a circular motion producing lather for at least 20 seconds, washing all surfaces of the fingers and hands (including the wrists).
 5. Clean under nails by rubbing fingertips on palm of hand.
 6. Rinse hands thoroughly from wrist to fingertips, keeping fingertips down.
 7. Dry hands on clean paper towel and discard.
 8. Obtain a clean paper towel and turn off faucet with clean paper towel.
 9. Discard towel appropriately without contaminating hands.

PROCEDURAL GUIDELINE #7 – ISOLATION PRECAUTIONS

Standard Precautions

A. Purpose: To prevent the transmission of known and unknown infection through blood and body fluids.

B. Guidelines for Standard Precautions

1. Use Standard Precautions for the care of all residents when contact with blood or body fluids are likely.

2. Standard Precautions

- (a) Blood
- (b) Body fluids, secretions and excretions (except sweat)
- (c) Mucous membrane and non-intact skin (of resident or nurse aide)

3. Follow Standard Precautions and the facility isolation policies/procedures.

C. Rules for Standard Precautions

1. **Hand-washing** (Procedural Guideline #6): Thoroughly wash your hands or any other skin surfaces that have come into contact with blood or body fluids. Wash hands before and after each resident contact and before applying and after removing gloves.

2. **Gloves** (Procedural Guideline #4):

(a) Wash hands. Wear clean, disposable examination gloves for anticipated contact with blood, body fluids or contaminated items/surfaces:

- (1) Put on clean gloves just before touching mucous membrane or non- intact skin.
- (2) Wear gloves if you have breaks in the skin of your hands.
- (3) Change gloves if they develop holes or tears.
- (4) Change gloves between different procedures on the same resident to prevent cross-contamination of different body sites.

(b) Remove and discard gloves (and wash hands) promptly after use:

- (1) After each resident contact.
- (2) Before touching other residents, yourself or other people.
- (3) Before touching non-contaminated environmental items/surfaces. This may require that you change gloves several times during the care of a single resident. Follow facility policy and the instructions of the nurse, as each situation is different.

(c) Avoid wearing gloves when they are not necessary. Excessive use of gloves decreases direct contact by touch, and may cause residents to feel physically and psychologically rejected and "isolated."

3. **Other Personal Protective Equipment** (Procedural Guideline #4):

(a) Wear a clean gown only when indicated to protect your skin and clothing from splashes or sprays of blood or body fluids.

(b) Wear a clean mask and goggles or a face shield only when indicated to protect your skin and the mucous membrane of your eyes, nose and mouth from splashes or sprays of

blood or body fluids.

4. **Needle and Sharp Precautions:** Follow facility policy for Needle and Sharp Precautions. Use extreme care in handling used needles, razors and other sharps to avoid puncture wounds and possible exposure to blood borne pathogens. Needles are never bent, broken, or recapped by hand. Discard used sharps immediately after use into a puncture- resistant container.

5. **Cleaning Blood Spills:** Promptly clean blood spills following facility policy.

6. **Contaminated Items:** Linen and equipment soiled with blood or body fluids should be handled carefully, contained in sturdy plastic bags (kept clean on the outside), labeled, and processed following facility policy. Contaminated environmental surfaces should be cleaned and disinfected following facility policy.

7. **Disposal of Biohazardous Waste:** Follow facility policy for the proper handling, labeling and disposal of items contaminated with blood or body fluids.

8. **Laboratory Specimens:** Consider laboratory specimens and specimen containers to be potentially infectious materials.

Transmission-based Precautions

A. Purpose: To prevent the spread of certain highly transmissible, known or suspected pathogens by airborne, contact or droplet spread.

B. Guidelines for Transmission-based Precautions

1. Use Airborne, Contact or Droplet Precautions (in addition to Standard Precautions) when ordered by the doctor and/or nurse for a specific resident. The nurse will determine the need for isolation, select the type of isolation and write directions for Isolation Precautions.

(a) Always use Standard Precautions in addition to Transmission-based Precautions.

(b) Follow the written directions and the facility policies/procedures.

(c) Ask the nurse for instructions and assistance as needed.

2. Isolation hand-washing should be performed following written directions and facility policy, which may include the following:

(a) Remove watch and other jewelry on hands and arms

(b) Roll sleeves to elbows

(c) Wash hands and exposed areas of forearms (Procedural Guideline #6)

(d) Use anti-microbial soap for isolation hand-washing

C. Rules for Transmission-based Precautions

1. **Airborne Precautions:** Use Airborne Precautions as ordered (in addition to Standard Precautions) to control infections spread by small pathogens that remain suspended in the air and travel over long distances. Examples include tuberculosis during the communicable period.

- (a) Place resident in a private isolation room with special ventilation to keep the pathogen from spreading. Keep resident in room with door closed.
- (b) Wear a special HEPA mask or N 95 or PFR 95 respirator inside the isolation room because the small pathogen will pass through a regular mask.
- (c) Wash hands before entering and before leaving the room.

2. **Contact Precautions:** Use Contact Precautions as ordered (in addition to Standard Precautions) to control infections spread by direct or indirect contact with certain pathogens and parasites such as MRSA, head lice, scabies and c-diff.

- (a) Wash hands and put on gloves before entering the isolation room. Wear a gown if your skin or clothing will have substantial contact with the resident or the environment.
- (b) Remove and discard gloves and gown and wash hands (usually with antimicrobial soap) before leaving the isolation room.

3. **Droplet Precautions:** Use Droplet Precautions as ordered (in addition to Standard Precautions) to control infections spread by large droplets that are placed in the air through coughing, sneezing and talking. The droplets do not travel more than 3 feet and do not remain suspended in the air. Examples include some childhood communicable diseases and some pneumonias.

- (a) Wear an isolation mask if working within 3 feet of the resident.
- (b) Wash hands before entering and before leaving the room

SECTION III – COMMUNICATION

PROCEDURAL GUIDELINE #8 – COMMUNICATION AND INTERPERSONAL SKILLS

A. Guidelines for Starting a Conversation

1. Knock on the door before entering, identify yourself by name and title and greet resident by the preferred name.
2. Approach the resident in a calm and courteous manner.
3. Explain why you are there and what you are going to do.
4. If you are going to perform a procedure, explain the procedure to resident and encourage resident to participate as appropriate.

B. Guidelines for Talking and Listening

1. Get resident's attention before speaking.
2. Use courtesy when communicating. Talk courteously with the resident during care, listening and responding appropriately.
3. Speak in a language that is familiar and appropriate for the resident--avoid slang or words with more than one meaning.
4. Use a normal tone of voice and adjust your volume to the resident's needs.
5. Speak slowly and adjust your rate to the individual resident's needs.
6. Speak clearly--avoid mumbling.
7. Keep your message brief and concise--avoid rambling.
8. Face the resident. Sit at resident's eye level and maintain frequent eye contact with the resident as appropriate.
9. Send positive messages by use of encouragement, praise, smiles, gentle touch and other methods acceptable to the resident.
10. Be sure your verbal and nonverbal message match.
11. Use open posture, leaning slightly toward the resident while listening.
12. Pay attention and really listen to what the resident is saying.
13. Give, receive and/or request feedback as appropriate to assure that the communication is understood.

C. Guidelines For Encouraging Residents To Express Feelings

1. Use silence to allow the resident to think and continue talking (this shows respect and acceptance).
2. Use broad opening statements like "You seem quiet today."
3. Use open-ended questions like "and then what happened?"
4. Use noncommittal responses like "Oh, I see", "Go on", "Hmm..."
5. Use responses that indicate you understand the resident's feelings, such as: "You really miss your son."

D. Guidelines for Avoiding Barriers to Conversation

1. Avoid interrupting or changing the subject.
2. Avoid expressing your opinion if it implies passing judgment.
3. Avoid talking about your own personal problems and the problems of other residents and co-workers.
4. Avoid pat answers such as "Don't worry" as this can make residents feel his/her concerns are not important.
5. Avoid questions that can be answered with "Yes" or "No" unless you want only direct answers.
6. Avoid questions that start with "Why" to avoid defensive responses.

E. Guidelines for Ending a Conversation

1. Tell the resident that you are finished, that you have to leave and, if appropriate, when you will be back. Be sure to come back at the designated time.
2. Tell the resident that you enjoyed the conversation. Such as: "Thanks for yourtime," "Thanks for sharing."
3. Leave the resident in a position of comfort and safety, with call signal and other needed items within easy reach.

F. Communicating with Residents Who Have Vision Loss

1. Follow steps A thru E of this Procedural Guideline.
2. Identify self by name and title as you enter room to avoid startling the resident.
3. Encourage and assist the resident to keep glasses clean and to wear them.
4. Stand comfortably close to the resident in a good light and face the resident when you speak.

5. Speak in a normal tone of voice. Do not speak too loud.
6. Use talk and touch to communicate. Encourage the resident to do the same.
7. Give ongoing, step-by-step explanations of what you are going to do and what is expected of the resident. Clarify the resident's understanding as appropriate.
8. Do not rearrange the environment without the resident's knowledge and approval. Replace items to their original location in the resident's room.
9. Tell the resident when you are finished and when you are leaving.

G. Communicating with Residents Who Have Hearing Loss

1. Follow steps A thru E of this Procedural Guideline.
2. Alert the resident by approaching from the front or side and lightly touching resident's arm. Avoid startling the resident.
3. Eliminate distracting background noise and activity if possible.
4. Speak at a slightly lower pitch and at a normal or only slightly increased volume-- avoid shouting.
5. Encourage and assist the resident to use a hearing aid as appropriate.
6. If the resident hears better in one ear, stand on the preferred side.
7. Stand comfortably close to resident in a good light and face the resident while you speak.
8. Speak slowly, clearly and distinctly using your lips to emphasize sounds--do not chew gum or cover your face with your hands while talking.
9. Use short words and sentences, clarify the resident's understanding then rephrase message if needed.
10. Keep conversations short and limited to a single topic.
11. Do not convey negative messages by your tone of voice or body language.
12. Write out key words, if needed, or use other communication assistive devices such as communication boards if available.

H. Communicating with Residents Who Have Problems with Speaking

1. Follow steps A thru E of this Procedural Guideline.
2. Keep conversation short, but frequent. Ask direct questions if the resident can answer "Yes" or "No."

3. Allow the resident adequate time to respond.
4. Listen carefully. Don't pretend to understand the resident if you don't.
5. Emphasize the positive aspects such as the words you understand.
6. If you can't understand the words, validate what you think the resident is saying or feeling.
7. Take time to complete each conversation to avoid conveying impatience.
8. Monitor your body language to assure you are not sending negative messages.
9. Encourage and assist the resident to point, nod, write, or to use assistive devices for communication such as picture boards and word boards as appropriate.
10. Request assistance when needed.

I. Communicating with Residents Who Have Problems with Confusion, Memory Loss and Other Language.

1. Follow steps A thru E of this Procedural Guideline.
2. Use simple sentences and words, and pronounce words clearly and slowly.
3. Keep conversation short, but frequent and focused on a single topic.
4. Give simple one-step instructions as appropriate.
5. Allow the resident adequate time to respond.
6. Monitor your body language to assure you are not sending negative messages.
7. Use gestures and expressions to enhance the message.
8. Use clues to go with your verbal message, i.e., as you ask the resident to brush his/her teeth, put the toothbrush into the resident's hand.
9. Take time to complete each conversation to avoid conveying impatience.

J. Guidelines for Effective Interpersonal Relations

1. Maintain open communication, be a good listener and encourage residents to express his/her feelings.
2. Be honest. Your best efforts will fail if you are not sincere.
3. Respect each resident as a unique individual with his/her own behavior patterns.
4. Be courteous, patient and hopeful.

5. Develop supportive and trusting relationships with residents by being supportive and trustworthy.
6. Show residents that you care "about" them as well as caring "for" them.
7. Understand and accept residents – without judging.

Recap of communicating with residents

- Knock on resident's door; wait to be invited into the resident's room.
- Identify yourself and your title, nurse aide.
- Do not walk up behind the resident, approach resident from the side or front.
- If possible, get on the resident's level to talk; try not to "look down" on the resident while talking.
- Stay in the resident's line of vision when talking; this helps the resident understand.
- Address the resident by proper name, such as Ms. Smith or Mr. Smith, unless the resident asks you to use his/her first name. Do not use pet names to address the resident such as "honey" etc.
- Ask the resident if you can turn the volume down on the television if it is loud and interfering with conversation or taking vital signs.
- Talk while giving the resident care. Explain step-by-step to the resident the care you are providing.
- Listen to the resident! Respond to resident questions or statements.
- Remain calm at all times.
- Do not give the resident your personal information or problems.
- Use courtesy at all times.
- Maintain professional boundaries.

UNIT IV - NUTRITION & HYDRATION

PROCEDURAL GUIDELINE #9 – ASSISTING WITH MEALS

A. Purpose

1. To provide nutrition to residents.
2. To serve meals to residents in a pleasant environment.

B. Precautions

1. Do not offer foods hot enough to burn to residents who drink from a straw or have visual problems, weakness, shakiness, inability to grasp objects or other problems that might lead to burns.
2. Do not attempt to feed a resident who is asleep, unresponsive, choking, unable to swallow, unable to tolerate at least a 75° elevation, whose head is tilted backward (airway is open), or whose head and chin are tilted downward and inward toward chest (airway is closed). Report promptly to nurse for directions.
3. Follow Procedural Guideline #3 if choking occurs.

C. Procedural Guidelines

1. Preparing residents prior to mealtime:
 - a. Assist with toileting, hand-washing, oral hygiene and other care as indicated.
 - b. Be sure resident has dentures and/or eyeglasses if needed.
 - c. Assist resident to safe and comfortable seating in the eating area as able.
 - d. Assure that resident is correctly positioned, sitting with head and body as straight upright as possible. Check with nurse for directions if resident cannot tolerate at least a 75° elevation.
 - e. Provide clothing protectors as indicated.
2. Serving diet trays:
 - a. Sanitize hands before handling food and serving trays.
 - b. Identify diet tray by card.
 - c. Identify the resident and place tray within easy reach of resident.
 - d. Remove food covers and assist with napkins as indicated.
 - e. Replace missing items following facility policy.
3. Assisting residents with eating:
 - a. Encourage resident to help self as much as possible.
 - b. Assist resident as needed to ensure adequate dietary intake.
 - c. Prepare food as needed such as open packets, cut meat, butter bread, offer condiments as preferred.
 - d. For residents with impaired vision, describe food and location of food as placed on

plate in relation to the face of the clock if appropriate.

e. Observe for and/or inquire about problems with eating, and try to correct problem if possible:

- (1) Offer encouragement and/or assistance as indicated.
- (2) Offer appropriate food substitutes if needed.
- (3) Offer to replace or rewarm food that has become cold.

f. Provide encouragement and help with assistive eating devices as indicated.

4. Monitoring mealtime:

- a. Allow resident ample time to eat.
- b. Encourage socialization.
- c. Remain pleasant and unhurried.
- d. Try to avoid or control unpleasant situations.
- e. Monitor and record dietary intake of all residents during mealtime and identify problems with eating.
- f. Notify nurse of residents who are absent or who have eating problems.
- g. For residents feeding self in own room, check frequently, offer assistance and visit briefly with resident as possible.

5. Removing trays if used

- a. Remove tray after resident has finished eating.
- b. Determine and record fluid and food intake as required following facility policy.
- c. Place used trays on cart after all clean trays have been served. d. Wash hands.

6. Assisting resident after meals:

- a. Assist residents with ambulation, oral hygiene, toileting, hand-washing and other needs after eating as appropriate.
- b. Assist resident to return to a position of comfort and safety.

PROCEDURAL GUIDELINE #10 – FEEDING THE DEPENDENT RESIDENT

A. Purpose: To feed the resident who needs assistance with eating.

B. General Guidelines and Precautions

1. Take care when serving hot foods to avoid burns. Check temperature of food by dropping a small amount on your wrist or forearm.
2. Try to reduce the stress and frustration the resident may feel about being fed. Converse pleasantly with the resident during meal.
3. Do not attempt to feed a resident who is asleep, unresponsive, choking, unable to swallow, unable to tolerate at least a 75° elevation; or whose head is tilted backward (airway is open), or whose head and chin are tilted downward and inward toward chest (airway is closed). Report promptly to nurse for directions.
4. Follow Procedural Guidelines #3 if choking occurs.
5. Don't leave the tray with the resident until ready to be fed.

C. Procedural Guidelines

1. Prepare the eating area by straightening the resident's room and sanitizing the table to be used for mealtime following facility policy.
2. Explain procedure to resident, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.
3. Before feeding the resident, ensure the resident is in an upright position (at least 75 degrees).
4. Place the tray where it can be easily seen by the resident.
5. Clean the resident's hands with a hand wipe before beginning the feeding.
6. Tell the resident what foods are on the tray and ask what the resident would like to eat first.
7. Use spoon and offer the resident one bite of each type of food on the tray. Tell the resident the content of each spoonful.
8. Offer beverages at least once during the meal.
9. Make sure the resident's mouth is empty before offering the next bite of food or sip of beverage.
10. At the end of the meal, wipe the resident's mouth and hands with a hand wipe (washcloth, napkin, paper towel or clothing protection wet or dry. Steps #6 & #11 can be the same wipe).

11. Remove the food tray and place the tray in the designated dirty supply area.
12. Ensure the signaling device is within the resident's reach.
13. Wash your hands. (Steps #6 & #11 can be the same wipe)

UNIT V – RESIDENT’S ENVIRONMENT

PROCEDURAL GUIDELINE #11 – MAKING THE UNOCCUPIED BED

A. Purpose: To provide a clean, comfortable bed for the resident who is able to get out of bed.

B. Procedural Guidelines

1. Wash hands. Wear gloves and follow Standard Precautions. If the resident is in isolation, check with the nurse.
2. Gather needed supplies at bedside on a clean, dry surface such as bedside or over bedtable:
 - a. Laundry bag, dirty linen container, or leak proof bag for wet linen following facility policy
 - b. 2 sheets – a top sheet and a bottom sheet
 - c. Draw sheet or incontinent pads if used
 - d. Blanket and/or bedspread if needed e. Pillowcase(s)
3. Lower side-rails and remove call signal and resident's personal items.
4. Adjust bed flat, elevate bed to comfortable working height, lock wheels and use good body mechanics.
5. Remove soiled linen from the bed.
 - a. Check linen for misplaced items such as dentures, hearing aids, eyeglasses.
 - b. Roll soiled linen away from you with dirty side inside.
 - c. Avoid touching soiled linen against your clothing.
 - d. Handle soiled linen as little as possible, and avoid shaking linen.
 - e. Place soiled linen directly into soiled linen container following facility policy. Keep the outside of the container clean. Do not place soiled linen on clean surfaces or on the floor unless it is in a leak proof bag.
 - f. Clean, dry and straighten mattress as needed. Observe for tears or holes in mattress and report them to the nurse.
 - g. Remove gloves and wash hands.
6. Apply clean bottom linen, working on the side of bed near the clean linen. Do not allow clean linen to touch the floor.
 - a. For a fitted bottom sheet: Place the fitted sheet corners over the top and bottom mattress corners.
 - b. For a straight sheet: Center and unfold lengthwise with bottom edge even with or just over the foot of the mattress. Tuck top of sheet under head of mattress and miter top corner.
 - c. If used, center draw sheet or pad on the bed.
 - d. Tuck in the bottom linen on the side where you are working.
7. Apply top linen on same side of bed.

- a. Center and unfold top sheet lengthwise, with upper edge even with top of mattress.
 - b. Center and unfold blanket and/or bedspread, with upper edge slightly below the edge of top sheet.
 - c. Tuck in top linen at the foot of bed and make a smooth corner following facility policy.
8. Move to the opposite side of the bed to complete bed making.
 9. Place corners of fitted sheet over mattress or miter top corner of bottom sheet.
 10. Pull and tuck in bottom linen, keeping it straight and centered. Assure bottom linen is tight, smooth and free of wrinkles (unless waterbed, egg crate, gel or air mattress).
 11. Tuck in top bedding at foot of bed, keeping it straight and centered. Make a smooth corner following facility policy.
 12. Smooth top linen and fold top sheet over edge of blanket if used.
 13. Apply clean pillowcase (with zippers and tags inside) and replace pillow on bed.
 14. Replace call signal and any needed items within resident's reach.
 15. Adjust height of bed and position of bed as appropriate.

PROCEDURAL GUIDELINE #12 – MAKING THE OCCUPIED BED

A. Purpose: To provide a clean, comfortable bed for the resident who is not able to get out of bed.

B. Procedural Guidelines

1. BEGINNING STEPS

a. Gather needed supplies at bedside on a clean, dry surface such as bedside or over bed table:

- (1) Laundry bag, dirty linen container, or leak proof bag for wet linen following facility policy
- (2) 2 Sheets -- a top sheet and a bottom sheet
- (3) Draw sheet or incontinent pad if used
- (4) Blanket and/or bedspread if needed
- (5) Pillow case(s)

2. Lock wheels of bed, put head of bed as flat as tolerated and assist resident to roll on side.

3. Check linen for misplaced items such as dentures, hearing aids, and eyeglasses.

4. Remove blanket and bedspread and set aside if they are to be reused. Leave resident covered with top sheet or bath blanket following facility policy.

5. Loosen bottom linen and roll or fanfold linen, soiled side inside, to center of bed.

6. Clean, dry and straighten mattress as needed.

7. Apply clean bottom linen, working on side of bed near clean linen. Do not allow clean linen to touch the floor.

- a. For fitted bottom sheet: Place fitted corners over top and bottom mattress corners.
- b. For straight sheet: Center and unfold lengthwise with bottom edge even with or just over the foot of the mattress. Tuck top of sheet under head of mattress and miter the top corner.
- c. If used, center the draw sheet or pad on the bed.
- d. Tuck in the bottom linen on the side you are working, keeping linen straight and centered.
- e. Roll the clean bottom linen to the center of the bed. If soiled linen is wet, keep clean linen separated from soiled linen.

8. Raise side rail, assist resident to roll over linen toward you, and assure that resident is comfortable and safe.

9. Raise side rail, then go to opposite side of bed and lower side rail.

10. Remove soiled linen from the bed.

- a. Roll soiled linen off of bed with dirty side inside.

- b. Avoid touching soiled linen against clothing.
- c. Handle soiled linen as little as possible and avoid shaking linen.
- d. Place soiled linen directly into soiled linen container following facility policy. Keep the outside of the container clean. Do not place soiled linen on clean surfaces or on the floor.
- e. Clean, dry and straighten mattress as needed. Report tears or holes in mattress to nurse.
- f. Remember to raise side rail before you leave the bedside.
- g. Remove gloves and wash hands.

11. Pull clean bottom linen away from resident's back.

12. Pull and tuck in bottom linen, assuring bottom linen is tight, smooth, and free of wrinkles (unless waterbed, egg crate, gel or air mattress).

13. Assist resident to roll back to the center of the bed.

14. Remove the pillow, change pillowcase (with zippers and tags inside), and replace pillow, providing support for resident's head if needed.

15. Remove the used top sheet or bath blanket as you apply the clean top sheet over the resident, avoiding unnecessary exposure.

16. Apply remaining top linen, keeping it straight and centered and tucking it in at foot of bed with smooth corners following facility policy.

UNIT VI - BASIC NURSING SKILLS

PROCEDURAL GUIDELINE #13 – INTAKE AND OUTPUT (I & O)

- A. Purpose: To provide an accurate record of the fluid balance.
- B. General Guidelines and Precautions
1. Always check if resident is on I & O before giving fluids or discarding specimens.
 2. Follow facility policy and procedures for Intake and Output
 - a. Fluid intake includes all fluids taken in by mouth, tube feeding and IVs. Oral intake includes fluids given during medication passes and fluids on meal trays. Most facilities count semi-liquid foods as fluid intake such as ice creams, popsicles, gelatins and puddings.
 - b. Fluid output includes all urine, vomitus, liquid stool and other measurable output such as drainage from wounds, tubes.
- C. Procedural Guidelines
1. Initiating I & O:
 - a. Check with care plan and nurse for instructions about I and O.
 - b. Identify resident, explain procedure and encourage participation.
 - c. Wash hands and gather needed supplies:
 - (1) Graduate or measuring container
 - (2) "Intake and Output" records
 - (3) "Intake and Output" signs if used by facility
 - (4) "Equivalent List of Liquid Measures" if used by facility
 - (5) Receptacle for output such as a urinal, bedpan or specimen to be placed under toilet seat.
 - d. Complete information on I & O record and place it in designated location.
 - e. Place a clean graduate and receptacle for output in bathroom.
 2. Measuring Intake:
 - a. Estimate or measure and record all fluid intake.
 - b. Check all serving containers for liquids.
 - c. Determine the amount of the serving from the equivalent list.
 - d. Accurately determine the amount of liquid remaining.
 - e. Subtract amount remaining from amount of serving to determine intake.
 - f. Record time and amount of intake on the I & O record.
 3. Measuring Output:
 - a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7) prior to contact with bedpan urine, blood or other body fluids.
 - b. Pour fluid output into the measuring container.
 - c. Measure the amount in the container at eye level and on a level surface.

- d. Discard fluid into toilet, unless a specimen should be collected or an unusual output should be shown to the nurse.
- e. Empty and rinse measuring container, urinal or bedpan. Dump water used for rinsing into toilet and place containers in designated area following facility policy.
- f. Remove and discard gloves following facility policy promptly after use to avoid environmental contamination. Wash hands.
- g. Record the time and amount of output on the I & O Record.
- h. Check with the nurse if the output cannot be measured. You may be asked to estimate the number of times or the volume of the output. Indicate on I & O record if amount was estimated and why measurement was not done.

PROCEDURAL GUIDELINE #14 – TEMPERATURE (ORAL, AXILLARY)

A. Purpose: To measure the body temperature using a thermometer.

B. Guidelines

1. Temperatures are taken as ordered by the physician, as instructed by the nurse and following facility policy. Elevated temperatures are generally taken every 4 hours.
2. Recheck unusual high or low temperatures with another thermometer, and report rechecked unusual temperatures to the nurse immediately.
3. If the resident has just finished smoking, eating or drinking anything hot or cold, wait about 15 minutes before taking oral temperature.

C. Beginning Steps

1. Wash hands. Wear gloves if contact with blood or body fluids is likely.
2. Gather needed supplies:
 - a. For oral temperature (by mouth) or axillary temperature (under the arm): clean oral thermometer and clean, disposable gloves
 - b. Disposable plastic thermometer cover if used at facility
 - c. TPR worksheet or pad and pencil
 - d. Tissues
3. Knock on door and identify self by name and title.
4. Greet resident by preferred name and identify resident per facility policy.
5. Explain procedure and encourage resident's participation as appropriate.
6. Provide privacy as appropriate such as close door/curtains, drape resident.
7. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
8. If side rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

D. Procedural Guideline for taking temperature

1. Demonstrate taking temperatures according to facility policy and manufacturing guidelines.
2. Always practice good infection control by providing a probe cover and wiping the outside of the machine before taking to another resident.
3. Record temperature reading and report unusual temperatures to nurse.

PROCEDURAL GUIDELINE #15 – MANUAL PULSE AND RESPIRATION

A. Purpose: To determine the rate and quality of the pulse and respiration.

B. Guidelines: Pulse and respiration are usually counted while temperature is being taken (Procedural Guideline #15).

C. Procedural Guidelines for Counting Radial Pulse

1. Assist resident into position of comfort with arm and hand supported.
2. Locate the radial pulse by placing the tips of your first three fingers on the thumb side of the resident's wrist. Do not use your thumb.
3. Exert slight pressure until you can feel the pulse. Do not press hard.
4. Look at second hand on watch
5. Count pulse for 1 full minute.
6. Note rate.
7. Record pulse rate following facility policy.
8. Report to nurse:
 - a. Pulse rate below 60 or above 100/minute (normal is about 76 and regular).
 - b. Irregular, weak or bounding pulse.
 - c. Problems or complaints related to pulse such as chest pain, pounding or skipping heartbeat.
 - d. Other significant observations.

D. Procedural Guidelines for Counting Respirations

1. Count respirations for 1 full minute.
2. Record rate according to facility policy.
3. Report to nurse.

PROCEDURAL GUIDELINE #16 – BLOOD PRESSURE (BP)

A. Purpose: To measure systolic and diastolic arterial blood pressure.

B. Precautions and Guidelines

1. Recheck a blood pressure no more than 3 times and wait at least 1 to 2 minutes before repeating the BP measurement on the same arm.
2. Report to the nurse for assistance if you cannot hear the BP or are unsure of what you are hearing after 3 tries. Don't guess at the BP reading.

C. Procedural Guidelines

1. Explain procedure, speaking clearly, slowly and directly, maintaining face-to-face contact whenever possible.
2. Before using stethoscope, wipe bell/diaphragm, earpieces of stethoscope with alcohol and assist resident to comfortable position.
3. Resident's arm is positioned with palm up and upper arm exposed.
4. Adjust the resident's clothing.
5. Feel for brachial artery on inner aspect of arm, at bend of elbow.
6. Place blood pressure cuff snugly on resident's upper arm, with sensor/arrow over brachial artery site.
7. Earpieces of stethoscope are in ears and bell/diaphragm is over brachial artery site.
8. Do one of the following:
 - a. Inflate cuff between 160 mm Hg to 180 mm Hg. (If beat heard immediately upon cuff deflation, completely deflate cuff, Re-inflate cuff to no more than 200 mmHg.)
9. Deflate cuff slowly and note the first sound (systolic reading) and last sound (diastolic reading). (If rounding needed, measurements are rounded UP to the nearest 2 mm of mercury.)
10. Remove cuff.
11. Place signaling device within reach.
12. After obtaining reading using BP cuff and stethoscope, record both systolic and diastolic pressures each within plus or minus 8 mm of evaluator's reading.
13. Disinfect equipment according to facility policy.

PROCEDURAL GUIDELINE #17 – HEIGHT AND WEIGHT

A. Purpose: To determine a baseline record of body weight and height and to monitor nutrition and hydration.

B. General Guidelines

1. Height and weight are generally measured on admission, and weight is measured monthly.
2. To assure that the weight measurement is accurate, measure weight at the same time of day, use the same scale each time and have the resident wear the same amount of clothing each time.
3. Follow facility policy and manufacturer's instructions on the proper use of specific scales such as standing, chair, platform and lift scale.
4. If the resident cannot safely stand on the scale, report to nurse and do not attempt to weigh.

C. Procedural Guidelines

1. Measuring the weight of an ambulatory resident:
 - a. Make sure the resident has on shoes before taking him or her to the scale.
 - b. Move both weights to the far left at zero.
 - c. Assist the resident to stand on the scale.
 - d. Check that the resident is balanced and centered on the scale with arms at sides and not holding onto anything.
 - e. Move larger bottom weight to right, just below estimated weight of resident. Be sure indicator is in the groove.
 - f. Then move small top weight to right until the scale is balanced.
 - g. Read lower bar and upper bar and add numbers together for total weight.
 - h. Record weight following facility policy.
2. Measuring the height of an ambulatory resident:
 - a. Assist the resident to remove his/her shoes.
 - b. Assist the resident to stand on the scale.
 - c. Have the resident stand straight and look straight ahead.
 - d. Raise height arm higher than the resident's head.
 - e. Gently lower the height arm until level with the top of the resident's head.
 - f. Read and record height in feet and inches following facility policy.
3. Measuring the weight of a non-ambulatory resident using a mechanical lift:
 - a. Carefully follow the manufacturer's instructions and facility policy for using the mechanical lift.
 - b. Request assistance as needed prior to this procedure.
 - c. Bring the mechanical lift with slings and other needed items to the bedside.
 - d. Lock the wheels of the bed.

- e. Position and attach slings and straps following manufacturer's instructions.
 - f. Lock the wheels of the mechanical left.
 - g. Slowly lift the resident free of the bed.
 - h. Adjust weights until the scale is balanced.
 - i. Read and record the weight following facility policy.
 - j. Slowly return the resident to the bed.
 - k. Detach and remove slings and straps.
4. Measuring the height of a non-ambulatory resident:
- a. Assist the resident to lie flat in bed with legs extended as able.
 - b. Measure top of head and at bottom of heels.
 - c. If resident is contracted, use a tape measure and measure from top of head to base of heel, following curves of spine and legs.
 - d. Record height following facility policy.

UNIT VII – PERSONAL CARE

PROCEDURAL GUIDELINE #18 – TUB OR SHOWER BATH

A. Purpose: To bathe residents who are able to get in and out of the tub or shower.

B. Precautions

1. Be sure the water temperature is regulated to avoid burns.
2. NEVER leave the resident unattended in the tub or shower.
3. Use emergency call signal to summon assistance if needed.
4. If resident becomes ill or uncooperative, call for help and turn off shower or open tub drain.

C. Procedural Guidelines

1. BEGINNING STEPS

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7) if contact with blood or body fluids is likely.

b. Needed supplies include the following:

- (1) Tub or shower that is available and clean
- (2) Shower chair or tub chair if indicated
- (3) Washcloth and towel
- (4) Soap or skin cleanser
- (5) Lotion and other personal care items as preferred

2. Request assistance as needed prior to the bath.

3. Assist resident to the bathing area as appropriate, providing needed support to prevent accidents and assuring resident is fully covered during transport.

4. Regulate the temperature and flow of water before the resident gets into the water and as needed during the bath.

a. Water temperature should be comfortably warm (about 105°F). Before use, test water temperature for comfortable warmth on your wrist or forearm or use bath thermometer. Have resident test water for comfort before bathing.

b. For tub bath, fill tub half-full with comfortably warm water.

c. For shower, regulate temperature and flow for comfort and safety.

5. Assist the resident with undressing and toileting as appropriate.

6. Assist the resident into tub or shower, facing the controls.

a. Provide adequate support to avoid falls and injuries.

- b. Encourage the resident to use the safety grab bars.
 - c. Use tub or shower chair as needed, locking wheels once chair is in position.
7. Stay with the resident assist with or supervise with bathing as appropriate.
 - a. Wash (with soap) and rinse entire body, working from clean to dirty areas.
 - b. Assure back, creases, skin folds, perineum, feet and between toes are thoroughly cleaned and rinsed.
 8. When bathing is complete, turn off the shower or open the tub drain.
 9. Assist the resident out of the tub or shower, providing adequate support to avoid falls.
 10. Assist the resident to dry thoroughly, with special attention to back, creases, skinfolds, perineum, feet and between toes.
 11. Remove gloves and wash hands after perineal care is completed.
 12. Assist with toiletries as desired. Apply lotion to dry skin, avoiding area between toes. Remove excess lotion from hands and feet.
 13. Supervise and/or assist the resident with dressing as appropriate.
 14. Assist the resident to return to his/her room and complete dressing and grooming as appropriate.
 15. Return the resident's belongings to his/her room.

PROCEDURAL GUIDELINE #19 - COMPLETE BED BATH

A. Purpose: To bathe the resident who cannot get out of bed for bathing.

B. General Guidelines

1. Utilize bath time as a time to communicate with the resident, make observations and provide other needed care.
2. Follow the resident's personal preferences for bathing as possible.
3. Change the bath water at least prior to washing the perineum and as needed during the bath to keep the water warm, clean and free of excess soap.
4. Wash, rinse and dry from clean to dirty areas.

C. Procedural Guidelines

1. BEGINNING STEPS

a. Supplies needed at the bedside on a clean, dry surface such as bedside or overbed table would include:

- (1) Wash basin with comfortably warm water (about 105° F). Test the water temperature for comfort on your wrist or forearm, or use a bath thermometer.
 - (2) Soap or skin cleanser as indicated
 - (3) Towels and washcloths
 - (4) Lotion and other personal care items as preferred
 - (5) Sheet or bath blanket
 - (6) Gloves
2. Offer assistance with toileting and undressing before the bath as needed.
 3. Lock the wheels of the bed, lower the head of the bed as appropriate and move the resident to the side of the bed near you.
 4. Remove upper bedding, leaving the resident covered with a top sheet or bath blanket to avoid unnecessary exposure.
 5. Supervise/assist the resident to wash, rinse and dry face, ears and neck, encouraging resident to do as much as able.
 - a. Fold washcloth
 - b. Wet washcloth and wash eyes (without soap), wiping from the inner to outer part of each eye and using a separate area of the wash cloth for each stroke.
 - c. Proceed to wash and dry the face (no soap).
 - d. Wet washcloth and apply soap. Wash, rinse, and dry ears and neck.
 6. Put towel under far arm. Supervise/assist residents to wash, rinse and dry the arm, axilla

and shoulder. Then repeat procedure for the other arm.

- a. Allow the resident to wash and soak hands directly in the wash basin.
- b. Clean and trim fingernails per facility policy (Procedural Guideline #29).

7. Place the bath towel over the resident's chest. Supervise/assist the resident to wash, rinse and dry his/her chest using the towel. Clean and dry the area under the resident's breasts.

8. Cover the chest and abdomen with lengthwise towel. Supervise/assist the resident to wash, rinse and dry his/her abdomen. Clean and dry skin folds and umbilicus.

- a. Apply deodorant to underarms and lotion to dry skin.
- b. Replace sheet or bath blanket over shoulders and remove the towel.

9. Remove the sheet or bath blanket from the resident's leg, ask the resident to flex his/her leg and place bath towel underneath. Wash, rinse and dry the leg and foot. Replace the sheet or bath blanket. Then repeat procedure for other leg.

- a. Clean and trim toenails per facility policy (Procedural Guidelines #30).
- b. Apply lotion as needed, avoiding area between toes. Wipe off excess lotion.
- c. Replace sheet or bath blanket and raise side-rail.

10. Assist the resident to turn on his/her side. Place towel lengthwise under the resident's back. Wash, rinse and dry the neck and back.

- a. Apply lotion to the skin as needed or a backrub may be given.

11. Change bath water and start with a clean washcloth.

12. Assist the resident to turn onto his/her back and supervise/assist the resident with washing perineal area.

- a. If no assistance is needed:
 - (1) Instruct resident to wash, rinse and dry perineal area.
 - (2) Place washcloth, soap, basin, and towel and call signal within easy reach.
 - (3) Instruct resident to signal when finished and provide privacy.
- b. If assistance is needed:
 - (1) Wash hands, wear gloves and provide perineal care following Procedural Guidelines #20 or #21 as appropriate.

PROCEDURAL GUIDELINE #20 – PERINEAL CARE/INCONTINENT CARE-FEMALE

A. Purpose: To clean the female perineum without contaminating the urethral area with germs from the rectal area. **Emphasizing clean to dirty.** (Facility policies may vary. Skill is for testing purposes.)

B. Procedural Guidelines

1. BEGINNING STEPS

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7).

b. Gather needed supplies:

(1) Washcloths (at least 2)

(2) Towel(s)

(3) Pad/linen protector

(4) Soap, wipes or other perineal cleanser following facility policy. **Facility policy supersedes all. Follow manufactures recommendations when using a product.**

(5) Clean wash basin of comfortably warm water

(6) Clean, disposable examination gloves

(7) Additional supplies as needed if heavy soiling is present.

(8) Remove heavy soiling prior to perineal care.

2. Lower head of bed and position the resident on his/her back with legs flexed and separated as able and as appropriate.

3. Before washing check water temperature for safety and comfort and ask client to verify comfort of water.

4. Put on clean gloves before washing perineal area.

5. Place pad/linen protector under perineal area before washing.

6. Expose perineal area while avoiding overexposure of client.

7. Apply soap to wet washcloth.

8. Wash genital area, moving from front to back, while using a clean area of the washcloth for each stroke.

9. Using clean washcloth, rinse soap from genital area, moving from front to back, while using a clean area of the washcloth for each stroke.

10. Dry genital area moving from front to back with towel.

11. After washing genital area, turn to side, then wash and rinse rectal area moving from

front to back using a clean area of washcloth for each stroke. Dry with towel.

12. Reposition resident.

13. Empty, rinse, and dry basin (Depending on product used).

14. After rinsing and drying the basin, return to designated storage area.

15. Dispose of used linen into soiled linen container and dispose of linen protector appropriately.

16. Avoid contact between your clothing and used linen.

17. After disposing of used linen, and placing used equipment in designated storage area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.

18. Place signaling device within reach and bed in low position.

19. Inform resident when finished and ask if anything is needed before you go.

PROCEDURAL GUIDELINE #21 – PERINEAL CARE/INCONTINENT CARE-MALE

A. Purpose: To clean the male perineum without contaminating the urethral area with germs from the rectal area. **Emphasizing clean to dirty.**

B. Procedural Guidelines

1. Beginning steps

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7).

b. Gather needed supplies:

(1) Washcloth(s)

(2) Towel(s)

(3) Pad/linen protector

(4) Soap, wipes or other perineal cleanser following facility policy. **Facility policy supersedes all.**

(5) Clean wash basin of comfortably warm water (about 105°F). Test water temperature for comfort on your wrist or forearm or use bath thermometer.

(6) Clean, disposable examination gloves

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

2. Lower head of bed and position the resident on his back with legs flexed and separated as able and as appropriate.

3. Before washing check water temperature for safety and comfort and ask client to verify comfort of water.

4. Put on clean gloves before washing perineal area.

5. Place pad/linen protector under perineal area before washing.

6. Expose perineal area while avoiding overexposure of client.

7. Reposition foreskin if retracted.

8. Apply soap to wet washcloth.

9. Wash genital area, moving from front to back, while using a clean area of the washcloth for each stroke.

10. Using clean washcloth, rinse soap from genital area, moving from front to back, while using a clean area of the washcloth for each stroke.

11. Dry genital area moving from front to back with towel.

12. Reposition foreskin if retracted.
13. After washing genital area, turn to side, then wash and rinse rectal area moving from front to back using a clean area of washcloth for each stroke. Dry with towel
14. Reposition resident.
15. Empty, rinse, and dry basin (Depending on product used).
16. After rinsing and drying the basin, place basin in designated storage area.
17. Dispose of used linen into soiled linen container and dispose of linen protector appropriately.
18. Avoid contact between your clothing and used linen.
19. After disposing of used linen, and placing used equipment in designated storage area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
20. Place signaling device within reach and bed in low position.
21. Inform resident when finished and ask if anything is needed before you go.

PROCEDURAL GUIDELINE #22 – CATHETER CARE

A. Purpose: To clean the catheter without contamination.

B. Procedural Guidelines

1. Beginning steps

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #7).

b. Gather needed supplies:

(1) Washcloths (at least 2)

(2) Towel(s)

(3) Linen protector

(4) Soap or other cleanser. Facility policy supersedes all.

(5) Clean wash basin of comfortably warm water

(6) Clean, disposable examination gloves

(7) Additional supplies as needed if heavy soiling is present

2. Lower head of bed and position the resident on his or her back.

3. Before washing check water temperature for safety and comfort and ask client to verify comfort of water.

4. Put on clean gloves before washing.

5. Place linen protector under perineal area before washing.

6. Expose area surrounding catheter while avoiding overexposure of client.

7. Apply soap to wet washcloth.

8. While holding catheter at meatus without tugging, clean at least four inches of catheter nearest meatus, moving in only one direction, away from meatus, using a clean area of the cloth for each stroke.

9. While holding catheter at meatus without tugging, rinse at least four inches of catheter nearest meatus, moving only in one direction, away from meatus, using a clean area of the cloth for each stroke.

10. While holding catheter at meatus without tugging, dry four inches of catheter moving away from meatus.

11. Change gloves, secure catheter to thigh according to facility policy.

12. Empty, rinse, and dry basin (Depending on product used).

13. After rinsing and drying the basin, place basin in designated storage area.

14. Dispose of used linen into soiled linen container and dispose of linen protector appropriately.
15. Avoid contact between your clothing and used linen.
16. After disposing of used linen and cleaning equipment, remove and dispose of gloves (without contaminating self) into waste container and washes hands.
17. Place signaling device within reach and bed in low position.

PROCEDURAL GUIDELINE #23 – BRUSHING THE TEETH

A. Purpose: To maintain clean and healthy gums and teeth.

B. Procedural Guideline

1. BEGINNING STEPS

a. Gather needed supplies:

- (1) Soft bristled toothbrush
- (2) Toothpaste
- (3) Glass of cool water or diluted mouthwash if permitted
- (4) Emesis basin
- (5) Towel
- (6) Clean, disposable examination gloves

2. Assist the resident into a safe and comfortable upright position, at least 75 degrees, as tolerated, or with head turned well to one side.
3. Place a towel across the resident's chest as needed.
4. Supervise/assist the resident to perform procedure as able, such as applying toothpaste to the toothbrush.
5. Wash hands and put on gloves prior to contact with oral secretions and mucous membrane.
6. Brush the teeth starting at upper back tooth and working in an orderly direction to brush the inner, outer and chewing surfaces of all upper and lower teeth.
7. Hold the brush on the gum line and gently brush at the gum line, using a short circular motion. Then brush up the tooth surface from gum to top of tooth.
8. Brush the inner surfaces of the front teeth by tilting the brush vertically and using gentle up and down strokes.
9. Brush the chewing surface of the upper and lower teeth using short back and forth strokes.
10. Repeat steps 7, 8 and 9 until all surfaces of the upper and lower teeth are brushed.
11. Gently brush the tongue as appropriate.
12. Have the resident rinse his or her mouth and spit into emesis basin or sink as needed and at the completion of brushing.
13. Wipe the resident's lips with tissues.
14. Maintain clean technique of toothbrush throughout the procedure.

PROCEDURAL GUIDELINE #24 – DENTURE CARE

A. Purpose: To maintain healthy gums and clean dentures.

B. Precaution

1. Take care to avoid damage or loss of dentures, as they are expensive and difficult to replace.
2. Hold dentures securely to avoid dropping but handle gently to avoid bending or breaking.

C. Procedural Guidelines

1. BEGINNING STEPS

a. Gather needed supplies:

- (1) Denture brush or toothbrush
- (2) Denture cleaner or toothpaste
- (3) Clean denture cup--labeled as required by facility
- (4) Glass of cool water or diluted mouthwash if permitted
- (5) Tissues
- (6) Clean, disposable examination gloves

2. Assist the resident into a safe and comfortable upright position as tolerated, or with head turned well to one side.

3. Wash hands and put on gloves prior to contact with oral secretions and mucous membranes.

4. Ask resident to remove dentures if applicable, provide gauze, paper towel or washcloth. Remove or assist with removal of dentures as needed.

5. Put dentures in a labeled denture cup and take to the appropriate area for cleaning. Dentures may be soaked in denture cleaner following facility policy.

6. Line at least the bottom of the sink with a towel or fill the sink half-full of water to prevent damage to dentures if dropped.

7. Thoroughly clean all surfaces of dentures (including inner, outer and chewing surfaces of upper and lower dentures) with denture cleanser and brush.

- a. Remove dentures from the container and rinse under moderate running water.
- b. Brush up and down rather than across dentures, holding securely but gently, to avoid dropping and damage.
- c. Rinse dentures in cool water and examine for broken or damaged areas.
- d. Clean denture cup and lid. Place clean dentures in cup with cool water and put lid on cup.

8. Return dentures to resident's bedside.

9. Assist residents to rinse mouth with mouthwash or water and wipe lips.

10. If dentures are to be replaced in mouth, apply gloves and assist as needed in replacing dentures.

11. If dentures are to be stored, follow facility policy for denture storage.

PROCEDURAL GUIDELINE #25 – SPECIAL MOUTH CARE

A. Purpose: To clean the mouth and teeth of the resident who is unconscious or has other special needs for gentle mouth care.

B. Precaution: Call the nurse immediately for assistance if choking occurs.

C. Procedural Guidelines

1. BEGINNING STEPS

a. Gather supplies below or follow facility policy for supplies:

- (1) Soft toothbrush, applicator sticks, toothettes or other cleaning device
- (2) Diluted mouthwash or other cleaning solution
- (3) Lubricant for lips
- (4) Towel
- (5) Clean, disposable examination gloves

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

3. Provide privacy with a curtain, screen, or door.

4. Before providing mouth care, place the resident in an upright sitting position (75-90 degrees).

5. Put on clean gloves before cleaning the mouth.

6. Place a clothing protector across the chest before providing mouth care.

7. Clean mouth, including the tongue and the surfaces of the teeth. Gently and thoroughly clean all surfaces of the mouth including gums, teeth, tongue, lips, roof, sides, base and back of mouth. Allow fluid to drain out of mouth.

8. Lubricate lips with product used in the facility such as petroleum jelly, cold cream or glycerin. If oxygen is in use, use a water-soluble lubricant or check with the nurse for an acceptable alternative.

9. Wipe mouth and remove the clothing protector.

10. Dispose of used linen into soiled linen container.

PROCEDURAL GUIDELINE #26 – HAIR CARE

A. Purpose: To maintain grooming, appearance and self-esteem.

B. Precaution

1. Do not share brushes/combs between residents to avoid cross-contamination.

C. Procedural Guidelines

1. BEGINNING STEPS

a. Gather needed supplies:

- (1) Clean comb and/or brush
- (2) Hair dressing (optional)

2. Position the resident upright in bed or chair as permitted.

3. Supervise and/or assist the resident to thoroughly brush and/or comb hair, following resident's preferences as possible.

- a. Have resident turn to comb or brush hair on back of head, beginning at ends and working toward scalp.
- b. Comb or brush hair on top and sides of head.
- c. If hair is tangled, part into sections and gently untangle with comb, beginning near ends and working toward scalp. Support hair between scalp and end of hair as you work.
- d. Apply hair dressing (optional).
- e. Arrange hair attractively following resident's preference. Avoid childish or inappropriate hairstyles.
- f. Long hair may be braided to prevent tangling if resident desires. Avoid tight braiding.

4. Encourage resident to examine results in mirror as appropriate.

PROCEDURAL GUIDELINE #27 – SHAMPOOING THE HAIR

A. Purpose: To clean the hair and scalp.

B. General Guidelines

1. Check care plan to determine the schedule for shampoos, type of shampoo/cleanser and/or beauty shop appointments.
2. Shampoos are generally given once or twice a week during tub or shower bath.
3. Most residents need some assistance with shampooing.

C. Procedural Guidelines

1. Follow Procedural Guideline #18 for Tub or Shower Bath, gathering shampoo and extra towel with other bath supplies.
2. Shampoo the hair at any time during the tub or shower bath as preferred by the resident or as appropriate.
3. If able, have the resident hold folded washcloth over eyes and tip head backward or lean forward during shampoo.
4. Wet hair and scalp with stream of comfortably warm water (about 105° F) directed close to scalp and away from face. Use shower spray or pitcher of water as available.
5. Apply selected shampoo and work up lather, massaging into scalp using tips of fingers--not fingernails.
6. Rinse hair thoroughly.
7. Towel dry hair and wrap head with dry towel if the resident desires.
8. Complete tub or shower bath as appropriate.
9. If allowed, dry hair with hair dryer following facility policy.
 - a. Never use hair dryers in damp areas.
 - b. Never place hair dryer in resident's lap.
 - c. Be sure dryer is on low setting.
 - d. Hold the dryer 8 to 10 inches from head.
 - e. Keep the dryer moving and direct airflow to hair--not scalp.
10. Assist with combing the hair following Procedural Guidelines #26--HairCare.
11. Wash hands.

PROCEDURAL GUIDELINE #28 – SHAVING THE RESIDENT

A. Purpose: To shave the resident and maintain appearance and self-esteem.

B. Precautions

1. Do not share razors between residents to avoid spreading infections.
2. Immediately discard used blades and disposable razors following facility policy to prevent bloodborne infections.
3. Do not use an electric shaver if oxygen is being used in room.

C. Procedural Guidelines

1. BEGINNING STEPS

a. Gather the following supplies if using an electric shaver:

- (1) Pre-shave and after-shave lotion (optional)
- (2) Towel

b. Gather the following supplies if using a safety or disposable razor:

- (1) Washcloth and towels
- (2) Basin of warm water
- (3) Shaving soap or cream
- (4) After-shave lotion (optional)
- (5) Clean, disposable examination gloves

2. Provide adequate lighting and assist the resident into a comfortable position in bed or chair as allowed.

3. Follow the resident's preferences as possible.

4. To shave a resident using an electric shaver:

- a. Follow the manufacturer's instructions for the safe use and care of the shaver. Most electric shavers should not be used with or immersed in water.
- b. Apply pre-shave lotion if desired.
- c. Place a towel over the resident's chest to protect clothing as appropriate.
- d. Turn shaver "on."
- e. Encourage resident to draw skin taut or pull skin taut with free hand.
- f. For shaver with flat or flexible head, generally use short up-and-down motion with the grain of the beard.
- g. For a shaver with a circular head, generally use small circular motions.
- h. Generally shave cheek areas first, around mouth and then the neck.
 - (1) Have resident tilt head back while shaving neck if able.
 - (2) Avoid shaving directly over a prominent Adam's apple by pulling skin to each side to shave the area.

5. To shave a resident using a safety or disposable razor:
 - a. Wash hands and put on gloves, as contact with blood is likely due to small cuts/nicks to skin.
 - b. Place a towel over the resident's chest to protect clothing.
 - c. Wet face with warm water to soften the beard.
 - d. Apply shaving soap or cream to bearded areas to be shaved.
 - e. Encourage the resident to make skin taut, or pull skin taut with free hand.
 - f. Generally shave in the direction the beard grows, using short and even downward strokes.
 - g. Follow step 4h above.
 - h. Rinse the razor in warm water as needed during use.
 - i. Remove excess shaving cream or soap as appropriate.
 - j. Rinse the razor in warm water as needed.
 - k. Discard used blade or disposable razor immediately following facility policy.
6. Apply after-shave if the resident desires.
7. Encourage the resident to examine the results in a mirror or by touch as appropriate.

PROCEDURAL GUIDELINE #29 – FINGERNAIL CARE

A. Purpose:

1. To clean and safely file fingernails if allowed by facility policy.

B. Precautions and Guidelines

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

C. Procedural Guidelines

1. BEGINNING STEPS

a. Gather needed supplies:

- (1) Nail file or emery board
 - (2) Orange stick or nail brush (optional)
 - (3) Basin of comfortably warm water (about 105°F)
 - (4) Towel, washcloth and soap if needed
2. Provide adequate lighting, and assist the resident into a comfortable position in chair or bed as appropriate.
 3. Explain the procedure, speaking clearly, slowly and directly, and maintaining face-to-face contact whenever possible.
 4. Before immersing fingernails, check water temperature for safety and comfort and ask the resident to verify comfort of water.
 5. Ensure basin is in a comfortable position for the resident.
 6. Put on clean gloves before cleaning fingernails.
 7. Immerse fingernails in the basin of water.
 8. Clean under each fingernail with orangewood stick.

9. Wipe orangewood stick on towel after each nail.
10. Dry fingernail area.
11. Feel each nail and file as needed.
12. Dispose of orangewood stick and emery board into waste container.
13. Empty, rinse and dry basin.
14. After rinsing basin, place basin in designated dirty supply area.
15. Dispose of used linen into soiled linen container.
16. After cleaning nails and equipment, and disposing of used linen, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
17. Ensure signaling device is within reach.

PROCEDURAL GUIDELINE #30 – FOOT CARE

A. Purpose:

1. To clean and groom feet.
2. To safely file toenails if allowed by facility policy.

B. Precautions and Guidelines

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

C. Procedural Guidelines

1. BEGINNING STEPS

a. Gather needed supplies:

- (1) Nail brush (optional)
- (2) Basin of comfortably warm water (about 105°F)
- (3) Towel, washcloth and soap if needed
- (4) Lotion

2. Provide adequate lighting, and assist the resident into a comfortable position in chair or bed as appropriate.
3. Explains the procedure, speaking clearly, slowly and directly, and maintaining face-to-face contact whenever possible.
4. Provide privacy with a curtain, screen or door.
5. Before washing check water temperature for safety and comfort and ask the resident to verify comfort of water.
6. Ensure basin is in a comfortable position for resident and on a protective barrier.
7. Put on clean gloves before washing foot.
8. Place resident's bare foot into the water (at least bottom of foot).
9. Apply soap to wet washcloth.

10. Lift foot from water and wash foot, including between the toes.
11. Rinse foot, including in between the toes.
12. Dry foot, including in between the toes.
13. Apply lotion to top and bottom of foot, removing excess (if any) with a towel.
14. Support foot and ankle during the procedure.
15. Empty, rinse and dry basin.
16. After rinsing basin, place basin in designated dirty supply area.
17. Dispose of used linen into soiled linen container.
18. After cleaning foot and equipment, and disposing of used linen, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
19. Ensure signaling device is within reach.

PROCEDURAL GUIDELINE #31 – DRESSING AND UNDESSING THE RESIDENT

A. Purpose: To maintain comfort, appearance, independence and self-esteem.

B. Procedural Guidelines

1. Encourage and/or assist the resident in selecting clothes as appropriate, or select clothes for the resident who is unable to participate in selecting.
2. Encourage residents to stand or sit to dress as able. Dependent residents are more easily dressed while in bed.
3. Supervise and/or assist the resident in dressing as needed, or dress the dependent resident.
4. For residents with weakness or paralysis:
 - a. Remove clothing from the strong side first.
 - b. Put clothing on the weak side first.
5. To put on garments that go over feet (pants, underwear):
 - a. Put one foot at a time into legs of pants, then pull up toward knees.
 - b. If resident can stand, assist resident to stand, pull clothing up over hips, then sit back down.
 - c. If resident is bedfast:
 - (1) Assist resident to raise hips and pull clothing up over hips.
 - (2) Or turn resident on side and pull clothing over hip on upper side. Then repeat for other side.
 - d. Close fasteners after shirt is tucked in.
6. To put on garments that go over arms or head (shirts, dresses):
 - a. To put arms into sleeves, put your hand through the sleeve from wrist to shoulder. Then grasp the resident's hand and guide resident's arm into sleeve.
 - b. For garments that open in the back: put one arm (affected, weak) in sleeve, smooth garment across chest and insert other arm.
 - c. For garments that open in front:
 - (1) Put one arm (affected, weak) in sleeve. Assist resident to lean forward, if able, and smooth back of garment across resident's back.
 - (2) Or assist resident to turn on side. Put sleeve on upper arm (affected, weak), then smooth garment across back.
 - (3) Put remaining arm (unaffected, strong) in other sleeve.
 - d. For pullovers, assist resident to put garment over arms (affected, weak first) and then gently overhead.
 - e. Close fasteners and tuck in shirt as appropriate.
7. Assist resident with undressing by reversing the steps above.
8. Assist resident with other dressing and grooming as needed.

PROCEDURAL GUIDELINE #32 – APPLYING KNEE HIGH ELASTIC (COMPRESSION) STOCKINGS

A. Purpose: To promote circulation and reduce the risk of Thrombus in the lower leg and promote blood flow to the heart while maintaining the comfort and safety of the resident. Indicated for residents with heart disease and circulatory disorders or on bed rest. Requires a physician order. Resident must be properly measured to order the appropriate stocking size.

B. Procedural Guideline:

1. Wash hands.
2. Gather supplies:
 - a. Properly fitted knee high elastic stockings
3. Explain the procedure to the resident.
4. Provide privacy for the resident (curtain or door).
5. Adjust bed to flat position. Resident should be lying supine in bed.
6. Locate the heel box of the stockings.
7. Turn the stockings inside out at least to the heel area.
8. Apply the stocking by placing the foot of the stocking over the toes, the foot, and the heel.
9. After applying the stocking over the foot and ensuring that the heel of the stocking is over the heel of the resident, gather the material of the stocking by placing thumbs inside of the stocking.
10. Spread the opening of the stocking as wide as is possible and gently ease up the ankle and the leg to the knee, moving the foot and leg gently and avoiding over- extension of the foot, leg and joints.
11. Smooth out any wrinkles or twists. **NEVER FOLD THE STOCKING OVER. THIS CREATES A BAND OF CONSTRICTION.**
12. Finish the procedure with the stocking over the lower leg to the knee and with no twists or wrinkles and the heel of the stocking over the heel of the resident and the opening in the toe area appropriately placed (either over the toe area or under the toe area depending on the make of the stocking).

UNIT VIII – ELIMINATION CARE PROCEDURAL GUIDELINE #33 – BEDPAN

A. Purpose: To assist with elimination when the resident is unable to get out of bed.

B. Beginning Steps

1. Wash hands. Wear gloves and follow Standard Precautions, if contact with blood or body fluids is likely.
2. Gather needed supplies:
 - a. Bedpan or fracture pan and cover
 - b. Tissue
 - c. Washcloth and towel
 - d. Soap and basin of comfortably warm water (about 105° F)

C. Assisting Resident with Bedpan:

1. Request assistance as needed.
2. Lower the head of the bed as tolerated and adjust the resident's clothing as appropriate.
3. Instruct the resident in using the bedpan. Ask the resident to raise his or her hips by bending knees and pushing with feet against mattress if able.
4. Slide the bedpan under the resident's hips, avoiding friction and trauma.
5. If the resident is unable to lift hips, turn the resident on his or her side, hold bedpan securely in place against buttocks and help the resident roll back onto bedpan.
6. Adjust the bedpan for comfort and position.
7. Raise side rails, if used, and elevate head of bed as upright as tolerated.
8. Leave the room while the resident uses the bedpan, if you can safely do so.
 - a. Place tissue and call signal in easy reach and raise side rails.
 - b. Give the resident a hand wipe and ask them to clean their hands when finished.
 - c. Give the resident the call signal and tell the resident to call when finished or if help is needed.
 - d. Leave the room and close the door for privacy. Wash hands.
 - e. Return to the room promptly when the resident calls, or check on the resident as appropriate, knocking on the door before entering.
9. Wash hands and put on gloves prior to contact with stool and/or urine.
10. Remove the bedpan when the resident is finished.
 - a. Lower the head of the bed, then lower the side rail as appropriate.
 - b. Provide perineal care if needed (Procedural Guideline #20 or #21 as appropriate).

D. Emptying bedpan.

1. Put on gloves for contact with urine or stool.
2. Measure and record urine if resident is on I and O.
3. Collect specimen if indicated.
4. Show unusual urine or stool to nurse, as a specimen may be needed.
5. Empty, rinse, clean and replace the bedpan following facility policy.

PROCEDURAL GUIDELINE #34 – URINAL

- A. Purpose: To assist with elimination when the resident is unable to get out of bed.
- B. Beginning Steps
1. Wash hands. Wear gloves and follow Standard Precautions if contact with blood or body fluids is likely.
 2. Gather needed supplies:
 - a. Urinal
 - b. Tissue
 - c. Washcloth and towel
 - d. Soap and basin of comfortably warm water (about 105° F)
- C. Assisting Resident with Urinal:
1. Instruct the resident in using the urinal.
 2. If the resident is able to stand, assist him to a standing position. If needed provide support to the resident while standing.
 3. If the resident is unable to stand, place the head of the bed as upright as tolerated.
 4. Give the urinal to the resident or, if needed, position and hold the urinal in place.
 5. Leave the room while the resident uses the urinal, if you can safely do so.
 - a. Place the call signal within easy reach.
 - b. Give the resident a hand wipe and ask them to clean hands when finished.
 - c. Tell the resident to call when finished or if help is needed.
 - d. Leave the room and close the door for privacy. Wash hands.
 - e. Return to room promptly when the resident calls, or check on the resident as appropriate, knocking on the door before entering.
 6. Wash hands and put on gloves prior to contact with urine.
 7. Remove the urinal when the resident is finished.
 - a. Assist the resident back to bed if standing.
 - b. Provide perineal care if needed (Procedural Guideline #20 or #21).
- D. Emptying urinal
1. Put on gloves for contact with urine.
 2. Measure and record urine if resident is on I and O.
 3. Collect specimen if indicated.
 4. Show unusual urine to nurse, as a specimen may be needed.

5. Empty, rinse, clean and replace the urinal following facility policy.

PROCEDURAL GUIDELINE #35 – INDWELLING URINARY CATHETER CARE

A. Purpose

1. To maintain the indwelling urinary drainage system.
2. To help avoid urinary tract infections.

B. Guidelines for Maintaining the Urinary Drainage System

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline#7) if contact with blood or body fluids is likely.
2. Check that the catheter remains secured with tape or leg strap following facility policy, to reduce friction and movement at the insertion site.
3. Check that the catheter is positioned over (not under) the leg.
4. Check that there is no disconnection or leaking of urine from the system (except into the drainage bag).
5. Check that urine is draining freely through the system.
6. Keep the catheter and drainage tubing free of kinks or obstructions.
7. Keep the urine-collecting bag below the level of the bladder at all times to prevent backflow of old urine into the bladder. Maintain position of urine-collecting bag according to manufacture guidelines.
8. Keep the drainage tubing and bag off the floor at all times to prevent contamination and damage.
9. Never disconnect the catheter drainage system.
10. When the resident is in bed, attach the collection bag to the bed frame--never to the side-rail.

C. Procedure for Emptying the Urinary Drainage Bag

1. The catheter drainage bag is emptied at least every 8 hours or more often as needed to keep the bag from becoming full.
2. Empty one urinary drainage bag at a time using a clean and separate graduate for each resident, washing hands and changing gloves between residents.
3. Remember to knock on the door, introduce yourself, greet the resident, identify the resident, explain the procedure and provide privacy.
4. Obtain a clean graduate container. Use a separate container for each individual resident to prevent cross contamination. The graduate container may be labeled with the resident's name

to reserve it for a single resident.

5. Wash hands and put on gloves prior to contact with urine.
6. Position the graduate to collect the urine.
7. Open the clamp on the drain located at the bottom of the drainage bag.
8. Empty the urine into the graduate touching only the clamp and using aseptic technique.
 - a. Note that the drain spout should not come in contact with the collecting graduate, hands or other objects.
 - b. If accidental contamination occurs, wipe drain spout with antiseptic wipe.
9. Close the clamp.
10. Measure output at eye level and on a flat surface and discard urine following facility policy.
11. Clean the container and store for use for the same resident following facility policy.
12. Remove and discard gloves following facility policy promptly after use to avoid environmental contamination. Wash hands.
13. Record urinary output.

D. Observe for and Report to Nurse:

1. Catheters that are not secured with tape or straps.
2. Kinks in tubing that cannot be corrected by simple repositioning.
3. Accidental disconnection of tubing.
4. Leaking of urine from tubing.
5. No evidence of drainage of urine through tubing.
6. Amount of urine output at time of emptying drainage bag.
7. Appearance of urine such as dark, red, cloudy. Presence of unusual substances such as solid particles, blood, odor.
8. Problems at catheter-meatal junction such as redness, irritation, swelling, crusting, drainage, bleeding, pain.
9. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain.

10. Other significant observations.

PROCEDURAL GUIDELINE #36 – URINE SPECIMEN COLLECTION

A. Purpose: To collect a routine or clean-catch urine specimen for testing.

B. Beginning Steps

1. Gather needed supplies:
 - a. Clean bedpan, urinal, commode or specimen pan
 - b. Appropriate urine specimen container with lid and transport bag if used
 - c. Label--filled out following facility policy
 - d. Laboratory request form--to be completed by nurse
 - e. Clean, disposable examination gloves
 - f. For clean-catch specimen: clean-catch kit or follow facility policy
2. Explain the procedure and encourage the resident's participation as appropriate.
 - a. Explain that a urine specimen is needed. Offer a glass of water if allowed.
 - b. Ask the resident to notify you when ready to urinate.

C. To Collect Routine Urine Specimen:

1. If perineum is heavily soiled, wear gloves and give perineal care (Procedural Guideline #20 or #21 as appropriate).
2. Wash hands and put on gloves prior to contact with urine.
3. When the resident is able to urinate, assist with toileting as appropriate. Remind the resident not to put tissue or to have a bowel movement in specimen.
4. Assist the resident to clean and dry his/her perineum.
5. Pour approximately 60cc of urine into the specimen container without contaminating the outside of the container.
6. If urine is accidentally spilled on the outside of the container, wipe the outside of the container clean with a disinfectant wipe.
7. Measure urine volume if resident is on I & O.
8. Empty, clean and replace the bedpan or urinal following facility policy.
9. Remove gloves and wash hands after contact with urine.
10. Record urine output on I and O.
11. Place lid securely on container, attach label, and place in transport bag if used.
12. Take the specimen promptly to nurse or follow facility policy.

PROCEDURAL GUIDELINE #37 – STOOL SPECIMEN COLLECTION

A. Purpose: To collect a routine stool specimen for testing.

B. BEGINNING STEPS

1. Gather needed supplies:
 - a. Clean bedpan, commode or specimen pan
 - b. Appropriate stool specimen container with lid and transport bag if used
 - c. Tongue blade
 - d. Label--filled out following facility policy
 - e. Laboratory request form--to be completed by nurse
 - f. Clean, disposable examination gloves
2. Explain the procedure and encourage the resident's participation as appropriate.
 - (1) Explain that a stool specimen is needed.
 - (2) Ask the resident to notify you when ready to have a bowel movement, or make other arrangements as appropriate.
3. Wash hands and put on gloves prior to contact with stool.
4. When the resident is ready to have a bowel movement, assist with toileting as appropriate.
5. When finished, assist the resident to clean and dry the rectal area and buttocks.
6. Using tongue blade, place requested amount of feces (usually about 2 tablespoons) into specimen container without contaminating outside of container.
7. If outside of container is accidentally contaminated with feces, wipe clean with disinfectant wipe.
8. Empty, clean and replace the bedpan following facility policy.
9. Remove gloves and wash hands.
10. Place lid securely on container, attach label and place in transport bag.
11. Take the specimen promptly to the nurse or follow facility policy.
12. Closing steps
 - a. Clean and store reusable items and discard disposables per facility policy.
 - b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
 - c. Provide for the resident's comfort and safety before leaving as appropriate such as straightening clothing/bedding, adjusting bed/side rails.
 - d. Always replace the call signal and needed items within the resident's reach.
 - e. Inform the resident when finished and ask if anything is needed before you go.

13. Observe for and report to the nurse:
 - a. Problems or complaints related to the procedure.
 - b. Time and type of specimen collected.
 - c. Amount and appearance of stool. Presence of unusual substances such as blood or mucus.
 - d. Bowel complaints such as pain, constipation, diarrhea, bleeding.
 - e. Other significant observations.

UNIT IX – CARING FOR RESIDENT DEATH

PROCEDURAL GUIDELINES #38 – POSTMORTEM CARE

A. Purpose

1. To prepare the body for viewing by family and/or friends.
2. To prepare the body for transfer to the mortuary.

B. General Guidelines and Precautions

1. Postmortem care is done after the resident is pronounced dead.
2. Handle the body gently to avoid bruising.
3. Respect the right to privacy and dignity after death, as well as during life.
4. Respect religious beliefs of deceased, such as Catholics who may have last rites after death.

C. Procedural Guidelines

1. Identify the resident following facility policy.
2. Assist the roommate to leave the room temporarily.
3. Provide privacy for the family until the body has been prepared for viewing.
4. Gather needed supplies:
 - a. Bath supplies
 - b. Linen
 - c. Shroud if indicated by facility policy
 - d. Bag for personal belongings
 - e. Waste receptacle
 - f. Clean, disposable examination gloves
5. Place a pillow under the head and shoulders.
6. Close the eyelids by gently pulling lashes downward.
7. Follow facility policy for dentures. Either place in mouth or place in labeled denture cup to be sent to mortuary.
8. Close the mouth.
9. The nurse will generally remove tubes, replace dressing and inventory valuables at this time.
10. Bathe soiled areas of body with water and comb hair if needed.

11. Place a pad at perineum or a bed protector under buttocks.
12. If body will be viewed by family or friends:
 - a. Apply a clean gown and clean bed linen, if necessary.
 - b. Reposition the body in good alignment and cover the body to the shoulders.
 - c. Arrange the room neatly.
 - d. Provide privacy, support and physical presence for family/friends as appropriate.
13. Identify and assemble the resident's personal belongings and eyeglasses and place in labeled bags for the family. Notify the nurse if you find valuables or jewelry.

UNIT X – BASIC RESTORATION SERVICES

PROCEDURAL GUIDELINE #39 – ASSISTING RESIDENT TO TRANSFER TO CHAIR OR WHEELCHAIR

- A. Purpose: To transfer resident to chair or wheelchair without trauma or avoidable pain.
- B. Guidelines and Precautions for Moving and Lifting Residents
1. Know the abilities and limitations of the resident to participate in moving.
 2. Request special instruction from nurse as needed prior to the move.
 3. Request assistance as needed prior to the move and use good body mechanics.
 4. Encourage and assist the resident to move as independently as possible.
 5. Use assistive moving mechanical devices as indicated following facility policy and manufacturing guidelines.
- C. Procedural Guideline
1. Put the bed in the lowest position, lock the wheels of the bed and raise the head of the bed.
 2. Place the chair or wheelchair parallel to the bed or at a 45° angle, position a sturdy chair so that the resident's strongest leg moves towards the chair.
 3. Lock the brakes on wheelchair.
 4. Remove footrests whenever possible, or fold or raise footrests out of the way.
 5. Assist resident to wear non-skid footwear.
- D. Assisting Resident to Transfer to Chair or Wheelchair using Transfer Belt
1. Assist the resident to sit up on the side of the bed (Procedural Guideline #44). Allow the resident to adjust to the sitting position before standing.
 2. Show the resident the transfer belt and explain its use as a safety device.
 3. Apply the transfer belt over the resident's clothing around the waist and check the fit by inserting your fingers under it.
 4. Stand in front of the resident with your knees bent, feet apart and back straight.
 5. Grasp the transfer belt with an under-hand grip and move the resident forward so his or her feet are flat on the floor.

6. Lean forward and instruct the resident to place his or her hands on your shoulders. Do not let the resident put his or her arms around your neck.
7. Place your hands on either side of the transfer belt, and on prearranged signal, gradually assist the resident up into a standing position, supporting the knees and feet with your legs and feet as appropriate.
8. Assist the resident to move until the back of his/her legs are touching the seat of the chair. Move your feet and turn your body instead of twisting.
9. Ask the resident to place his or her hands on the arms of chair and support his/her self, if able.
10. Bend your knees as you assist the resident to safely lower him/herself into the chair.
11. Remove the transfer belt from the resident's waist.
12. Place the foot rest in proper position. Place the resident's feet on the foot rest and release wheelchair locks if applicable.
13. Assure that the head and spine are erect.
14. Place arms on armrests.
15. Place pillows or pads as needed to maintain position.
16. Assure that hips are all the way back in the chair.
17. Assure the upper and lower leg form a 90° angle.
18. Support feet on floor or, if used, on footrest of wheelchair. Do not let feet dangle.

E. Two Person Transfer with a Draw Sheet

To be utilized when transferring residents who are non-weight bearing.

1. One person stands at the head of the bed, the other at the area of the knees.
2. Using a draw sheet, move the resident to edge of the bed.
3. Position the wheelchair/geri-chair/recliner/stretcher parallel to the bed.
4. The person at the head should place the knee closest to the head of the bed onto the bed so that the resident can be brought into a semi-reclined position and the draw sheet can be grasped on the sides in the area of the trunk (if possible, have the resident place his/her

hands across his/her chest).

5. The person at the knees should grasp the draw sheet on the sides in the area of the mid-thighs.
6. On command, the resident is lifted up and over onto the transfer surface.
7. Reposition the resident using the draw sheet as needed.

PROCEDURAL GUIDELINE #40 – AMBULATION AND AMBULATION AIDS

A. Purpose: To assist the resident to ambulate as independently as possible, without falls, trauma or avoidable pain.

B. Guidelines and Precautions

1. Know the abilities and limitations of the resident to ambulate.
2. Request special instruction from the nurse as needed prior to ambulation.
3. Request assistance as needed prior to ambulation and use good body mechanics.
4. Encourage and assist the resident to ambulate as independently as possible.
5. Use assistive ambulation devices as indicated following facility policy.
6. Encourage the ambulating resident to:
 - a. Walk the required time or distance.
 - b. Rest as needed.
 - c. Support self with guardrails as needed, if not using cane or walker.
 - d. Stand with back straight and head up.
 - e. Walk normally with the heel of the foot touching the floor first.

C. Procedural Guidelines

1. Provide safety as appropriate such correct body mechanics.
 - a. Put bed in lowest position and lock wheels of bed.
 - b. Assist the resident into safe and appropriate clothes and non-skid foot wear.
 - c. Assist the resident to sit up on the side of the bed and adjust to the upright position (Procedural Guideline #44).
2. To Ambulate Resident Using Transfer Belt (Note this is the preferred method):
 - a. Apply transfer belt over the resident's clothing, around the waist and check fit by inserting two fingers under gate belt to make sure it's secure.
 - b. Stand in front of resident with your knees bent, feet apart and back straight.
 - c. Move resident forward so feet are flat on floor or touching the floor by grasping the belt with an underhand grip.
 - d. Lean forward and Instruct resident to place his/her hands on your shoulders. Do not let resident put his/her arms around your neck.
 - e. Place your hands on either side of the transfer belt, and on signal, gradually assist the resident up into a standing position, supporting the knees and feet with your legs and feet as appropriate.
 - f. Hold the transfer belt firmly at the resident's back and stand on the resident's weak side if applicable.
 - g. Allow the resident to stand until ready to ambulate.
 - h. Ambulate resident, walking slightly behind and to one side of the resident and supporting the resident with the transfer belt.

3. To Ambulate Resident Using a Walker (see #2 above to ambulate using a gate belt)
 - a. Place the walker close to the resident.
 - b. Assist the resident to hold hand grips and move inside the walker.
 - c. Instruct the resident to:
 - (1) Lift and move the walker about six inches ahead of his/her body.
 - (2) Walk forward into walker while leaning on walker for support.
 - (3) Repeat step (1) and (2) to ambulate.
 - d. Ambulate the resident, walking slightly behind and to one side, and supporting the resident with a transfer belt as needed.
 - e. Assist the resident into a chair or bed, as indicated, after ambulation. Remove the transfer belt.

4. To Ambulate Resident Using a Cane (see #2 above-to ambulate using a gate belt)
 - a. Instruct the resident to:
 - (1) Hold the cane on the strongest side of the body.
 - (2) Place the cane about 8 inches to the side of foot.
 - (3) Move the cane about twelve inches ahead of the body.
 - (4) Move the weakest leg forward to the cane.
 - (5) Move the strong leg forward to slightly beyond the cane.
 - (6) Repeat steps (1) through (5) to ambulate.
 - b. Ambulate the resident, walking slightly behind and to one side and supporting the resident with the transfer belt as needed.
 - c. Assist the resident into a chair or bed, as indicated, after ambulation. Remove the transfer belt.

PROCEDURAL GUIDELINE #41 – PASSIVE RANGE OF MOTION (PROM) EXERCISES

A. Purpose: To maintain the function of joints and muscles without trauma or pain.

B. Precautions and Rules for PROM

1. PROM exercises must be completed according to the care plan and instructions from the nurse.
2. Perform each exercise 3 times or following facility policy or directions of the nurse.
3. Move each joint gently, smoothly and slowly through its PROM to the point of resistance. Do not force a joint to move beyond its free PROM.
4. Stop any PROM exercise immediately if pain occurs. Notify nurse immediately if pain is sharp or unexpected.

C. Procedural Guidelines

Perform Passive Range of Motion (PROM) For One Shoulder

1. Explain the procedure, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.
2. Provide privacy with a curtain, screen or door.
3. Instruct the resident to inform you if pain is experienced during the exercise.
4. Support the resident's arm at the elbow and wrist while performing range of motion for the shoulder.
5. Raise the resident's straightened arm from side position upward toward head to ear level and returns arm down to side of body (extension/flexion)(AT LEAST 3 TIMES unless pain is verbalized).
6. Move the resident's straightened arm away from the side of the body to shoulder level and return to the side of the body (abduction/adduction) (AT LEAST 3 TIMES unless pain is verbalized).
7. While supporting the limb, move the joint gently, slowly and smoothly through the range of motion, discontinuing exercise if the resident verbalizes pain.
8. Place signaling device within reach and bed in low position.
9. Wash hands.

Perform Passive Range of Motion (PROM) For One Knee and One Ankle

1. Explain the procedure, speaking clearly, slowly, and directly, and maintaining face- to- face contact whenever possible.
2. Place privacy with a curtain, screen or door.
3. Instruct the resident to inform you if pain is experienced during exercise.
4. Support the leg at the knee and ankle while performing range of motion for the knee.
5. Bend the knee and then return the leg to the resident's normal position (extension/flexion) (AT LEAST 3 TIMES unless pain is verbalized).
6. Support the foot and ankle close to the bed while performing range of motion for the ankle.
7. Push/pull foot toward the head (dorsiflexion) and push/pull foot down, toes pointed down (plantar flexion) (AT LEAST 3 TIMES unless pain is verbalized).
8. While supporting the limb, move the joint gently, slowly and smoothly through the range of motion, discontinuing the exercise if the resident verbalizes pain.
9. Place signaling device within reach and bed in low position.
10. Wash hands.

UNIT XI – PREVENTION OF PRESSURE ULCERS

PROCEDURAL GUIDELINE #42 – POSITIONING RESIDENTS

A. Purpose: To maintain body alignment and comfort and to avoid contractures and skin break down.

B. Guidelines

1. Know the abilities and limitations of the resident to participate in moving.
2. Properly position resident after moving or lifting.
3. Request special instruction from the nurse as needed prior to the move.
4. Request assistance as needed prior to the move and use correct body mechanics.
5. Use assistive moving devices as indicated following facility policy.
6. Encourage and assist the resident to move as independently as possible.
7. Use a lift sheet when possible to avoid skin trauma.
8. After positioning, always check that the resident has body alignment with spine straight and with head, arms, hands, legs, feet and lower back supported.
9. Confirm with the resident that he or she is comfortable.

C. Procedural Guidelines

1. Sitting position. It is helpful in relieving respiratory distress, preventing aspiration and promoting activities such as eating and reading in bed. This position increases pressure on buttocks and coccyx and should not be used for more than 2 hours.
 - a. Position the resident on his or her back in the center of the bed and move the resident up in bed if needed (Procedural Guideline #44).
 - b. Elevate the head of the bed to the desired angle (usually 45° or 30°) but may be higher or lower.
 - (1) For Semi-Fowlers--head of the bed is usually elevated to a 45° angle.
 - (2) For Low Fowlers--head of the bed is usually elevated to a 30° angle.
 - c. Reposition pillow under head and shoulder.
 - d. Slightly elevate foot of bed to prevent sliding down in bed if allowed.
 - e. Position the resident so that both legs are slightly bent, with the top leg a little behind the bottom leg and supported by a pillow.
 - f. Position the resident's upper arm in a position of comfort with the wrist resting on the abdomen or pillow.

2. Supine position is lying flat on back. It is often preferred for sleeping.
 - a. Place bed in flat position and remove pillow if tolerated.
 - b. Position the resident on his or her back in the center of the bed and move the resident up in bed if needed (Procedural Guideline #44).
 - c. Replace pillow under head and shoulders.
 - d. Place pillows under the resident's arms with hand slightly elevated as indicated.
 - e. Use positioning devices under hands to support them in good alignment as indicated.
 - f. Use positioning devices against outer thighs to keep legs straight and toes pointed upward.
 - g. Use other positioning methods and devices as indicated to maintain full body alignment.

3. Tilt position is a variation of the supine position. It is not a lateral (side-lying) position but rather a tilt. The benefits are reduced pressure on sacrum, coccyx and buttocks without added pressure to hip.
 - a. Turn the resident on his/her side toward you (Procedural Guideline #43).
 - b. Place a pillow behind the resident's back. Push the resident slightly back against the pillow to support the back and relieve pressure on the arm or shoulder.
 - c. Place another pillow under the resident's top leg, level with the hip joint.
 - d. Position the resident so that both legs are slightly bent, with the top leg a little behind the bottom leg and supported by a pillow.
 - e. Position the resident's upper arm in a position of comfort with the wrist resting on the abdomen or pillow.

4. Prone position is lying on the abdomen. The benefit of this position is that it eliminates all pressure on the back. This position is uncomfortable for many residents and may cause respiratory distress. Do not put a resident into the prone position unless instructed to do so by the nurse.

5. Semi-Prone position is the reverse of Tilt position. It is a comfortable position that reduces pressure and contractures.

6. Lateral position is lying on either side. There are many variations of the lateral position. It is a comfortable position, which relieves pressure on the sacrum, coccyx and buttocks.
 - a. Adjust bed flat, remove pillow, turn the resident on his/her side toward you (Procedural Guideline #43), and replace pillow under head.
 - b. Raise side rail and go to other side of the bed and lower side rail.(if applicable)
 - c. Use turn sheet to pull resident toward the center of the bed. Position resident to make sure they are not lying directly on shoulder.
 - d. Place a pillow against back and push slightly under back to form a roll and maintain correct body alignment.
 - e. Position upper leg slightly in front of lower leg and place a pillow between knees and ankles for support.
 - f. Support hand and arm on pillow if indicated.

PROCEDURAL GUIDELINE #43 – TURNING RESIDENT ON SIDE TOWARD YOU

- A. Purpose: To turn the resident on his/her side without trauma or avoidable pain.
- B. Guidelines and Precautions for Repositioning Residents
1. Know the abilities and limitations of the resident to participate in moving.
 2. Properly position the resident after moving or lifting.
 3. Request special instruction from the nurse as needed prior to the move.
 4. Request assistance as needed prior to the move and use correct body mechanics.
 5. Use assistive moving devices as indicated following facility policy.
 6. Encourage and assist the resident to move as independently as possible.
 7. Use a lift sheet when possible to avoid skin trauma.
 8. After positioning, always check that the resident has body alignment with spine straight and with head, arms, hands, legs, feet and lower back supported.
 9. Confirm with the resident that he or she is comfortable.
- C. Assisting Resident to Turn on Side Toward You (One person partial assist)
1. Move the resident to the far side of the bed as needed to allow enough space for the turn (Procedural Guideline #44).
 2. Cross the resident's far leg over the near leg and cross the resident's arms over chest as able.
 3. Instruct the resident to grasp the side-rail if able.
 4. Stand on the side of the bed midway between the resident's head and shoulders, with your feet separated and knees bent.
 5. Place one hand behind the resident's shoulder and the other hand behind the resident's hip.
 6. Gently roll the resident toward you.
 7. Position the resident as indicated following Procedural Guideline #42.
- D. Turning Resident on Side Toward You With Assistant and Lift Sheet (Two person total assist)
1. Request assistance, give directions and coordinate the move with your assistant.

2. Assure that a lift sheet/pad is in place under the resident from neck to knees.
3. Stand on one side of the bed with your assistant standing on the opposite side.
4. Lower the side rails on both sides.
5. Use the lift sheet to move the resident to the far side of bed as needed to allow enough space for the turn (Procedural Guideline #44).
6. Cross the resident's far leg over the near leg and cross the resident's arms over the chest as able.
7. Stand on the side of bed midway between the resident's head and shoulders with your feet separated and knees bent.
8. Your assistant rolls the lift sheet/pad close to resident's body and grasps the lift sheet at the resident's shoulders and hip.
9. On a prearranged signal, your assistant uses the lift sheet to roll the resident onto the side toward you, and assist the turn with your hands on the resident.
10. Raise the side rail and position the resident as indicated (Procedural Guideline #42).

PROCEDURAL GUIDELINE #44 – MOVING RESIDENT IN BED

A. Purpose: To move the resident in bed without trauma or avoidable pain.

B. Guidelines and Precautions for Moving and Lifting Residents

1. Know the abilities and limitations of the resident to participate in moving.
2. Properly position the resident after moving or lifting.
3. Request special instruction from the nurse as needed prior to the move.
4. Request assistance as needed prior to the move and use correct body mechanics.
5. Use assistive moving devices as indicated following facility policy.
6. Encourage and assist the resident to move as independently as possible.
7. Use a lift sheet when possible to avoid skin trauma.
8. After positioning, always check that the resident has body alignment with spine straight and with head, arms, hands, legs, feet and lower back supported.
9. Confirm with the resident that he or she is comfortable.

C. Moving Resident to Head or Side of Bed with Assistant and Lift Sheet.

1. Request assistance and give direction and coordinate the move with your assistant.
2. Assure that a lift sheet/pad is in place under the resident from neck to knees.
3. Stand on one side of the bed with your assistant standing on the opposite side.
4. Lower the side rails on both sides, if applicable.
5. Use correct body mechanics, with feet separated, knees flexed and one foot forward.
6. Cross the resident's arms over his or her chest.
7. If moving the resident to the head of the bed, remove the pillow and place it against the headboard to protect the head.
8. If moving the resident to the side of the bed, determine the direction of the move and clarify the direction with the assistant.
9. Roll the lift sheet/pad close to the resident on each side.
10. Grasp the lift sheet/pad at thighs and shoulders on each side.

11. On signal, lift the resident high enough to clear the bed and move the resident to the desired position in bed.
12. Repeat, if needed, to reach desired position.
13. Replace the pillow and position resident as indicated (Procedural Guideline #42).

PROCEDURAL GUIDELINE #45 – ASSISTING RESIDENT TO SIT UP ON SIDE OF BED

A. Purpose: To assist the resident to sit up on the side of the bed without trauma or avoidable pain.

B. Guidelines and Precautions for Moving and Lifting Residents

1. Know the abilities and limitations of the resident to participate in moving.
2. Request special instruction from the nurse as needed prior to the move.
3. Request assistance as needed prior to the move and use good body mechanics.
4. Encourage and assist the resident to move as independently as possible.
5. Use assistive moving devices as indicated following facility policy.

C. Procedural Guidelines

1. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
 - (a) Lock the wheels of the bed and raise the head of bed as upright as tolerated. Lower the bed in order for the resident's feet to be placed flat on the floor.
2. Move the resident close to the side of the bed with his or her feet off the edge of the mattress.
3. Face the head of the bed and lean toward the resident with your feet separated and one foot ahead of the other.
4. Put your arm under the resident's arm and around the resident's shoulders. Place your other arm under the resident's knees.
5. On a prearranged signal, turn the resident about a quarter of a turn and allow the legs to go over the side of the bed, as the trunk becomes upright.
6. Instruct the resident to support self with hands against the mattress if able.
7. Position resident so that his or her feet are flat on floor.
8. Stay with resident and provide support as needed, allowing the resident to adjust to the upright position.
 - a. If the resident feels faint or dizzy, assist the resident to lie back in bed and the notify nurse.

The NNAAP® Skills List for 2018 is a list of skills that a nurse aide candidate may be asked to demonstrate during the Skills Evaluation. Within each skill is a list of the steps that should be performed in order to demonstrate that skill.

Many skills have steps highlighted in bold type—these are Critical Elements. If a nurse aide candidate leaves out a Critical Element or does not perform a Critical Element properly, the candidate will not pass the skill. Also, a candidate who performs only the Critical Element Step correctly in a skill does not automatically pass that skill. A predetermined number of steps must be correctly demonstrated to meet the passing standard (or cut score) for each skill.

SKILL 1 - HAND HYGIENE (HAND WASHING)

- 1 Address client by name and introduces self to client by name
- 2 Turns on water at sink
- 3 Wets hands and wrists thoroughly
- 4 Applies soap to hands
- 5 Rubs all surfaces of wrists, hands, and fingers producing friction, for at least 20 (twenty) seconds, keeping hands lower than the elbows and the fingertips down
- 6 Cleans fingernails by rubbing fingertips against palms of the opposite hand
- 7 Rinse all surfaces of wrists, hands, and fingers, keeping hands lower than the elbows and the fingertips down
- 8 Uses clean, dry paper towels to dry all surfaces of fingers, hands, and wrists staining at fingertips then disposes of paper towels into waste container
- 9 Uses clean, dry paper towels to turn off faucet then disposes of paper towel/towels into waste container or uses kick/foot control to turn off faucet
- 10 Does not touch inside of sink at anytime

SKILL 2 - APPLIES ONE KNEE-HIGH ELASTIC STOCKING

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Client is in supine position (lying down in bed) while stocking is applied
- 4 Turns stocking inside-out, at least to the heel
- 5 Places foot of stocking over toes, foot, and heel
- 6 Pulls top of stocking over foot, heel, and leg
- 7 Moves foot and leg gently and naturally, avoiding force and overextension of bones and joints
- 8 Finishes procedure with no rashes or wrinkles and the heel of foot, if present, is over heel and opening into area (if present) is either over or under toe area; if wearing a mannequin, candidate may state stocking needs to be wrinkle-free
- 9 Signaling device is within reach and bed is in low position
- 10 After completing skill, wash hands

SKILL 3 - ASSISTS TO AMBULATE USING TRANSFER BELT

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before assisting to stand, client is wearing non-slip shoes/footwear
- 4 Before assisting to stand, bed is at a safe level
- 5 Before assisting to stand, checks and/or locks wheels
- 6 Before assisting to stand, client is assisted to sitting position with feet flat on the floor
- 7 Before assisting to stand, applies transfer belt securely at the waist over clothing/gown
- 8 Before assisting to stand, provides instructions to client to assist in standing including prearranged signal to alert client to begin standing
- 9 Stands facing client positioning self to ensure safety of client and client during transfer. Counts to three (or says other prearranged signal) to alert client to begin standing
- 10 On signal, gradually assists client to stand by grasping transfer belt on both sides with an underhand grasp (candidate's hands are in upward position), and maintaining stability of client's legs by standing in line with client
- 11 Walks directly behind and to one side of client for a distance of ten (10) feet, while holding onto the belt
- 12 Assists client to bed and removes transfer belt
- 13 Signaling device is within reach and bed is in low position
- 14 After completing skill, wash hands

SKILL 4 - ASSISTS WITH USE OF BEDPAN

- 1 Explains procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before placing bedpan, lowers head of bed
- 4 Places bedpan in toilet before placing bedpan under client
- 5 Places bedpan correctly under client's buttocks

- 6 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
- 7 After positioning client on bedpan and removing gloves, raises head of bed
- 8 Toilet tissue is within reach
- 9 Hand wipe is within reach and client is instructed to dehydrate hands with hand wipe when finished
- 10 Signaling device within reach and client is asked to signal when finished
- 11 Places bedpan in designated dirty supply area
- 12 Head of bed is lowered before bedpan is removed
- 13 Ensures client is covered except when urinating and removing bedpan
- 14 Empties and rinses bedpan and pours rinse into toilet
- 15 Places bedpan in designated dirty supply area
- 16 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
- 17 Signaling device is within reach and bed is in low position

SKILL 5 - CLEANS UPPER OR LOWER DENTURE

- 1 Places denture in designated container
- 2 Bottom of sink is lined and for sink is partially filled with water before denture is held over sink
- 3 Rinses denture in moderate temperature running water before brushing them
- 4 Applies denture toothpaste to toothbrush
- 5 Brushes all surfaces of denture
- 6 Rinses all surfaces of denture under moderate temperature running water
- 7 Rinses denture cup and lid
- 8 Places denture in denture cup with moderate temperature water/solution and pincers on cup
- 9 Rinses toothbrush and places in designated toothbrush basin/container
- 10 Maintains denture technique with placement of toothbrush and denture
- 11 Sink liner is removed and disposed of properly and/or sink is drained
- 12 Removes and disposes of gloves (without contaminating self) into waste container and washes hands

SKILL 6 - COUTRRS AND RECORDS RADIAL PULSE

- 1 Explains procedure, speaking d early, slowly, and dirctly, maintaining fu.cc-to-fxe co ntactwhene\er possible
- 2 Places fingertips on thumb side of ic-nt's wrist to locate radial pulse
- 3 Count belts forone full minute
- 4 Signaljng device is within reach
- 5 Befure recording, washes hands
- 6 Records pulse rate within plusor min us 4 beats of evaluator's reading

SKILL 7 - COUTRRS AND RECORDS RESPIRATIONS

- 1 Explains procedure (for testing purposes), spciking clearly, slowly, and dircedy, nu incaining face-to-face contact whenever possible
- 2 Counts respir-.16o n.s foro ne full minute
- 3 Signaljng device is within reach
- 4 Befure recording, washes hands
- 5 Records respiration rate within plu.s or m in us 2 breaths of evaluator's reading

SKILL 8 - DONNING AND REMOVING PPE (GOWN AND GLOVES)

- 1 Picks up gown and unfo lds
- 2 F.tcing the back opening of the gown pl:accs arms through cxh sleeve
- 3 F.tstns the neck opening
- 4 &c ures gown at waist making sure dm back of clothing is covered by gown (as much as possible)
- 5 Putson glo\cs
- 6 Cuffs of glo\cs o\crlap cuffs of gown
- 7 Befure removing gown, with oneglo,-ed hand, grasps the other glove at the palm, remove glove
- 8 S(jps fingers from u.nglo,-ed band underneath cuff of remaining glo,-eat ""-rist, and removes glo,-etu.ming it ins-jde out as it is removed
- 9 Disposcs of glo,-cs into desigm:cd waste container without contaminating sdf
- 10 After removing glo,-cs, unfustens gown at waist and neck
- 11 After removing glo,-cs, removes gown without touching outside of gown
- 12 While removing gown, holdsgown away from body without touching the Boor, rums gown inward and keeps it inside ut
- 13 D isposcs of gown in designated container without contaminating self

14 After completing skn , washes hands

SKILL 9 - DRESSES CLIENT WITH AFFECTED (WEAK) RIGHT ARM

- 1 Explains procedure, speaking d early, slowly, and dirctly, maintaining fu.cc-to-fxe co ntact whene,-er possible
- 2 Privacy is p rovided with a curtain, screen, or doo r
- 3 Asks which shrt he/she would like to we.u and dresseshim/ her in shin of choice
- 4 Avoidso,er exposure of client by ensuring d ient's chest is covered

- 5 Refflo\es gown from the ldt (un:affected) side first, then remo:cs gown &om the right (affected d weak) side
- 6 Ekforced ressing client. disposcs of gown into soiled linen container
- 7 Assists to put the rjght (affected/wea.L): arm through the right slen-eof of the shin. before placing garment on left (unaffected) arm
- 8 While putting on shirt, mo,-cs body gendy and natu.tlly, avoiding force and over-extension of f jms and joints
- 9 Finishes with clothing in plac
- 10 Signaling elev-ice is within reach and bed is in low position
- 11 After completing skill, washes hands

SKILL 10 - FEEDS CLIENT WHO CANNOT FEED SELF

- 1 Explains procedure to client, speaking d early, slowly, and directly, main taining f:ace-co-fuceco ntaa whene,-er possible
- 2 Ekfor fC't'ding, looks at name card on tray and asks client to state name
- 3 Before fet.ding client, client is in an uprights-j-tting position (75-90 de grees)
- 4 Pbcstray where the fuod can be C1 Sily seen by client
- 5 Candidate ans client >sh a nds before

- beginning fC't'ding
- 6 Candidate sits in a chair facing d ient during fC't' di ng
- 7 Tells client what foods and beverage ar on ""Y
- 8 Asks client what he/shewould Bkc- toe.nf m
- 9 Usingspoon, offers d ient one bite of each type of food on cny, tding client the content of each s:poonful
- 10 O ffers beverage at least o nce during meal
- 11 Candidate asks client if they arc ready for next bite of food or sip o f beverage
- 12 At end of meal, candidate d eans d icru's mouth and hands
- 13 Refflo\es food tray
- 14 Leaves d ient in upright sitting position (75-90 degr<S) with sign:aling device within client's reach
- 15 After completing skill, washes hands

SKILL 11 - GIVES MODIFIED BED BATH (FACE AND ONE ARM, HAND AND UNDERARM)

- 1 Explains procedure, speaking d early, slowly, and direcdy, mainta ining f:ace-co-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or doo,
- 3 Refflo\es gown and places directly in soiled linen container while ensuring client's chest and lower body is covered
- 4 Ekfor washin chcd:s water tcmpe d ure for safety and comfort and asks client to verify comfort of water
- 5 Puu on cbn glo,-cs before washing client.
- 6 Beginning with eyes, washes eyes with wet washcloth (no soap), using a different a tea of the washcloth for each stroke, washing inner aspect to outer aspect then proct'OOS to ""-ash face

- 7 Dries & ce with dryd oth tow/d wash do th
- 8 Exposone arm and places d oth tow/d underne.lth arm
- 9 Appliessoap to wet wash do th
- 10 Washes fingers (ind uding fingernails), hand, arm, and under-um keeping rest of body co,-ered
- 11 Rinscs and dries fingers, hand, arm, and underann
- 12 Mewes body gently and naturally, avoiding force and o,-er--o: tension of limbs and joints
- 13 Puts d ean gown on client
- 14 Empties, rinses, and dries basin
- 15 Places basin in designated dirty supply are.i
- 16 Disposcs of l inen into soiled linen container
- 17 Avoidsco ntact between candjdate d othing and used linens
- 18 Remo,-cs and disposcs of gloves (without contaminating self) into waste container and washes hands
- 19 Signaling device is within reach and bed is in low position

SKILL 12' - MEASURES AND RECORDS ELECTRONIC BLOOD PRESSURE - STATESPECIFIC (EVALUATOR DO NOT SUBSTITUTE THIS SKILL FOR SKILL 2J 'MANUAL BLOOD PRESSURE')

- 1 Has client in comfortable lying or sitting position
- 2 Has client in comfortable lying or sitting position
- 3 Has client in comfortable lying or sitting position
- 4 Client's arm positioned at level of heart with palm up and upper arm is exposed
- 5 Selects appropriate cuff size
- 6 Ensures cuff is placed on upper arm, and sensor/arrow is over the brachial artery site
- 7 Places cuff on upper arm and sensor/arrow is over the brachial artery site
- 8 Turns on the machine and ensures device is functioning. If the machine has different settings for infants, children, and adults, selects the appropriate setting
- 9 Pushes start button. If cuff inflates to more than 200 mm Hg then stops machine and uses cuff on client's other arm
- 10 Waits until the blood pressure reading appears on the screen and for the cuff to deflate, then removes the cuff
- 11 Signaling device is within reach
- 12 Before recording, washes hands
- 13 After obtaining reading using BP cuff, records both systolic and diastolic pressures exactly as displayed on the digital screen

SKILL 13 - MEASURES AND RECORDS URINARY OUTPUT

- 1 Puts on and wears gloves before handling bedpan
- 2 Pours the contents of the bedpan into measuring container without spilling or splashing urine outside of container
- 3 Rinses bedpan and pours rinse into toilet
- 4 Measures the amount of urine at cylinder with container on a scale (if between measurement lines, round up to nearest 2; mL)
- 5 After measuring urine, empties contents of measuring container into toilet
- 6 Rinses measuring container and pours rinse into toilet
- 7 Records and reports output, time, and disposes of gloves (without contaminating self) into waste container and washes hands
- 8 Records contents of container within plus or minus 25 mL/cc of evaluator's reading

SKILL 14 - MEASURES AND RECORDS WEIGHT OF AMBULATORY CLIENT

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Client has non-skid shoes/footwear on before walking to scale
- 3 Before client steps on scale, candidate sets scale correctly
- 4 Asks client to step on center of scale and obtains weight
- 5 Asks client to step off scale
- 6 Before recording weight, candidate washes hands
- 7 Records weight based on indicator on scale. Weight is within plus or minus 2 lbs of evaluator's reading. If weight recorded in kg weight is within plus or minus 0.9 kg of evaluator's reading

SKILL 15 - PERFORMS MODIFIED PASSIVE RANGE OF MOTION (PROM) FOR ONE KNEE AND ONE ANKLE

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Ensures that client is supine in bed and instructs client to inform candidate if pain is experienced during exercise
- 4 While supporting the leg at knee and ankle, bends the knee and then returns leg to client's normal position (flexion/extension) (AT LEAST 3 TIMES unless pain is, otherwise). Moves joints gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain.
- 5 While supporting the foot and ankle, dorsiflexes the foot, plantar flexes/pulls foot toward head (dorsiflexion), and pushes/pulls foot down, toes point down (plantar flexion) (AT LEAST 3 TIMES unless pain is, otherwise). Moves joints gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain.

6 Signaling device is within reach and bed is in low position

7 After completing skin, washes hands

SKILL 16 - PERFORMS MODIFIED PASSIVE RANGE OF MOTION (PROM) FOR ONE SHOULDER

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Instructs client to inform candidate if pain experienced during exercise
- 4 While supporting arm at the elbow and at the wrist, raises client's straightened arm from side position upward toward head to eat level and returns arm down to side of body (flexion/extension) (AT LEAST 3 TIMES unless pain is, otherwise). Moves joint gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain.
- 5 While supporting arm at the elbow and at the wrist, moves client's straightened arm away from the side of body to shoulder level and returns to side of body (abduction/adduction) (AT LEAST 3 TIMES unless pain is, otherwise). Moves joint gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain.
- 6 Signaling device is within reach and bed is in low position
- 7 After completing skin, washes hands

SKILL 17 - POSITIONS ONE SIDE

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before turning, lowers head of bed
- 4 Raises side rail on side to which body will be turned
- 5 Undrape assists client to slowly roll onto side toward raised side rail
- 6 Places or adjusts pillow under head for support
- 7 Undrape repositions arm and shoulder so that client is not lying on arm
- 8 Supports top arm with support, device
- 9 Places support device behind client's back
- 10 Places support device between client's legs with top knee flexed; knee and ankle supported
- 11 Signaling device is within reach and bed is in low position
- 12 After completing skin, washes hands

SKILL 18 - PROVIDES CATHETER CARE FOR FEMALE

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water

4 Puts on and wears gloves before washing
5 Places linen protector under perineal area

including buttocks before washing

- 6 Exposes area surrounding a thigh (only exposing client between hip and knee)
- 7 Applies soap to wet washcloth
- 8 While holding catheter at meatus without tugging, cleans at least four inches of catheter from meatus, moving in only one direction, away from meatus, using a clean area of the washcloth for each stroke
- 9 While holding catheter at meatus without tugging, using a clean washcloth, cleans at least four inches of catheter from meatus, moving only in one direction, away from meatus, using a clean area of the washcloth for each stroke
- 10 While holding catheter at meatus without tugging, cleans at least four inches of catheter moving away from meatus using a dry cloth towel/washcloth
- 11 Empties, rinses, and dries basin
- 12 Places basin in designated dirty supply area
- 13 Disposes of used linen into soiled linen container and disposes of linen protector appropriately
- 14 Avoids contact between candidate and dated clothing and used linen
- 15 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
- 16 Signaling device is within reach and bed is in low position

SKILL 19 - PROVIDES FOOT CARE ON ONE FOOT

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water
- 4 Basin is in a comfortable position for client and on protective barrier
- 5 Puts on and wears gloves before washing foot
- 6 Client's heel is placed into the heater
- 7 Applies soap to wet washcloth
- 8 Lifts foot from heater and washes foot (including between the toes)
- 9 Foot is rinsed (including between the toes)
- 10 Dries foot (including between the toes) with dry cloth towel/washcloth
- 11 Applies lotion to top and bottom of foot (excluding between the toes) removing excess with a towel/washcloth
- 12 Supports foot and ankle during procedure
- 13 Empties, rinses, and dries basin
- 14 Places basin in designated dirty supply area
- 15 Disposes of used linen into soiled linen container
- 16 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
- 17 Signaling device is within reach

SKILL 20 - PROVIDES MOUTH CARE

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before providing mouth care, client is in upright sitting position (75-90 degrees)
- 4 Puts on clean gloves before opening mouth
- 5 Places cloth towel across chest before providing mouth care
- 6 Secures cup of water and moistens toothbrush
- 7 Before opening mouth, applies toothpaste to moistened toothbrush
- 8 Cleans mouth (including tongue and all surfaces of teeth), using gentle motions
- 9 Maintains clean technique with placement of toothbrush
- 10 Candidate holds client's chin while client rinses mouth
- 11 Candidate wipes mouth and removes clothing protector
- 12 Disposes of used linen into soiled linen container
- 13 Rinses toothbrush and empties, rinses, and dries basin
- 14 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
- 15 Signaling device is within reach and bed is in low position

SKILL 21 - PROVIDES PERINEAL CARE (PERI-CARE) FOR FEMALE

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water
- 4 Puts on clean gloves before washing perineal area
- 5 Places pad/linen protector under perineal area including buttocks before washing
- 6 Exposes perineal area (only exposing between hips and knees)
- 7 Applies soap to wet washcloth
- 8 Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke
- 9 Using clean washcloth, rinses soap from genital area, moving from front to back, while using a clean area of the washcloth for each stroke
- 10 Dries genital area moving from front to back with dry cloth towel
- 11 After washing genital area, turns to side, then washes rectal area moving from front to back using a clean area of the washcloth for each stroke.
- 12 Using clean washcloth, rinses soap from rectal area, moving from front to back, while using a clean area of the washcloth for each stroke

- 13 Dries rectal area moving from front to back with dry cloth towel/washcloth
- 14 Repositions client
- 15 Empties, rinses, and dries basin
- 16 Places basin in designated dirty supply area
- 17 Disposes of used linen into soiled linen container and disposes of linen protector appropriately
- 18 Avoids contact between candidate clothing and used linen
- 19 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
- 20 Signaling device is within reach and bed is in low position

SKILL 22 - TRANSFERS FROM BED TO WHEELCHAIR USING TRANSFER BELT

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact when possible
- 2 Privacy is provided with a curtain, screen, or door
- 3 Before assisting to stand, wheelchair is positioned alongside of bed, at head of bed facing foot of bed
- 4 Before assisting to stand, footrests are folded up or removed
- 5 Before assisting to stand, locks wheels
- 6 Before assisting to stand, bed is at a safe level
- 7 Before assisting to stand, checks and for locks bed wheels
- 8 Before assisting to stand, client is assisted to a sitting position with feet flat on the floor
- 9 Before assisting to stand, client is wearing shoes
- 10 Before assisting to stand, applies transfer belt securely at the wrist over clothing/gown
- 11 Before assisting to stand, provides instructions to enable client to assist in transfer including prearranged signal to alert when to begin standing
- 12 Stands facing client positioning self to ensure safety of candidate and client during transfer. Counts to three (or six) after prearranged signal to alert client to begin standing
- 13 On signal, gradually assists client to stand by grasping transfer belt on both sides with an upward grasp (candidate's hands are in upward position) and maintaining stability of client's legs by standing knee to knee or toe to toe with the client
- 14 Assists client to turn to stand in front of wheelchair with back of client's legs against wheelchair
- 15 Lowers client into wheelchair
- 16 Positions client with hips touching back of wheelchair and transfer belt is removed
- 17 Positions feet on footrests
- 18 Signaling device is within reach
- 19 After completing skill, washes hands

SKILL 23 - MEASURES AND RECORDS MANUAL BLOOD PRESSURE 'STATESPECIFIC (EVALUATOR: DO NOT SUBSTITUTE THIS SKILL FOR SKILL 12 'ELECTRONIC BLOOD PRESSURE

- 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
- 2 Before using stethoscope, wipes bell/diaphragm and earpieces of stethoscope with alcohol
- 3 Client's arm is positioned with palm up and upper arm is exposed
- 4 Feels for brachial artery on inner aspect of arm, at bend of elbow
- 5 Places blood pressure cuff snugly on client's upper arm, with sensor/arrow over brachial artery site
- 6 Earpieces of stethoscope are in ear and bell/diaphragm is over brachial artery site
- 7 Candidate inflates cuff between 160 mm Hg to 180 mm Hg. If heard immediately upon cuff deflation, completely deflate cuff. Re-inflate cuff to no more than 200 mm Hg
- 8 Deflates cuff slowly and notes the first sound (systolic reading) and last sound (diastolic reading) (If rounding needed, measurements are rounded up to the nearest 2 mm of mercury)
- 9 Removes cuff
- 10 Signaling device is within reach
- 11 Before recording, washes hands
- 12 After obtaining reading using BP cuff and stethoscope, records both systolic and diastolic pressures each within plus or minus 8 mm of evaluator's reading

APPENDIX A

A. GUIDELINES FOR USING THE TEXAS CURRICULUM FOR NURSE AIDES IN LONG-TERM CARE FACILITIES

1. Instruction

The curriculum was first developed in 1988 and the latest revision was completed in May 2013 in response to the Omnibus Budget Reconciliation Act of 1987 (OBRA) as amended, the federal regulations at 40 CFR Part 483, and the state Nurse Aide Rules at 26 TAC Chapter 556. It is important that you read Chapter 556 in order to train nurse aides in compliance with the state and federal regulations.

The curriculum is divided into 4 major parts:

- Part 1 is the “Course Content”
- Part 2 is the “Procedural Guidelines”
- Part 3 is the “National Nurse Aide Assessment Program (NNAAP) Skills”
- Part 4 is the “Appendix”

The nurse aide program (including the regulations, curriculum, training and testing) is based on the principle of competency-based education which requires that each graduate attain a minimal level of competency in performing the duties of an entry-level nurse aide.

2. Purpose

The purpose of the curriculum is to:

- a. Establish the content to be taught in approved NATCEPs in Texas
- b. Provide guidance to NATCEP directors and instructors
- c. Promote standardization of NATCEPs in Texas
- d. Establish the foundation for the Competency Evaluation Program (CEP)
- e. Improve the quality of NATCEP training

The curriculum is written for NATCEP staff to let the instructors know what to teach. All approved NATCEPs in Texas must teach the Texas curriculum. To obtain approval to teach a NATCEP, see item #15 of this appendix.

3. Authorization for NATCEPs to Reproduce the Curriculum

Although the curriculum is not written for use by nurse aides, instructors may want to use selected parts of the curriculum as instructional handouts. The Texas Health and Human Services Commission gives permission to distribute or reproduce for educational purposes if:

- a. The Texas Curriculum for Nurse Aides in Long Term Care Facilities is credited as the source of the material.
- b. No profit is made on the sale of curriculum materials.
- c. No charge is made to the nurse aide trainees for curriculum materials pursuant to 42 CFR 483.152(c)(1).

4. Teaching Materials (Textbooks, Workbooks, Instruction Guides, Audiovisual Materials)

The department does not approve teaching materials for NATCEPs. The program must:

- a. Select teaching materials to be used in the NATCEP
- b. Assure that the selected materials comply with the Texas curriculum.

5. Course Length and Hours

Section §556.3(i) states that each NATCEP must provide at least 100 hours of training:

- a. 60 hours of classroom training, defined as classroom and skills training which does not involve direct care of residents by trainees.
- b. 40 hours of clinical training, which includes care of residents and has at least one program instructor for every 10 trainees.
- c. 100 hours of total training.

Section §556.3(j) states that each NATCEP must teach the curriculum established by the department. The first 16 hours, Section I, are required hours and content that must be taught prior to any direct contact with a resident. The hours for the remaining sections can be arranged as needed as long as the total 100 hours are met:

Section I	Introduction of LTC	16 required hours
Section II	Personal Care Skills	
Section III	Basic Nursing Skills	
Section IV	Restorative Services	
Section V	Mental Health & Social Service Needs	
Section VI	Social Skills	
Total Class Hours		100

6. Course Schedules

NATCEP classes should be scheduled to meet the following requirements:

- a. The minimum hours specified at item 5 MUST be met.
- b. Section I MUST be completed prior to any direct contact with a resident (see §556.3(j)).
- c. The facility MUST NOT use an individual as a nurse aide for more than 4 months unless the individual has successfully completed a NATCEP or meets other specified requirements (see Nursing Facility Requirements for Licensure and Medicaid Certification §19.1903(2)).

7. Part 1 Course Outline

Part 1 is the Course Outline which must be taught by approved NATCEPs in the first 60 hours of classroom training. The COURSE OUTLINE includes:

- a. Course Content is the content which must be taught. Follow the content outline in preparing lesson plans and selecting teaching methods.
- b. Procedural Guidelines are listed by name and number in the Course Content to indicate when they should be taught (see item#8).
- c. Instructor Notes are special information and instructions for the instructor.
- d. Student Objectives are behaviors or competencies that the student will be expected to exhibit by the end of the training; thus, the objectives should guide the instructional process and student evaluation.

Some re-ordering and re-arranging of the Course Content may be done; however, the first 16 hours of content (Section I) MUST be completed first, as written, prior to contact with a resident. Section II through VI may be re-ordered and re-arranged. It is recommended that you keep the Sections or at least the Units intact, re-arranging only the order of Sections II through VI and/or an occasional Unit. If you do re-order the content, be careful to assure that you have adequate time to re-order, all the content is taught and the order of the content promotes effective learning and complies with state and federal requirements.

8. Part 2 "PROCEDURALGUIDELINES"

Part 2 contains the 45 Procedural Guidelines that must be taught in approved NATCEPs. They should be taught as close as possible to their related Course Content. The Procedural Guidelines that are also the NNAAP Skills (those with an asterisk on the Performance Record) must also be taught and checked off in the skills lab and/or the clinical training to assure that trainees are competent to perform the skills and pass the CEP. It is not educationally sound nor in compliance with the rules to teach only the NNAAP Skills. After the related course content is taught in the classroom, most Procedural Guidelines are best taught first in a pre-clinical skills lab (using demonstration by teacher and practice/return demonstration by trainee). The advantage is that it makes the most effective use of teaching time by providing an environment more realistic than the classroom and more controlled than the clinical. A pre-clinical skills lab can be as simple as an unoccupied resident unit or a bed and a sink in the classroom with needed supplies. If you cannot get a preclinical skills lab, find creative ways to make the best use of classroom and clinical time for skills training.

After the pre-clinical skills training, ideally the Procedural Guidelines would then be performed in clinical training. Some additional suggestions for teaching the Procedural Guidelines follow:

- a. Use manikins (to protect the privacy and safety of volunteer subjects) when teaching skills such as perineal care in the skills lab.
- b. Some Procedural Guidelines are not really manual skills and may best be presented in the classroom and then re-enforced in clinical training, e.g., communication. This Procedural Guideline may be useful as a handout.

Also see the requirements of §556.3(l) and 556.3(m) listed below at item #9 and, especially item 9f.

9. Clinical Training

Each NATCEP MUST teach at least 40 hours of clinical training, defined as hands-on care of residents in a nursing facility by trainees under the direct supervision of a licensed nurse. The clinical training provides the opportunity for the trainee to learn to apply the classroom training to the care of residents with the assistance and direct supervision of the instructor.

Section 556.3(l) states that a NATCEP MUST verify that a trainee:

- a. Is not listed on the Nurse Aide Registry in revoked status.
- b. Is not listed as unemployable on the Employee Misconduct Registry established pursuant to the Texas Health and Safety Code, Chapter 253.
- c. Has not been convicted of a criminal offense listed in Texas Health and Safety Code, §250.006(a), or convicted of a criminal offense listed in 250.006(b) within the five years immediately before participating in the NATCEP.

Section 556.3(m) states a NATCEP must ensure that a trainee:

- d. Complete the first 16 introductory hours of training (Section I of the curriculum) before having any direct contact with a resident.
- e. Only performs services for which the trainee has been trained and has been found to be proficient by an instructor.
- f. Is under the direct supervision of a licensed nurse when performing skills as part of a NATCEP until the trainee has been found competent by the program instructor to perform that skill.
- g. Is under the general supervision of a licensed nurse when providing services to a resident after a trainee has been found competent by the program instructor.
- h. Is clearly identified as a trainee during the clinical training portion of the NATCEP.

While all portions of the NATCEP training are important, the clinical training is probably the most important part of the instructor's job, because if the trainee cannot use the knowledge and skills, learning did not occur. Make the most of every minute of clinical time and, if possible, obtain additional assistance and/or hours for clinical training. Your job will be much easier if the students have already been checked off on the Procedural Guidelines in a pre-clinical skills lab.

Check the students off during clinical training on as many Procedural Guidelines as possible, focusing on those with an asterisk on the Nurse Aide Performance Record (see Appendix B).

Use the National Nurse Aide Assessment Program (NNAAP) Skills (Part 3) as the criteria for checking the skills performance as Satisfactory (S) or Unsatisfactory (U) in both the skills lab and clinical. They will provide you with objective criteria for evaluating the students' ability to perform skills and pass the skills test and will provide the student with experience in taking a skills test. Use the Procedural Guidelines as the criteria for checking the performance of skills that are not NNAAP Skills.

10. Nurse Aide Performance Record

Section 556.3(o) requires NATCEPs to use the HHSC "Nurse Aide Performance Record". A copy of the "Performance Record" and instruction for its use are at Appendix B.

11. Course Grade for Training Programs

Section 556.3(p)(4) requires the NATCEPs to give a final course grade to each trainee indicating "pass" or "fail". For this competency-based training, pass should generally be defined as "competent to function as an entry level nurse aide" and/or "competent to pass the CEP". A trainee must pass the course in order to be eligible to take the CEP. The course grade is to be part of the NATCEP records. Methods for determining the course grade are up to individual programs. Some general suggestions for course grading are:

- a. Determine your grading system ahead of time and put it in writing if possible.
- b. Base the grade on performance in the classroom and clinical training.
- c. Explain the grading system and the requirements for passing to the students at the start of the class.
- d. Keep students informed on how they are doing and how they can improve during the course.
- e. Apply the grading system to students without discrimination.

12. Daily Sign-in Record

Section 556.3(p)(5) requires NATCEPs to use the Daily Sign-In Record. See Appendix C.

13. Part3 "NNAAP SKILLS"

Part 3 of the curriculum contains the NNAAP Skills. They are the checkpoints that will be scored by the Skills Examiner during the Skills Examination. The NNAAP Skills were developed to evaluate skills performance--not as teaching tools. Thus, they should not be used as the sole training material because they do not include some important information and procedures. Each trainee should be given a copy of the NNAAP Skills to assist them in preparing for the Skills Exam. The NNAAP Skills can be very beneficial during the NATCEP to:

- a. Assist the teacher in stressing important points

- b. Assist the students to gain competency in all skills
- c. Prepare the students for the Skills Exam
- d. Evaluate students' performance on the skills

14. Competency Evaluation Program (CEP)

The NATCEP staff is responsible for scheduling trainees (who passed the course) for the state CEP. To schedule a state nurse aide exam, contact Nurse Aide Competency Evaluation Services (NACES) at 1-800-444-5178. For additional information on testing, refer to §556.6 and the Texas Nurse Aide Testing Program handbook.

15. Reference Material for NATCEPs

You may obtain the following program materials on the HHSC-NATCEP website at:

<http://www.HHSC.state.tx.us/providers/NF/credentialing/NATCEP/index.html>

- Nurse Aide Rules at 26 TAC Chapter 556--Review these rules before starting a NATCEP
- NATCEP Application--apply and receive program approval before starting a NATCEP
- Curriculum
- NNAAP Skills
- Nurse Aide Performance Record

You may obtain the following program material from NACES by calling 1-800-444-5178:

- Texas Nurse Aide Testing Program handbook

APPENDIX B

TEXAS HEALTH AND HUMAN SERVICES COMMISSION REGULATORY SERVICES
NURSE AIDE TRAINING PROGRAM PO BOX 149030; MAIL CODE E-420
AUSTIN, TEXAS 78714-9030
512-438-2017

TEXAS NURSE AIDE PERFORMANCE RECORD

Guidelines for use:

- A. The Texas Nurse Aide Performance Record is a list of 45 Procedural Guidelines which **MUST** be taught in approved NATCEPs.

- B. At the start of a NATCEP, the instructor must initiate a Nurse Aide Performance Record for each trainee as follows:
 1. Copy blank forms as needed.
 2. Complete the identifying information at the top of the form.
 3. Explain the use of the Performance Record to trainees.

- C. During the training program the instructor must:
 1. Teach all of the Procedural Guidelines and evaluate the competency of each trainee on each Procedural Guideline in the classroom, skills lab and/or clinical training.
 2. Check off each trainee on each Procedural Guideline (on the appropriate column of the Performance Record) by entering “S” for Satisfactory or “U” for Unsatisfactory, the date and the initials corresponding to the signature.
 - a. The Procedural Guidelines that **are not** NNAAP skills (those without an asterisk on the Performance Record) **MUST** be taught and checked off at least in the Classroom and/or, as possible, in the “Skills Lab” and/or “Clinical”.
 1. Use the Procedural Guidelines as the criteria to determine S or U performance.
 - b. The Procedural Guidelines that **are** also NNAAP Skills (those with an asterisk on the Performance Record) **MUST** also be taught and checked off in the “Skills Lab” and/or “Clinical” to assure trainees are competent to perform the skills and pass the test.
 1. Use the NNAAP skills as the criteria to determine S or U performance.

- D. At the completion of the training program:
 1. Each nurse aide should be checked off as “S” on all of the Procedural Guidelines listed on the Performance Record.
 2. The nurse aide should receive a copy of his/her own completed Performance Record.
 3. The employer should receive a copy of the trainee’s Performance Record if applicable.
 4. The NATCEP must retain a copy of Performance Records.

APPENDIX D
Texas Administrative Code

Title 26 **Health and Human Services**
Chapter 556 **Nurse Aides**
Rule §556.9 **Nurse Aide Registry and Renewal**

- (a) To be listed on the NAR as having active status, a nurse aide must successfully complete a NATCEP, as described in §556.6(i) of this chapter (relating to Competency Evaluation Requirements).
- (b) HHSC does not charge a fee to list a nurse aide on the NAR or to renew the nurse aide's listing of active status on the NAR.
- (c) A nurse aide listed on the NAR must inform HHSC of the nurse aide's current address and telephone number.
- (d) A listing of active status on the NAR expires 24 months after the nurse aide is listed on the NAR or 24 months after the last date of verified employment as a nurse aide, whichever is earlier. To renew active status on the NAR, the following requirements must be met:
- (1) A facility must submit a HHSC Employment Verification form to HHSC that documents that the nurse aide has performed paid nursing or nursing-related services at the facility during the preceding year.
- (2) A nurse aide must submit a HHSC Employment Verification form to HHSC to document that the nurse aide has performed paid nursing or nursing-related services, if documentation is not submitted in accordance with paragraph (1) of this subsection by the facility or facilities where the nurse aide was employed.
- (3) A nurse aide must complete at least 24 hours of in-service education every two years. The in-service education must include training in geriatrics and the care of residents with a dementia disorder, including Alzheimer's disease. The in-service education must be provided by:
- (A) a facility;
- (B) an approved NATCEP;
- (C) HHSC; or
- (D) a healthcare entity, other than a facility, licensed or certified by HHSC; by the Department of State Health Services; or by the Board of Nursing.
- (4) No more than 12 hours of the in-service education required by paragraph (3) of this subsection may be provided by an entity described in paragraph (3)(D) of this subsection.

Source Note: The provisions of this §556.9 adopted to be effective September 24, 2018, 43 TexReg 6326

Title 26 **Health and Human Services**

Chapter 556 **Nurse Aides**

Rule §556.12 **Findings and Inquiries**

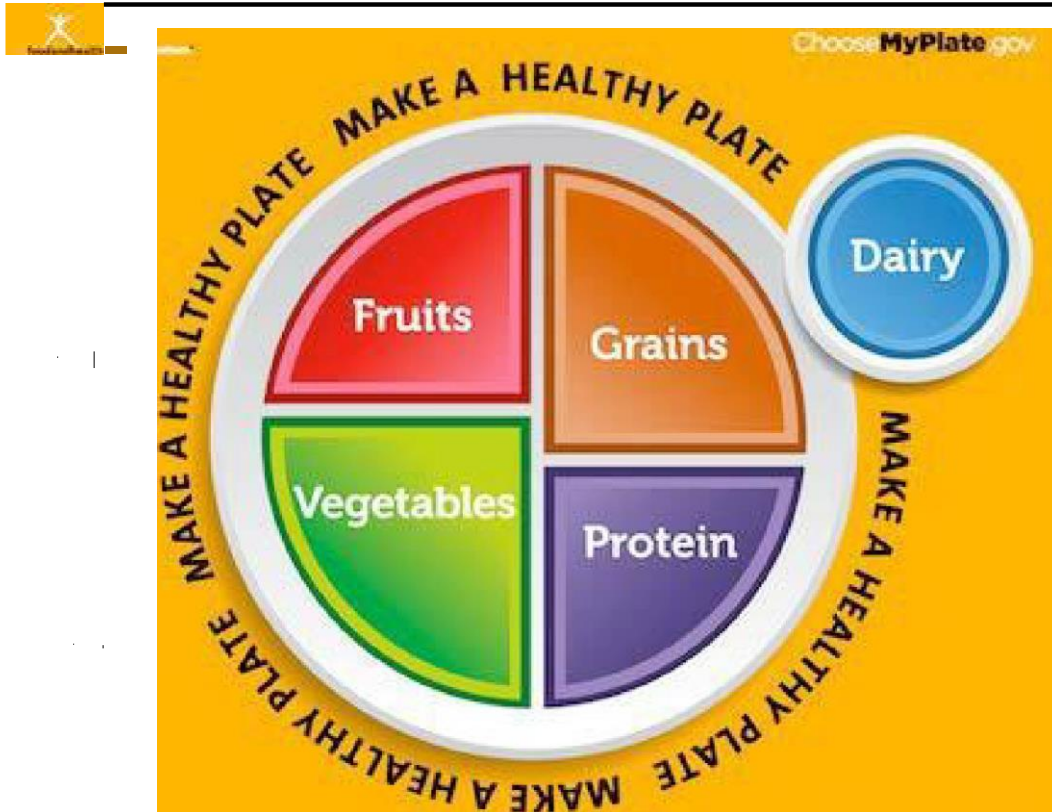
- (a) HHSC reviews and investigates allegations of abuse, neglect, or misappropriation of resident property by a nurse aide employed in a facility. If HHSC finds that a nurse aide committed an act of abuse, neglect, or misappropriation of resident property, before entry of the finding on the NAR, HHSC provides the nurse aide an opportunity to dispute the finding through an informal review (IR) and a hearing as described in this section.
- (b) If HHSC finds that a nurse aide committed an act of abuse, neglect or misappropriation of resident property, HHSC sends the nurse aide a written notice regarding the finding. The notice includes:
- (1) a summary of the findings and facts on which the findings are based;
 - (2) a statement informing the nurse aide of the right to an IR to dispute HHSC findings;
 - (3) a statement informing the nurse aide that a request for an IR must be made within 10 days after the date the nurse aide receives the written notice; and
 - (4) the address and contact information for the local HHSC regional office, where the nurse aide must submit a request for an IR.
- (c) If a nurse aide requests an IR, HHSC sets a date to allow the nurse aide to dispute the findings of the investigation of abuse, neglect, or misappropriation of resident property. The nurse aide may dispute the findings by providing testimony, in person or by telephone, to an impartial HHSC staff person at the local HHSC regional office.
- (1) If the staff person does not uphold the findings, HHSC notifies the nurse aide of the results of the IR and closes the investigation. HHSC does not record information related to the investigation in the NAR.
 - (2) If the staff person upholds the findings, HHSC notifies the nurse aide of the results of the IR. The nurse aide may request a hearing in accordance with subsection (d) of this section.
 - (3) If the nurse aide does not request an IR, or fails to appear for a requested IR, HHSC upholds the findings. The nurse aide may request a hearing in accordance with subsection (d) of this section.
- (d) A nurse aide may request a hearing after receipt of HHSC notice of the results of an IR described in subsection (c)(2) of this section. 1 Texas Administrative Code (TAC) Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act), and 40 TAC Chapter 91 (relating to Hearings Under the Administrative Procedure Act) govern the hearing, except that a nurse aide must request a formal hearing within 30 days after receipt of HHSC notice in compliance with 42 CFR §488.335. If the nurse aide fails to request a hearing, the nurse aide waives the opportunity for a hearing and HHSC enters the finding of abuse, neglect, or misappropriation of resident property, as appropriate, on the NAR.
- (e) If HHSC receives an allegation that a nurse aide, who has a medication aide permit under Chapter 557 of this title (relating to Medication Aides--Program Requirements), committed an act of abuse, neglect, or misappropriation of resident property, HHSC investigates the allegation under this section regarding the nurse aide practice and under Chapter 557 of this title to determine if the allegation violates the medication aide practice. The investigations run concurrently. If after the investigations, the nurse aide requests hearings on the findings under the nurse aide practice and the medication aide practice, only one hearing, conducted in accordance with subsection (d) of this section, is available to the nurse aide.
- (f) If HHSC finds that a nurse aide committed an act of abuse, neglect, or misappropriation of resident property, HHSC reports the finding to:
- (1) the NAR;
 - (2) the nurse aide;
 - (3) the administrator of the facility in which the act occurred; and
 - (4) the administrator of the facility that employs the nurse aide, if different from the facility in which the act occurred.
- (g) The NAR must include the findings involving a nurse aide listed on the NAR, as well as any brief statement of the nurse aide disputing the findings.
- (h) The information on the NAR is available to the public.
- (i) If an inquiry is made about a nurse aide's status on the NAR, HHSC must:
- (1) verify if the nurse aide is listed on the NAR;
 - (2) disclose information concerning a finding of abuse, neglect, or misappropriation of resident property involving the nurse aide; and

(3) disclose any statement by the nurse aide related to the finding.

(j) If a nurse aide works in a capacity other than a nurse aide in a facility and is listed as unemployable in the EMR, HHSC changes the status of the nurse aide's listing on the NAR to revoked or suspended. The due process available to the nurse aide before placement on the EMR satisfies the due process required before HHSC changes the nurse aide's status on the NAR.

(k) If HHSC lists a nurse aide's status on the NAR as suspended or revoked because of a single finding of neglect, the nurse aide may request that HHSC remove the finding after the finding has been listed on the NAR for one year. To request removal of the finding, the nurse aide must submit a HHSC Petition for Removal of Neglect Finding to HHSC in accordance with the petition's instructions.

Source Note: The provisions of this §556.12 adopted to be effective September 24, 2018, 43 TexReg 6326



Vegetables	Fruits	Grains	Protein	Dairy
<p>Vary your veggies.</p> <p>Any vegetable or 100% vegetable juice counts as a member of the Vegetable Group.</p> <p>Fill half your plate with fruits and vegetables.</p>	<p>Focus on fruits. Whole fruit is preferable to juice but any fruit counts: fresh, frozen, canned, 100% juice or dried.</p> <p>Fill half your plate with fruits and vegetables.</p>	<p>Make at least half your grains whole.</p> <p>Read labels to find more whole grain foods.</p> <p>Whole wheat, oatmeal and brown rice are all good.</p>	<p>Go lean with protein.</p> <p>Keep portion to 1/4 of the plate.</p> <p>Nuts, beans/peas, seeds, poultry, lean meat, seafood, soy and eggs are in this group.</p>	<p>Get your calcium-rich foods.</p> <p>Remember to buy skim milk or 1% milk.</p> <p>Go easy on cheese.</p> <p>Skim yogurt is a good choice, too.</p>

GLOSSARY OF TERMS

A.M. Morning

AD *acronym:* Alzheimer's Disease

ADL *acronym:* Activities of Daily Living

AIDS *acronym:* Acquired Immune Deficiency Syndrome

b.i.d. *abbreviation:* Latin bis in die meaning "twice a day"

BP *acronym:* Blood Pressure

cc *abbreviation:* cubic centimeter

CDC *acronym:* Centers for Disease Control

CEP *acronym:* Competency Evaluation Program

CPR *abbreviation:* cardio pulmonary resuscitation

CVA *abbreviation:* cerebrovascular accident – a general term which encompasses such problems as stroke and cerebral hemorrhage.

EMS *acronym:* Emergency Medical Service

mmHg *abbreviation for:* millimeters of mercury to measure the partial pressure of a gas (as for measurement of blood pressure).

HIV *abbreviation:* human immunodeficiencyvirus

I & O *acronym:* Intake and Output

IV *abbreviation:* Within or into a vein.

LTC *acronym:* Long Term Care

ml *abbreviation:* measures, milliliter

mm *abbreviation:* measures, millimeter

MDS *acronym:* Minimum Data Set

MRSA *acronym:* Methicillin Resistant Staphylococcus Aureus

MSDS *acronym:* Material Safety Data Sheets

NATCEP *acronym:* Nurse Aide Training and Competency Evaluation Program

NPO Do not take anything by mouth.

OBRA *acronym:* Omnibus Reconciliation Act of 1987

°F *abbreviation:* Degrees Fahrenheit

OSHA *acronym:* Occupational Safety And Health Administration

oz *abbreviation:* Italian on zameaning ounce or ounces (fluid measure)

P *abbreviation:* Pulse

P.M. Evening

PPE *acronym:* Personal Protective Equipment worn by health care workers such as gloves, gowns, masks.

R *abbreviation:* Respiration

SoB *abbreviation:* Shortness of Breath

STAT A common medical abbreviation derived from the Latin word *statim* which means immediately. Used to imply “urgent” or “rush.”

T *abbreviation:* Temperature

- AX *abbreviation:* Temperature taken at the axilla (under arm area).

TAC *acronym:* Texas Administrative Code

TB *abbreviation:* commonly used for tuberculosis

TPR *acronym:* Temperature/Pulse/Respiration

USDA *abbreviation:* United States Department of Agriculture

VRE *acronym:* Vancomycin Resistant Enterococcus

Reference Page

Centers for Disease Control and Prevention: <http://www.cdc.gov/>

Centers for Medicare & Medicaid Services (CMS) – Minimum Data Set (MDS) Manual

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/>

Health and Human Services Commission – Behavioral & Environmental Interventions

<http://qmweb.HHSC.state.tx.us/BehaviorMgm.asp>

Health and Human Services Commission – Employability Checks:

- Texas Department of Public Safety Crime Record Service
- Nurse Aide Registry (NAR)
- Employee Misconduct Registry (EMR)

<http://www.HHSC.state.tx.us/providers/employability/index.html>

Health and Human Services Commission – Information regarding Culture Change: <http://www.HHSC.state.tx.us/culturechange/>

Health and Human Services Commission – Information regarding Infection Control:

<http://www.HHSC.state.tx.us/qualitymatters/qcp/infectioncontrol/index.html>

Health and Human Services Commission - Nurse Aide Competency and Evaluation Program (NATCEP) website:

<http://www.HHSC.state.tx.us/providers/NF/credentialing/NATCEP/index.html>

Health and Human Services Commission - Nurse Aide Registry (NAR) website:

<http://www.HHSC.state.tx.us/providers/NF/credentialing/nar/index.html>

Department of State Health Services - Audiovisual Library:

<http://www.dshs.state.tx.us/avlib/>

Maslow's Hierarchy of Needs: http://www.abraham-maslow.com/m_motivation/Hierarchy_of_Needs.asp

National Council of State Boards of Nursing (NCSBN):

<https://www.ncsbn.org/ProfessionalBoundariesbrochure.pdf>

National Council of State Boards of Nursing (NCSBN) - Professional Boundaries: <https://www.ncsbn.org/ProfessionalBoundariesbrochure.pdf>

National Council of State Boards of Nursing (NCSBN) - Social media:

https://www.ncsbn.org/NCSBN_SocialMedia.pdf

National Nurse Aide Assessment Program(NNAAP):

<https://www.ncsbn.org/1721.htm>

Pearson VUE-Texas Nurse Aide website:

<http://www.asisvcs.com/indhome.asp?CPCat=0644NURSE>

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules website:

<http://www.hhs.gov/ocr/privacy/>

*Websites are subject to change