State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM
Student Manual
Version 1. Full Text
July 2019

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section

NCDHHS is an equal opportunity provider and employer

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NURSE AIDE I TRAINING PROGRAM

MODULE AA
Measurement

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Module AA – Measurement
Definition List

Vital Signs:

Afebrile – without a fever

Analog Watch – a watch that has moving hands and typically marked from numbers 1 through 12

Aneroid Manometer – that part of the sphygmomanometer (BP cuff) that includes the dial that indicates the systolic and diastolic pressures during blood pressure checks

Apical Pulse – a pulse point located over the heart

Apnea – no breathing

Arteries – blood vessels that carry blood with oxygen and nutrients away from the heart and to the cells

Atria (right and left) – two upper chambers of the heart

Blood pressure – the amount of force exerted by the blood against the walls of the artery

Body temperature – how much heat is in the body and balances the heat created by the body and heat lost to the environment

Brachial Pulse – pulse points located in the crooks of the elbows typically used during blood pressure checks

Bradycardia – a pulse rate less than 60 beats per minute

Bradypnea – a respiratory rate less than 12 breaths per minute

Cardiovascular System – also called the circulatory system and is the continuous movement of blood though the body

Carotid Pulse – pulse points located in both sides of the neck

Centigrade – metric scale used to measure temperature, expressed in degrees

Cheyne-Stokes – alternating periods of slow, irregular breathing and rapid, shallow breathing, plus short periods of absent breathing

Diaphragm – that part of the stethoscope located on the chest-piece used to listen to the presence or absence of brachial artery blood flow during blood pressure check

Diarrhea – frequent passage of loose, watery stools (bowel movements)

Diastole – the resting phase of the heart when the heart fills with blood; the bottom number of a blood pressure reading (diastolic)

Dyspnea – painful or difficult breathing

Eupnea – normal breathing

Exhale – when carbon dioxide is expelled out of the nose and the mouth from the lungs

Expiration – also called exhalation and involves the breathing out of carbon dioxide through the nose and mouth; the chest falls

Fahrenheit – scale used to measure temperature, expressed in degrees

Febrile – with a fever

Fever – an elevated temperature

Heart – the pump of the cardiovascular (circulatory) system consisting of four chambers

Hypertension – high blood pressure

Hyperventilation – rapid and deep breathing

Hypotension – low blood pressure

Hypoventilation – slow, shallow breathing that may be irregular

Inhale – when air (or oxygen) is pulled in through the nose and down into the lungs

Inspiration – also called inhalation and involves the breathing in of oxygen through the nose; chest rises

Lungs – elastic, spongy, cone-shaped air-filled structures involved and the location where the exchange of oxygen and carbon dioxide occur

Millimeters of Mercury – (mm Hg) the unit of measure for blood pressure

Objective – information collected by the nurse aide's senses

Orthostatic Hypotension – abnormal low blood pressure occurring when the resident suddenly stands up; resident complains of weakness, faintness, dizziness, and seeing spots

Pain – whatever the resident says that it is

Pedal Pulse – pulse points located in the top of the feet and used to check circulation of the leg

Pulse – is the beat of the heart felt at an artery, as a wave of blood passes through the artery; is the numbers of heart beats per minute

Pulse Force – the strength of the pulse and should be easy to feel

Pulse Rate – the number of heart beats (or pulses) per minute

Pulse Rhythm – the regularity of the heart beats (pulses) and should be the same interval between beats

Radial Pulse – pulse points located in the wrists, which is used most often, easy to reach, easy to find, and used for routine vital signs

Respiration – the process that supplies oxygen to the cells and removes carbon dioxide from cells

Respiratory rate (or respirations) – the number of inspirations (inhalations) the person takes in a minute

Respiratory System – involves the breathing in of oxygen (inspiration) and the breathing out of carbon dioxide (expiration)

Sphygmomanometer – also known as the BP cuff; is the equipment used to check a person's blood pressure

Stethoscope – instrument used to listen to heart sounds, lung sounds, and the brachial pulse during blood pressure checks

Subjective – information provided by the resident

Systole – the working phase of the heart when the heart is pumping blood to the body; the top number of a blood pressure reading (diastolic)

Tachycardia – a pulse rate more than 100 beats per minute

Tachypnea – a respiratory rate more than 20 breaths per minute

Temporal Pulse – a pulse point located in the temples of the head

Temporal Thermometer – a thermometer that measures heat from skin over the forehead, specifically over temporal artery

Thermometer – a device used to check a resident's temperature

Tympanic Thermometer – a thermometer that uses the ear as the site to check a resident's temperature

Veins – blood vessels that carry blood with waste products away from the cells and to the heart

Ventricles (Right and Left) – two lower chambers of the heart

Vital Signs – (also called TPR & BP) include the measurement of temperature, pulse, respiration, and blood pressure that show how well vital organs are functioning

Intake and Output (I&O):

Catheter Bag – collection device for urine that is connected to an indwelling (Foley) catheter which drains the bladder

Commode Hat (or specimen pan) – a plastic collection container placed under a commode lid, used when resident has bathroom privileges and Is on output and/or has a urine or stool specimen ordered

Cubic Centimeter (or cc) – a unit of measure in the metric system used to count the volume of anything (including fluids); is equal to 1 milliliter

Dehydration – when fluid output is more than fluid intake

Diarrhea – frequent passage of loose, watery stools (bowel movements)

Edema – when fluid intake is more that fluid output and body tissues swell with water

Emesis Basin – a plastic, shallow basin shaped like a kidney that fits against the resident's neck and collects body fluids when a resident is nauseated and during mouthcare

Encourage Fluids – a doctor's order that increases the resident's fluid intake

Fluid Balance – fluid intake roughly equals fluid output

Food Intake – comparison of the amount of food eaten by a resident at mealtime with the amount of food provided

Gastric Suction Material – stomach contents that are suctioned out using a nasogastric tube

Graduate – an accurate measuring device for fluids used in a health care setting

Hydration – having the right amount of fluid in the body

Intake (input) – the amount of fluid taken in by the body

Intake and Output (I&O) – used to evaluate fluid balance whereby intake and output are measured and documented

Milliliter (mL) – a unit of measure in the metric system used to count fluids; is equal to 1 cubic centimeter

Nothing by Mouth (NPO) – a doctor's order that states that a resident is not to eat or drink anything

Output – the amount of fluid lost from the body

Restrict Fluids – a doctor's order that limits the resident's fluid intake

Special Fluid Orders – orders a doctor writes that state how much fluid a resident must drink per day in order to maintain fluid balance

Thickened Liquids – a doctor's order that states that all fluids taken in by resident are thickened

Urinal – a plastic, elongated device used by men to urinate into, particularly when confined to bed or on output

Vomiting – the ejection of food and fluids from the stomach via the esophagus and mouth

Vomitus – food and fluids ejected from the stomach via the esophagus and mouth

Height and Weight:

Height Rod – the device used on a standing scale that measures a resident's height (or tallness)

Kilogram – a unit of measure in the metric system used to determine weight

Module AA – Measurement (Vital Signs)	
(S-1) Title Slide **(S-2, 3, 4, 5 & 6) Objectives** 1. Identify the structure and function of the cardiovascular and respiratory systems. 2. Define body temperature and associated terminology. 3. List equipment needed to measure pulse, respirations, blood pressure, temperature, intake of fluids, output, height, and weight. 4. Compare and contrast the various thermometers used to measure temperature. 5. Label components of select equipment used to measure blood pressure, height, and weight. 6. Compare and contrast normal and abnormal findings of the following measurements: pulse, respirations, blood pressure, and temperature. 7. Locate sites used to measure pulse, respirations, blood pressure and temperature. 8. Describe the nurse aide's role in the care of residents who have not achieved fluid balance – edema and dehydration. 9. Explain how to use equipment that measures blood pressure, temperature, intake of fluids, output, height, and weight. 10. Differentiate units of measurement nurse aides use during the care of residents – millimeters of mercury (mm Hg), degrees Fahrenheit, ounces, milliliters (mL), cubic centimeters (cc), inches, and feet. 11. Convert ounces to milliliters and inches to feet/inches.	
Content	**Notes**
(S-7) Title Slide	
(S-8) Vital Signs • Show how well vital organs are functioning – heart and lungs, plus the regulation of temperature • Include temperature, pulse, respiration, and blood pressure • May also be called TPR & BP	
(S-9) Vital Signs – Importance • Changes in vital sign measurements can indicate that resident's condition is worsening • Can reflect how body is responding to medication and/or treatment • The value of a vital sign may be the basis for a medication that the nurse gives to the resident • Accuracy when taking vital signs is crucial; never guess; if unsure ask for help • Report abnormal vital signs immediately to the nurse and per facility policy	
(S-10) The 5th Vital Sign – Pain • Facilities may consider pain the 5th vital sign because it is considered as important as the other vital signs • Whereas other vital signs are objective (collected by the nurse aide's senses), pain is different because it is subjective and reported to health care provider by the	

Module AA – Measurement (Vital Signs)	
resident • Pain is whatever the resident says it is and response to pain varies from resident to resident • Will learn more about pain later in the course	
(S-11) Respiratory System • Respiratory system – the breathing in of oxygen into the lungs and the breathing out of carbon dioxide from the body	
(S-12) Structure and Function of the Lungs • The location in the respiratory system where the exchange of oxygen and carbon dioxide occur • Left lung has two lobes and right lung has three lobes	
(S-13) Respiration • Is the process that supplies oxygen to the cells and removes carbon dioxide from cells • Involves o Inspiration (inhalation) – breathing in of oxygen through nose; chest rises o Expiration (exhalation) – breathing out of carbon dioxide through nose and mouth; chest falls • Each respiration involves one inspiration and one expiration • Respiratory rate (or respirations) – is the number of inspirations (inhalations) the person takes in a minute	
(S-14) Respiratory Site • Watch the chest rise and fall • Count the chest rises (inspirations) only	
(S-15) Respiratory Values – Normal • Called eupnea • Rate = between 12 and 20 breaths per minute, • Regular, quiet, with both sides of chest rising and falling equally • Document	
(S-16) Respiratory Values – Abnormal • Bradypnea – less than 12 breaths per minute • Tachypnea – more than 20 breaths per minute • Apnea – none (apnea) • Hypoventilation – slow, shallow breathing that may be irregular • Hyperventilation – rapid, deep breathing • Dyspnea – painful or difficult breathing • Cheyne-Stokes – alternating periods of slow, irregular breathing and rapid, shallow breathing, plus short periods of apnea • Document and notify nurse	

Module AA – Measurement (Vital Signs)	
(S-17) Checking Respirations – Equipment • Analog watch with a second hand • Note pad/assignment sheet and pen	
(S-18) Analog Watch • Definition – a watch that has moving hands and typically marked with from numbers 1 through 12 • Has an hour hand, minute hand, and second hand • The nurse aide uses the second hand to count respirations and pulse rate	
(S-19) Analog Watch – 60 Seconds • When counting respirations for 60 seconds, while watching the second hand, start counting and stop counting on the same number	
(S-20) Using an Analog Watch – Practice • Counting respirations for 60 seconds o Start with second hand on 3, stop with second hand on 3 o Start with second hand on 6, stop with second hand on 6 o Start with second hand on 10, stop with second hand on 10 o Start with second hand on 12, stop with second hand on 12 o Start with second hand on 8, stop with second hand on 8 o Start with second hand on 1, stop with second hand on 1	
(S-21) Respirations – Observation and Documentation • The nurse aide counts respiratory rate (respirations) for 60 seconds (1 minute) • For respiratory rate, recall that 1 respiration equals 1 inspiration (chest rising) • While watching the second hand of an analog watch, the nurse aide starts counting and stops counting on the same number; do not wait until 12 • Document on the resident's record if the respirations o Fall within the range of 12 and 20 and are o Regular, quiet, with both sides of chest rising and falling equally • Document on the resident's record and notify the nurse, if respirations are abnormal	
(S-22) Stealth Respirations • Check respirations right after checking pulse (without moving hand from wrist) so resident does not realize respirations are being counted; tend to change pattern if	

Module AA – Measurement (Vital Signs)	
resident is aware it is being checked	
(S-23) Checking Respirations – Example #1 • Nurse aide begins counting respirations when the second hand is on 4 and stops counting respirations when the second hand lands on 4 • Nurse aide counts 16 chest rises in 60 seconds • 16 is the number the nurse aide would document	
(S-24) Checking Respirations – Example #2 • Nurse aide begins counting respirations when the second hand is on 10 and stops counting respirations when the second-hand lands on 10 • Nurse aide counts 24 chest rises in 60 seconds • 24 is the number the nurse aide would document • Nurse aide would notify the nurse. Why?	
(S-25) Cardiovascular System • Cardiovascular (circulatory) system – continuous movement of blood through the body	
(S-26) Structure and Function of the Blood Vessels • The transportation system of the cardiovascular (circulatory) system o Veins – carry blood with waste products away from the cells and to the heart o Arteries – carry blood with oxygen and nutrients away from the heart and to the cells	
(S-27) Structure and Function of the Blood Vessels • Pulse – the beat of the heart felt at an artery, as a wave of blood passes through the artery o Pulse rate – is the number of heart beats (or pulses) per minute o Pulse rhythm – is the regularity of the heart beats (pulses) and should be the same interval between beats o Pulse force – is the strength of the pulse and should be easy to feel	
(S-28) Pulse Sites • Temporal • Carotid – never check pulse rates on both carotid arteries at the same time • Apical – over the heart and taken with a stethoscope • Brachial – typically used during blood pressure checks • Radial – used most often, easy to reach, easy to find, used for routine vital signs • Pedal – used to check circulation of the leg	
(S-29) Radial Pulse Site • Typically used to take pulse during routine vital signs	

Module AA – Measurement (Vital Signs)	
checks • Does not expose resident • Located on thumb side of wrist • First 2 or 3 fingers used; never use thumb	
(S-30) Pulse Values • Normal pulse for adults (document) o Rate = between 60 and 100 beats per minute o Regular, and strong • Abnormal pulse for adults (document and notify nurse) o Bradycardia – less than 60 beats per minute o Tachycardia – more than 100 beats per minute o Irregular pulse rhythm o Weak in strength	
(S-31) Counting Pulse – Equipment • Watch with a second hand • Note pad/assignment sheet and pen	
(S-32) Analog Watch – 60 Seconds • When counting pulse for 60 seconds, while watching the second hand, start counting and stop counting on the same number	
(S-33) Using an Analog Watch – Practice • Counting pulse for 60 seconds o Start second hand on 2, stop second hand on 2 o Start second hand on 5, stop second hand on 5 o Start second hand on 12, stop second hand on 12 o Start second hand on 10, stop second hand on 10 o Start second hand on 4, stop second hand on 4 o Start second hand on 6, stop second hand on 6	
(S-34) Pulse – Checking Pulse and Documentation • The nurse aide counts pulse rate for 60 seconds (1 minute) • While watching the second hand of an analog watch, the nurse aide starts counting and stops counting on the same number • Document on the resident's record if the pulse falls within the range of 60 and 100 and is regular and strong • Document on the resident's record and notify the nurse, if pulse is abnormal	
(S-35) Checking Pulse – Example #1 • Nurse aide begins counting pulse rate when the second hand is on 7 and stops counting pulse when the second hand lands on 7 • Nurse aide counts a pulse rate of 82 in 60 seconds • 82 is the number the nurse aide would document	
(S-36) Checking Pulse – Example #2	

Module AA – Measurement (Vital Signs)	
• Nurse aide begins counting pulse rate when the second hand is on 10 and stops counting pulse when the second hand lands on 10 • Nurse aide counts a pulse rate of 109 in 60 seconds • 109 is the number the nurse aide would document • Nurse aide would notify the nurse. Why?	
(S-37) Structure and Function of the Heart • The pump of the cardiovascular (circulatory) system • Consists of 4 chambers – right and left atria, and right and left ventricles	
(S-38) Structure and Function of the Heart • Has 2 phases o (1) Working phase, or systole, when the heart is pumping blood to the body, and the top number of a blood pressure reading and o (2) The resting phase, or diastole, when the heart fills with blood, and the bottom number of a blood pressure reading	
(S-39) Structure and Function of the Heart • Blood pressure – is the amount of force exerted by the blood against the walls of the artery o Top number is the systolic pressure and the pressure when the heart contracts and pumps blood out o Bottom number is the diastolic pressure when the heart rests as the heart fills with blood	
(S-40) Blood Pressure • Important indicator of health status; shows how well heart is working • Can change from minute to minute depending on: o The activity of the resident (for position, BP is higher lying in bed than seated in chair or standing; for exercising, BP increases) o Lifestyle choices (BP increases with smoking and drinking; BP higher if resident is overweight and decreases as weight is lost; BP may be high if resident eats a high salt diet) o Reaction to stressful events (BP increases with anxiety, emotional responses, and stress) o Acute injury or emergency (a blood volume decrease from injury will decrease BP; BP increases with pain) o Medications (raises or lowers BP depending on the medication)	
(S-41) Blood Pressure • Genetic factors affect blood pressure: o Age (BP increases with age) o Gender (women's BP usually lower)	

Module AA – Measurement (Vital Signs)	
o Race (black residents BP higher than white)	
(S-42) Blood Pressure Site • The brachial artery and the upper arm are sites most often used by the nurse aide when checking blood pressure	
(S-43) The Blood Pressure Value • Measured in millimeters of mercury (mm Hg) • Recorded as a fraction, for example 120/80 o Top number is systolic o Bottom number is diastolic o Pronounced as 120 over 80	
(S-44) Blood Pressure Values • Normal blood pressure ranges for adult o Systolic (top number) – 90 mm Hg to 119 mm Hg o Diastolic (bottom number) – 60 mm Hg to 79 mg Hg • Document on record	
(S-45) Abnormal Blood Pressure Values • Elevated blood pressure ranges (likely to develop high blood pressure unless steps are taken to control the blood pressure) o Systolic (top number) – 120 mm Hg to 129 mm Hg AND o Diastolic (bottom number) – below 80 mm Hg • Hypertension – consistent elevated systolic or diastolic values o Systolic (top number) – 130 mm Hg or higher, OR o Diastolic (bottom number) – 80 mm Hg or higher • Hypotension – too low systolic and/or diastolic values o Systolic (top number) – less than 90 mm Hg o Diastolic (bottom number) – less than 60 mm Hg • Always document on the record and report abnormal blood pressures to nurse	
(S-46) Using What You Have Learned • Using factors effecting blood pressure and normal/abnormal values for blood pressure, evaluate the health of the people on the next 3 slides	
(S-47) Blood Pressure Scenario for Mrs. Smith • BP = 116/72 • A 64-year old white female • Weighs 130 pounds • She has finished baking an apple pie • She doesn't smoke or drink	
(S-48) Blood Pressure Scenario for Mr. Brown • BP = 162/86 • A 72-year old black male • Weighs 260 pounds	

Module AA – Measurement (Vital Signs)	
• He is eating a couple of hot dogs and potato chips for lunch and is on his 4th beer • He just sent his son to the store for cigarettes	
(S-49) Blood Pressure Scenario for Mr. Spencer • BP = 180/94 • A 22-year old white male • Weighs 170 pounds • He just wrecked his brand new truck • He has a broken leg • He is on a stretcher in the back of an ambulance	
(S-50) Blood Pressure • The nurse aide uses three senses simultaneously when checking a resident's blood pressure: o Seeing – watches the needle's movement in relation to the numbers on the manometer o Hearing – using the stethoscope, listens for sounds indicating changes in blood flow in the brachial artery o Touching – controls the inflation and deflation of the cuff using the thumb and index finger	
(S-51) Checking Blood Pressure - Equipment • Stethoscope • Sphygmomanometer, also known as a blood pressure cuff (hereafter referred to as BP cuff) • Alcohol wipes • Note pad/assignment sheet and pen	
(S-52) Stethoscope • Instrument used to listen to heart and lung sounds • For blood pressure checks, used to listen to sounds in brachial artery • May be single-head (with diaphragm only) or dual-head (with diaphragm and bell)	
(S-53) Stethoscope – Parts • Ear pieces • Binaurals • Rubber or plastic tubing • Chest-piece (with diaphragm or diaphragm/bell)	
(S-54) Stethoscope – Ear Pieces • To prevent infection, always clean before use and after use with an alcohol wipe • Insert ear pieces into ears so that they point forward toward the nose • Should fit snugly in ears to block out noise	
(S-55) Dual-head Stethoscope – Diaphragm • Before using dual-head stethoscope to take blood pressure, determine which side of chest-piece is active	

Module AA – Measurement (Vital Signs)	
• To check blood pressure, diaphragm needs to be active	
(S-56) Two Ways to Check for an Active Diaphragm • After inserting ear pieces into ears, tap diaphragm lightly to determine if tap is heard; if tap not heard, rotate chest-piece at tubing, and repeat the tap • If chest-piece has an indicator dot, rotate chest-piece so indicator dot is closed	
(S-57) Diaphragm Concepts • To prevent infection, always clean before use, between residents, and after use with an alcohol wipe • Warm diaphragm with hand before making contact with resident • To use diaphragm, apply enough pressure to make a seal against the brachial artery at the crook of the elbow	
(S-58) BP Cuff • Two types o Manual (aneroid) and o Electronic (digital)	
(S-59) Electronic Type • No stethoscope • After BP cuff is placed on arm, button is pressed causing cuff to inflate/deflate automatically • BP reading is displayed	
(S-60) Aneroid BP Cuff – Parts • Manometer • Cuff with bladder • Inflation bulb with air-release valve • Tube from cuff to manometer • Tube from cuff to the handheld inflation bulb	
(S-61) Manometer • Marked with long and short lines and has a needle o The long lines mark 10 mm Hg o The short lines mark 2 mm Hg • Watch the needle as the cuff deflates while listening for sounds through stethoscope	
(S-62) Manometer • The long lines equal 10 mm Hg • The short lines equal 2 mm Hg • If the needle lands between 2 lines at the point that the systolic sound is heard, or the sound is no longer heard (diastolic), then the number value is rounded up to the next 2 mm Hg; odd numbers are not recorded/reported when using a manual BP cuff	
(S-63) Manometer • When checking a blood pressure, you will be watching	

Module AA – Measurement (Vital Signs)	
the needle as it drops from a higher number to a lower number, so you will be counting backwards	
(S-64) Example of Blood Pressure Reading • Systolic is 150 mm Hg • Diastolic is 88 mm Hg • BP is written down as 150/88 • BP is pronounced as “150 over 88”	
(S-65) Cuff • After wrapping the cuff around the bare upper arm, o The cuff inflates and puts pressure on the brachial artery o As cuff deflates, BP is determined	
(S-66) Cuff • Cuffs come in child-sized, small (circumference of arm is 7-9 inches), regular (circumference of arm is 9-13 inches), and extra-large (circumference of arm is 13-17 inches) • Important to choose correct size because a too big or too small cuff can impact accuracy of reading	
(S-67) Cuff • Typically has 1 or 2 arrows (left arm/right arm) on cuff which align with brachial artery • Cuff positioned/wrapped at least an inch above the elbow • Cuff or stethoscope should not be placed over clothing	
(S-68) Tubing • Made of rubber • Two tubes connect the: o (#1) Cuff to the manometer and o (#2) Cuff to the handheld inflation bulb	
(S-69) Inflation Bulb with the Air-release Valve • To inflate cuff, turn air-release valve clockwise to close valve; then squeeze the bulb; remember thumb goes up, needle goes up	
(S-70) Inflation Bulb with the Air-release Valve • To deflate cuff and open valve, turn air-release valve counterclockwise with the thumb and index finger in a slow and controlled manner; remember thumb goes down, needle goes down	
(S-71) Inflation Bulb with the Air-release Valve • Inflate cuff to between 160 mm Hg to 180 mm Hg • If beat is heard immediately, deflate the cuff; wait 30 – 60 seconds; inflate cuff to no more than 200 mg Hg	
(S-72) Inflation Bulb with the Air-release Valve • Goal: learn how to inflate the cuff and how to deflate the cuff in a slow, controlled manner	

Module AA – Measurement (Vital Signs)	
o Place the BP cuff on the swim noodle (keep it there) o Using the inflation bulb and air-release valve, take turns inflating the cuff and deflating the cuff in a slow, controlled manner	
(S-73) Blood Pressure – Nevers • Do not take blood pressure on an arm with an IV, dialysis shunt, or other medical device in place • Avoid taking blood pressure on a side that has been injured or burned, is paralyzed, has a cast, or has had a mastectomy	
(S-74) Orthostatic Hypotension • Defined – abnormal low blood pressure that occurs when the resident suddenly stands up; complaints of feeling weak, dizzy, faint and seeing spots before the eyes • May be a complication from being on bed rest	
(S-75) Orthostatic Hypotension – Process • Nurse aide may be asked to take an orthostatic blood pressure measurement; process includes: o BP checked while lying down, record in note pad o Have resident sit up, wait 2 minutes, check BP, record in notepad o Have resident stand up, wait 2 minutes, check BP, record in notepad o Record and report findings to nurse • Throughout process, nurse aide should check to see if resident is feeling weak, dizzy, faint, or seeing spots	
(S-76) Orthostatic Hypotension – Prevention • Per care plan and directive from nurse o Increase activity in stages: bed rest then sitting on side of bed (dangling) then walking o Before standing, while sitting on side of bed (dangling), have resident cough/deep breathe and move legs back-and-forth in circles, 1 to 5 minutes o Ask resident to report weakness, dizziness, faintness, or seeing spots	
(S-77) Body Temperature • Defined – amount of heat created by the body; balance between the amount heat produced and the heat lost • Is typically stable • Produced – created in the body when cells use food for energy • Lost to the environment – through skin, breathing, urine, and stool	
(S-78) Body Temperature - Terminology • Fever – an elevated temperature	

Module AA – Measurement (Vital Signs)	
• Febrile – with a fever • Afebrile – without a fever • Thermometer – device used to measure body temperature • Fahrenheit (F) and Centigrade (C) – scales used to measure temperature; stated in degrees (º)	
(S-79) Factors Affecting Temperature • Age (older lower temperature than younger) • Illness (typically increases with infection) • Stress (causes an increase) • Environment (dependent upon humidity and temperature) • Exercise (causes an increase) • Time of day (lowest in the morning; higher in afternoon and evening)	
(S-80) Sites • Important to check with nurse or care plan to see what type of thermometer is used o Mouth (oral) o Rectum (rectal) – most accurate; never let go of rectal thermometer while checking temperature o Armpit (axilla) – least accurate o Ear (tympanic) o Temporal artery (forehead)	
(S-81) When NOT to Take an Oral Temperature • Is unconscious • Recent facial or mouth surgery • Recent injury to face • Has sores, redness, or mouth pain • Is confused or agitated • History or seizure • Is using oxygen • Is mouth-breather • Has a feeding tube	
(S-82) When NOT to Take a Rectal Temperature • Has diarrhea • Has rectal problem • Has heart disease • Recent rectal surgery • Is confused or agitated	
(S-83) Temperature Values • Oral o Baseline – 98.6ºF o Normal range – 97.6ºF to 99.6ºF • Rectal o Baseline – 99.6ºF	

Module AA – Measurement (Vital Signs)	
o Normal range – 98.6°F to 100.6°F • Axillary o Baseline – 97.6°F o Normal range – 96.6°F to 98.6°F	
(S-84) Temperature Values • Tympanic membrane o Baseline – 98.6°F o Normal range – 97.6°F to 99.6°F • Temporal o Baseline – 98.6°F o Normal range – 97.6°F to 99.6°F	
(S-85) Types of Thermometers • Digital – oral, rectal, axillary • Electronic – oral, rectal, axillary • Tympanic – ear • Temporal – forehead • Non-mercury, liquid-filled glass (oral – green tipped) • Non-mercury, liquid-filled glass (rectal – red tipped)	
(S-86) Digital Thermometer • Oral, rectal, or axillary • Displays results digitally and is quick, within 2 – 60 seconds, and beeps or flashes when done • Battery-operated • Requires a disposable sheath	
(S-87) Electronic Thermometer • Oral, rectal, or axillary • Have oral (blue tipped) and rectal (red tipped) probes; for axillary temperature use oral (blue tipped) thermometer • Displays results digitally and is quick, within 2 – 60 seconds, and beeps or flashes when done • Battery-operated and stored in recharging device • Requires a probe cover	
(S-88) Tympanic Thermometer • Ear • Registers temperature in seconds • May need practice to operate accurately	
(S-89) Temporal Thermometer • Measures heat from skin over the forehead, specifically over temporal artery • Done by a stroke or scan over the area • Registers within 3 seconds • Noninvasive	
(S-90) Non-mercury, Liquid-filled Glass Thermometers – Equipment • Thermometer	

Module AA – Measurement (Vital Signs)	
• Sheath • Gloves • Watch • Pen • Notepad • Alcohol wipe • Water soluble lubricant (rectal temperature only)	

(S-91) Non-mercury, Liquid-filled Glass Thermometers
• Oral, rectal, or axillary
• Color-coded
  o Either blue or green for oral
  o Red for rectal
• Takes a long time to register – 3 to 10 minutes based on site
• Held at the stem of the thermometer and read at eye level
• The nurse aide must read the thermometer after it registers the temperature; held at stem; read at eye level
• Most health care providers use the Fahrenheit scale to measure temperature, even though both Fahrenheit and Celsius values are typically seen on thermometer	

(S-92) Reading the Non-mercury, Liquid-filled Glass Thermometer
• For Fahrenheit readings:
  o The long line represents 1 degree
  o The short line represents two tenths (2/10) of a degree	

(S-93) Example of an Oral Temperature Reading • Temperature of 102.8^{o}F	

Module AA – Measurement (Intake and Output)	
Content	**Notes**
(S-94) Title Slide	
(S-95) Fluid Balance • Living things need water to survive • Adult needs about 1500 mL of water intake daily to survive • About 2000 to 2500 mL needed for normal fluid balance • Hydration – having the right amount of water in the body's tissues	
(S-96) Fluid Balance • The body takes in water by drinking fluids and eating foods • The body loses water by way of urine, feces (bowel movement), vomit, perspiration (sweat), and lungs (breathing out), plus drainage from wounds or liquids from stomach suctioning • Death can occur if the body has too much or too little water in the tissues	
(S-97) Intake and Output • Intake (also called input) – the amount of fluid taken in by the body • Output – the amount of fluid lost from the body • Intake and output are typically seen together and commonly abbreviated (I&O) • For fluid balance to occur fluid intake roughly equals fluid output	
(S-98) Fluid Balance Not Achieved – Edema • When fluid intake is greater than fluid output, edema occurs • Body tissues swell with water • May occur from heart or kidney disease	
(S-99) Edema – Nurse Aide's Role • Obtain accurate weights per order • Increase pillows per resident's request • Restrict fluids per doctor's order • Measure and record I&O accurately, if ordered • Observe for and report signs/symptoms: weight gain of 1 to 2 pounds in a day; decrease in urine output; increased heart rate; difficult breathing or shortness of breath; fatigue; swelling of ankles, feet, fingers, hands; coughing; tight, smooth, shiny skin	
(S-100) Fluid Balance Not Achieved – Dehydration • When fluid intake is less that fluid output, dehydration occurs • Body tissues are lacking in water • May occur from vomiting, diarrhea, fever, or simply refusing to drink fluids	
(S-101) Dehydration – Nurse Aide's Role • Determine preferences of fluids and offer fluids each time nurse aide enters room • Assure water pitcher and cup are within reach	

Module AA – Measurement (Intake and Output)	

• Measure and record I&O accurately, if ordered
• Force fluids (encourage to drink more fluids), if ordered by the doctor
• Observe for and report signs and symptoms of potential dehydration and presence of dehydration
  o Warning signs for dehydration – drinks less than six 8-ounce glasses of fluids per day; drinks little or no fluids during meals; needs help drinking fluids; has trouble swallowing fluids; has fever, vomiting, diarrhea; complaints of thirst, dry mouth; decrease in urinary output
  o Signs/symptoms of dehydration – rapid, weak pulse; irregular heartbeat; low blood pressure; dark, strong-smelling urine, in small amounts; severe thirst; dry mouth and mucous membranes; cracked lips; warm, dry, wrinkled skin; flushed face; constipation; weight loss; weakness, dizziness, confusion; headache; irritable	

(S-102) I&O • Ordered by the doctor; found on care plan and directive from nurse • Typically calculated at the end of each shift and totaled every 24-hours • Documented on a facility-specific form in the appropriate column • Calculations and totals based on the milliliter (mL)	
(S-103) The Milliliter (mL) • A unit of measure in the metric system • Fluids measured using the milliliter (mL) • Another unit of measure used in healthcare is called the cubic centimeter (cc); however nurse aides should use the abbreviation, mL instead of cc when documenting volume of fluid • 1 milliliter is equal to 1 cubic centimeter • Most people are familiar with the teaspoon; there are 5 mL in a teaspoon	
(S-104) The Graduate • Accurate measuring device for fluids when resident is on I&O • Even though graduate is marked in ounces, plus milliliters (mL) or cubic centimeters, fluid for I&O is measured and documented in mL • Measure fluid at eye-level on flat surface • If both intake and output are to be measured with the graduate, two separate graduates are used and labelled	
(S-105) Units of Measure for the Graduate • The C.C. (cubic centimeter) side of the measurement scale is used in health care • Recall 1 C.C. on the graduate = 1 milliliter (mL) • Shortest line represents either 25 cc/mL or 75 cc/mL	

Module AA – Measurement (Intake and Output)	
• Longest lines represent multiples of 50 cc/mL	
(S-106) Measuring I&O – Importance • Used to evaluate fluid balance • Used to evaluate kidney function • Assists in planning and evaluating medical treatment • Assists with carrying out special fluid orders • Used to help prevent or detect complications from fluid intake • Fluid intake is one factor that reflects the resident's nutritional status	
(S-107) Fluids Considered as Intake • Liquids that the resident drinks • Semi-liquid foods that are eaten • Other fluids including intravenous (IV) fluids and tube feedings that nurse is responsible for maintaining and measuring	
(S-108) Fluids – Liquids • Water • Milk • Coffee • Tea • Juices • Soups • Soft drinks	
(S-109) Fluids – Semi-liquid Foods • Milkshakes • Ice cream • Sherbet • Custard • Pudding • Gelatin • Popsicles	
(S-110) Providing Drinking Water • Residents need fresh drinking water provided each shift and if water pitcher is empty • Before providing water, check with care plan or nurse to see if resident can have ice and a straw and if special fluid orders are in place • Follow facility's procedure regarding time schedule and process	
(S-111) Providing Drinking Water – Concepts • Ensure resident's name and room number is labeled on ice pitcher • Check for cracks and chips in water pitcher and cup when filling; also make sure they are clean; replace when needed • Never touch inside or rim of cup and pitcher • Never take resident's used water pitcher directly to ice machine;	

Module AA – Measurement (Intake and Output)	
can transmit germs • Never scoop ice with resident's watcher pitcher • Always place ice into the water pitcher first, then fill with water	
(S-112) Special Fluid Orders • In order to maintain fluid balance, the doctor may order amount of fluid a resident must drink a day • Encourage fluids o Resident drinks increased amount of fluids o Fluids that resident likes and are on resident's diet are left at bedside within easy reach; kept at appropriate temperature; may require being placed on ice in a pan o Nurse aide offers fluids regularly if person is dependent and cannot feed self or is confused o Nurse aide offers fluids each time he/she enters the room • Restrict fluids o Fluids are limited to certain amount o Fluids offered in small amounts o Water pitcher removed from room (or out of sight) o Resident will require frequent mouth care • Nothing by mouth (NPO) o Not allowed to eat or drink anything o Typically ordered before/after surgery, before certain lab tests, before special diagnostic procedures, and for certain illnesses o Water pitcher removed from room (or out of sight) o Resident will require frequent mouth care • Thickened liquids o All fluids must be thickened, even water o Thickness depends on resident's ability to swallow • Located on the care plan • Nurse aide must measure and record intake very carefully	
(S-113) Determining Oral Fluids as Intake • To determine intake, nurse aide must know serving sizes of containers that fluids are served in a facility o Typically found on the I&O sheet o Nurse aide will eventually know serving sizes of containers without needing to refer to I&O sheet as resource • Two methods to measure intake of oral fluids o Measures – using a designated graduate, the nurse aide measures the amount of fluid left in the container and subtracts that amount from the total amount the container holds o Using fractions – knowing the amount in milliliters that a serving container holds, the nurse aide uses fractions to calculate how much fluid the resident drank based on the amount of fluid left in the container	

Module AA – Measurement (Intake and Output)	
• Follow facility policy and/or procedure when determining intake of fluids during and between meals	
(S-114) Typical Serving Sizes of Liquids • Water glass = 240 mL • Tea glass = 180 mL • Juice glass = 120 mL • Milk carton = 240 mL • Coffee cup = 240 mL • Soft drink can = 360 mL • Gelatin = 120 mL • Soup bowl = 180 mL • Ice chips = 1/2 amount of mL in container	
(S-115) Determining Intake – Measures • The nurse aide knows that the glass with the resident's apple juice holds 240 mL of fluid • Using the graduate and measuring the apple juice left in the glass, the nurse aide notes that the resident did not drink 120 mL of apple juice • Subtracting 120 mL of apple juice, the resident didn't drink from the number of mL the glass holds • The nurse aide determines the resident drank 120 mL of apple juice	
(S-116) Determining Intake – Fractions • To determine fluid intake using fractions, the nurse aide needs a basic understanding of fractions in relation to a whole, which is 1 • The entire bar is = 1 and includes o 4 equal parts or 4 fourths o 2 equal parts or 2 halves o 3 equal parts or 3 thirds	
(S-117) Determining Intake – Fractions • 2/3 of 240 mL of coffee o The 2 – numerator tells the number of parts the resident drank o The 3 – denominator tells the number of parts that were originally in the container o The 240 – amount of fluid served to resident	
(S-118) Determining Intake – Fractions • 2/3 of 240 mL of coffee • 240 mL in the resident's coffee cup • Resident drank 2/3 cup of coffee • Resident drank 160 mL of coffee	
(S-119) Determining Intake – Fractions • 1/2 of 240 mL of coffee • 240 mL in the resident's coffee cup • Resident drank 1/2 cup of coffee	

Module AA – Measurement (Intake and Output)	
• Resident drank 120 mL of coffee	

(S-120) Recall Determining Intake – Fractions
• 2/3 of 240 mL of coffee
  o The 2 – numerator tells the number of parts the resident drank
  o The 3 – denominator tells the number of parts that were originally in the container
  o The 240 – amount of fluid served to resident	

(S-121) Determining Intake – Fractions (Quick)
• 2/3 of 240 mL of coffee
  o Determine what 1 part of total coffee equals by dividing the total mL amount of coffee (240) by 3 = 80
  o Resident drank 2 of the 3 parts of the coffee, so multiply 80 (which is 1 part) by 2 because the resident drank 2 of the 3 parts = 160
• The resident drank 160 mL of the coffee	

(S-122) Milliliters and Ounces • A common conversion in health care is changing (or converting) ounces to milliliters • 1 ounce = 30 mL • To convert ounces to milliliters, simply multiply number of ounces by 30	
(S-123) Conversion Problem – Apple Juice • 8 fluid ounces of apple juice in the glass • 1 fluid ounce = 30 milliliters (mL) • 8 x 30 milliliters (mL) = 240 milliliters (mL) • 240 mL of apple juice in the glass	
(S-124) Milliliters (mL) and Cubic Centimeters (cc) • Devices in health care are often marked in cubic centimeters (cc) • A common conversion is changing (or converting) cc to milliliters (mL) • 1 cubic centimeter (cc) = 1 milliliter (mL) • To convert cc to mL, simply use the exact number measured	
(S-125) Conversion Problem – Grape Juice • 120 cubic centimeters (cc) of grape juice in the glass • 1 cc = 1 milliliter (mL) • 120 mL of grape juice in the glass	
(S-126) Fluids Considered as Output • Urine • Vomit • Diarrhea • Wound drainage • Gastric suction material	
(S-127) Devices That Collect Output • Catheter bag	

Module AA – Measurement (Intake and Output)	
• Urinal • Commode hat • Emesis basin	
(S-128) Foley Catheter Bag • Connected to indwelling (Foley) catheter which drains bladder of urine • Emptied into a measuring device at end of shift (or sooner, if full) • Measurement done using measuring device instead of catheter bag; measurement markings are not as accurate as a graduate	
(S-129) The Urinal • A plastic, elongated device, angled at the top and used by men to urinate into, particularly when confined to bed or on output • Meant for single-resident use • As a measuring device, it is marked in ounces and cc (same as mL), with 100 cc (mL) increments marked lines and 50 cc (mL) unmarked lines between	
(S-130) The Commode Hat (or Specimen Pan) • A plastic collection container placed under the commode lid • Used when resident has bathroom privileges and o Is on output and/or o Has a urine or stool specimen ordered • As a measuring device, it is marked in ounces and cc (same as mL) and has a grooved edge allowing for ease of emptying into the commode • Important for resident to not put toilet paper into the hat/pan, but into the commode	
(S-131) The Emesis Basin • A plastic, shallow basin shaped like a kidney that fits against the resident's neck and collects body fluids • Used o During mouthcare o When a resident is nauseated • As a measuring device, it is marked in ounces and cc (same as mL), with 100 cc (mL) increments	
(S-132) RECALL: Units of Measure for the Graduate • The C.C. (cubic centimeter) side of the measurement scale is used in health care • Recall 1 C.C. on the graduate = 1 milliliter (mL) • Shortest line represents either 25 cc/mL or 75 cc/mL • Longest lines represent multiples of 50 cc/mL • [Using the graduate, next 3 slides will include graduates of urine to measure]	
(S-133) Measuring Urine #1 • Long line = 200 cc (mL) • Short line = 25 cc (mL)	

Module AA – Measurement (Intake and Output)	
• Amount = 225 cc (mL) • Document = 225 mL	
(S-134) Measuring Urine #2 • Long line = 500 cc (mL) • Amount = 500 cc (mL) • Document = 500 mL	
(S-135) Measuring Urine #3 • Long line = 300 cc (mL) • Short line = 25 cc (mL) • Amount = 325 cc (mL) • Document = 325 mL	
(S-136) Determining/Documenting Food Intake	
(S-137) Determining and Documenting Food Intake – Importance • Determining intake of meals accurately is important in identifying the resident at risk for or already experiencing impaired nutrition • Food intake is one of the factors that reflects the resident's nutritional status • Poor food intake at meals or changes in food intake that persists for multiple meals may indicate an underlying problem or illness and should be reported to the nurse • Much of a resident's daily fluid intake comes from meals; when resident has decreased appetite, can result in fluid/electrolyte imbalance.	
(S-138) Determining Food Intake • The nurse aide compares the amount of food that was eaten with the amount of food served • To measure food intake, the nurse aide needs a basic understanding of percentages in relation to a whole, which is 100%	
(S-139) Understanding Percentages of a Whole • The entire circle = 100% and includes 4 equal parts • Each 25% is ¼ of the whole • 25% + 25% = 50% (or ½ of the whole) • 25% + 25% + 25% = 75% (or ¾ of the whole)	
(S-140) Determining Food Intake • Follow facility procedure regarding determining and recording food intake, for example o Listing exact food that was eaten (all of chicken, all green beans, ½ of mashed potatoes, ¼ of biscuit, all of pie) o Using specific words (all, good, fair, poor, refused) o Using percentages of food eaten (100%, 75%, 50%, 25%, 0%)	
(S-141) The Resident is Served His Meals • Breakfast consists of 2 eggs, 2 slices of bacon, fried apples,	

Module AA – Measurement (Intake and Output)	
grits, biscuit, coffee, and apple juice • Lunch consists of 4 grilled chicken tenders, mashed potatoes, broccoli, a corn muffin, coffee, and water	
(S-142) Resident Ate 0% of Meals (Refused) • Refused meal completely or ate only one or two bites of each item	
(S-143) Resident Ate 25% of Meals (Poor) • Ate about 25% of entrée or 50% of one item	
(S-144) Resident Ate 50% of Meals (Fair) • About 50% of food has been eaten (for example, 50% of entrée and 25% of a vegetable)	
(S-145) Resident Ate 75% of Meals (Good) • Most of meal has been eaten, but a large part of one item or two items have been left (for example, 25% of entrée or 75% of a vegetable not eaten)	
(S-146) Resident Ate 100% of Meals (All) • All of meal has been eaten except for a small amount of food (for example, less than 25% of a vegetable has not been eaten)	

Module AA – Measurement (Height and Weight)	
Content	**Notes**
(S-147) Title Slide	
(S-148) Weight and Height – Overview • Both weight and height are measured on admission to the facility • Units of measure o Weight may be measured using pounds or kilograms, per facility policy o Height may be measured using feet and inches or just inches, per facility policy; centimeters typically are not used • After admission o Height typically not measured again o Weight measured per facility policy or per doctor's order; as directed by nurse and care plan – daily, weekly, monthly	
(S-149) Weights of Residents in Long-term Care Facilities • Current standards of practice in long-term care facilities recommend weighing resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission, and at least monthly thereafter to help identify and document trends such as weight loss or gain • Crucial that weight is obtained accurately and consistently so comparisons along time are more reliable o Facility-wide scales must be calibrated and functioning appropriately o A consistent process in place	
(S-150) Weights – Consistent Process • Weigh the resident: o Wearing a similar type of clothing o At approximately the same time of the day (preferably before breakfast) o Using the same scale o Either consistently wearing or not wearing orthotics or prostheses	
(S-151) Accurate Weights – Importance • Weight is one of the parameters that reflects the resident's nutritional status • Fluid loss or retention can cause short term weight changes; abrupt weight changes along with change in food intake are signs of fluid and electrolyte imbalance. • Weight loss may be important indicator of a change in resident's health status or sign of malnourishment	

Module AA – Measurement (Height and Weight)	
• If significant weight loss noted, health care team reviews for possible causes	

(S-152) Physician Mechanical Beam Scale
• Used for measuring weight and height
• Residents who cannot stand
  o Weighed using chair, wheelchair, bed, or mechanical lift, as directed by the nurse or care plan
  o Height measured in the bed using a tape measure and ruler	

(S-153) Physician Mechanical Beam Scale • Balance beam with upper and lower poise bars • Weight indicators • Balance bar and window • Height rod with upper and lower sections • Head piece – resting and active • Scale platform • Pillar and pillar head	
(S-154) Balance Beam • Has 2 poise bars – the upper bar and the lower bar • May include pounds only or pounds on the top part of each bar and kilograms on the bottom part of each bar; may have interchangeable pound and kilogram bars	
(S-155) Upper Poise Bar • Long lines represent pounds • Short lines represent ¼ pounds each; increments include ¼, ½, ¾	
(S-156) Lower Poise Bar • Single lines represent increments of 50 pounds • Grooves located along the top of the lower bar align with weight increments	
(S-157) Weight Indicators • Both upper and lower bars have movable weight indicators • The weight indicator for the lower bar fits into the groove as weight is obtained	
(S-158) Balance Bar and Balance Window • Always ensure that the balance bar is floating freely and in the center of the window when upper/lower bars are set on 0 and resident is not standing on scale • If balance bar is off-center and/or touching the window when upper and lower bars are set on 0 and resident is not standing on scale, do not weigh resident and notify the nurse	
(S-159) Reading the Weight • To determine weight: add the value for the lower bar to	

Module AA – Measurement (Height and Weight)	
the value for the upper bar • 100 pounds + 38 pounds = 138 pounds	
(S-160) Height Component – Head Piece • Becomes active when extended upward in preparation for measuring the resident's height • Lowered and placed on resident's head and height measured • Becomes at rest when flat and low against height rod	
(S-161) Height Component – Rod • 2 Units of measure o Inches o Centimeters • 2 sections o Movable upper section o Non-movable lower section	
(S-162) Height Component – Rod • Movable upper section o Raised or lowered to adjust to resident's height o "Read height here" area is the location of the weight value if resident's height is located in this section o Numbers increase from top to bottom • Non-movable lower section o Height read in lower section if resident's height is located in this area o Numbers increase from bottom to top	
(S-163) Measuring the Height • When measuring in feet and inches using height rod o Long lines represent inches o Shorter lines represent ¼ inch each; increments include ¼, ½, ¾ • Read height to the nearest ¼ inch	
(S-164) Measuring the Height • How tall is the resident? • Resident's height is 68 inches	
(S-165) Converting Inches into Feet and Inches • Resident's height is 68 inches • How does the nurse aide convert 68 inches to feet and inches?	
(S-166) Converting Inches into Feet and Inches • There are 12 inches in 1 foot • To convert inches to inches and feet, divide the number of inches by 12 • The quotient is the feet and the remainder (if there is one) is the inches	
(S-167) Height in Feet and Inches	

Module AA – Measurement (Height and Weight)	
• Resident's height is 68 inches • How does the nurse aide convert 68 inches to feet and inches? o 1 foot = 12 inches o Divide 68 inches by 12 inches o Quotient = 5, remainder = 8 o Answer = 5 feet, 8 inches	

Handout #1AA Analog Watch

A watch that has moving hands and typically marked with numbers 1 – 12

Has an hour hand, minute hand, and second hand

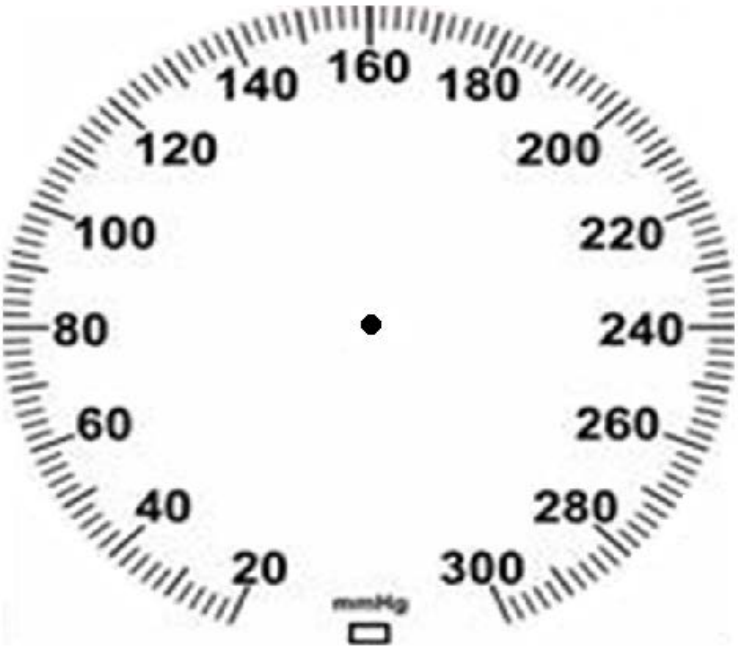
The nurse aide uses the second hand to count respirations and pulse rate

If you are counting respirations or pulse rate for 60 seconds, while watching the second hand, start counting and stop counting on the same number

Do not wait until the second hand lands on the 12 to start counting. Just remember which number you started with when you count.

Number Start	Number Stop	Number Start	Number Stop
1	1	7	7
2	2	8	8
3	3	9	9
4	4	10	10
5	5	11	11
6	6	12	12

Handout #2AA Aneroid Blood Pressure Manometer



- **Long lines mark 10 mm Hg**
- **Short lines mark 2 mm Hg**

If the needle lands between 2 lines at the point that the systolic sound is heard or the sound is no longer heard (diastolic), then the number value is rounded up to the next 2 mm Hg; odd numbers are not recorded/reported when using a manual BP cuff

When checking a blood pressure, you will be watching the needle as it drops from a higher number to a lower number, so you will be counting backwards.

Measured in millimeters of mercury (mm Hg),

Recorded as a fraction

120 (systolic)
80 (diastolic)

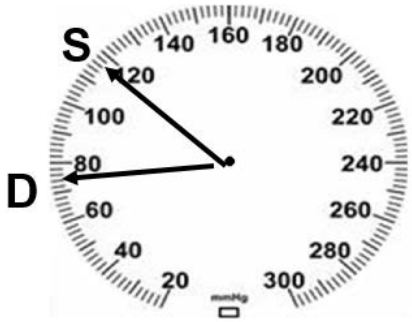
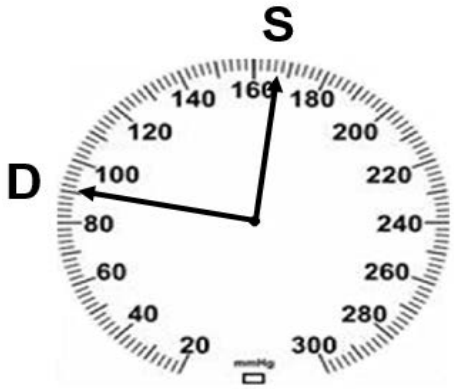
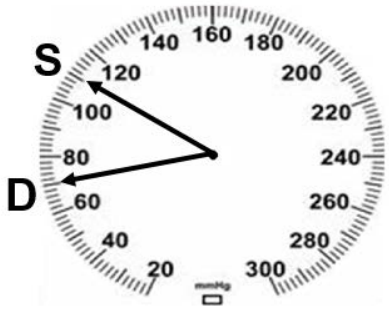
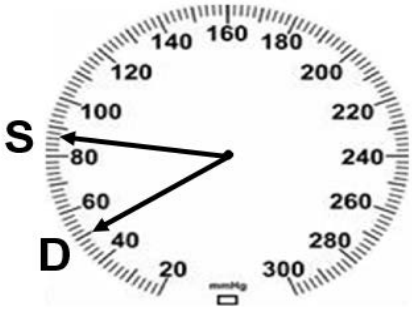
Pronounced “120 over 80”

ACTIVITY #2AA Blood Pressure and Factors of Select People

For numbers 1 – 5, write specific information for each individual. For numbers 6 – 15, place a check if the specific factor applies to the individual. If a factor is not included in the description of the individual, imply that it is not present.

Specific Factors	Mrs. Smith	Mr. Brown	Mr. Spencer
1. Blood pressure			
2. Age			
3. Gender			
4. Race			
5. Weight			
6. Lying down now?			
7. Exercising now?			
8. Smokes?			
9. Drinks alcohol?			
10. Overweight?			
11. High salt diet?			
12. Stressed now?			
13. Anxious now?			
14. Injured now?			
15. Pain now?			

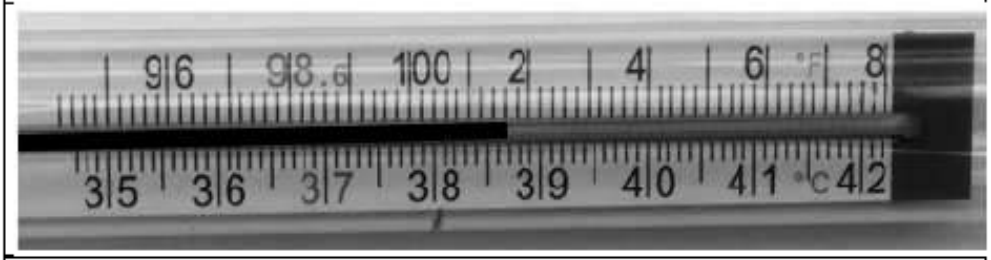
Activity #5AA Aneroid Blood Pressure

#1  	#2 
What is the blood pressure? Is the blood pressure normal? ____ yes ____ no You will: ____ notify the supervisor ____ document the blood pressure ____ both	What is the blood pressure? Is the blood pressure normal? ____ yes ____ no You will: ____ notify the supervisor ____ document the blood pressure ____ both
#3  	#4 
What is the blood pressure? Is the blood pressure normal? ____ yes ____ no You will: ____ notify the supervisor ____ document the blood pressure ____ both	What is the blood pressure? Is the blood pressure normal? ____ yes ____ no You will: ____ notify the supervisor ____ document the blood pressure ____ both

#5 	#6
Draw the following blood pressure value, labelling systolic with an S and diastolic with a D: 134/82	Draw the following blood pressure value, labelling systolic with an S and diastolic with a D: 122/74
#7 	#8
Draw the following blood pressure value, labelling systolic with an S and diastolic with a D: 1464/90	Draw the following blood pressure value, labelling systolic with an S and diastolic with a D: 90/60
#9 	#10
Draw the following blood pressure value, labelling systolic with an S and diastolic with a D: 180/96	Draw the following blood pressure value, labelling systolic with an S and diastolic with a D: 96/64

Activity #7AA Fahrenheit Temperature

#1



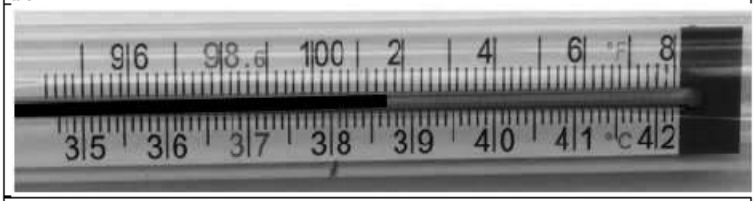
- What is the oral Fahrenheit temperature? _____
- Based on the oral temperature reading, the resident is:
  - ____ afebrile
  - ____ febrile
- Will you:
  - ____ notify the supervisor
  - ____ document the temperature
  - ____ both

#2

- What is the rectal Fahrenheit temperature? _____
- Based on the rectal temperature reading, the resident is:
  - ____ afebrile
  - ____ febrile
- Will you:
  - ____ notify the supervisor
  - ____ document the temperature
  - ____ both

Activity #7AA Fahrenheit Temperature

#1



- What is the oral Fahrenheit temperature? _____
- Based on the oral temperature reading, the resident is:
  - ____ afebrile
  - ____ febrile
- Will you:
  - ____ notify the supervisor
  - ____ document the temperature
  - ____ both

#2

- What is the rectal Fahrenheit temperature? _____
- Based on the rectal temperature reading, the resident is:
  - ____ afebrile
  - ____ febrile
- Will you:
  - ____ notify the supervisor
  - ____ document the temperature
  - ____ both

Activity #9AA Intake Calculations

Using the following serving sizes of containers common in health care facilities, determine intake for the fluids listed below. Use fractions.

• Water glass = 240 mL • Tea glass = 180 mL • Juice glass = 120 mL • Milk carton = 240 mL	• Coffee cup = 240 mL • Soft drink can = 360 mL • Gelatin = 120 mL • Soup bowl = 180 mL

Located on Meal Tray	Show Fraction Here	Intake in mL
The resident drank 1/2 of his orange juice. How many mL of orange juice did the resident drink?		
The resident ate 1/3 of his tomato soup. How many mL of soup did the resident eat?		
The resident drank 2/3 of his coffee. How many mL of coffee did the resident drink?		
The resident ate 3/4 of his gelatin. How many mL of gelatin did the resident drink?		
The resident drank 1/4 of his tea. How many mL of tea did the resident drink?		

Using the following serving sizes of containers common in health care facilities, determine intake for the fluids listed below. Use clean, labelled graduate to measure.

• Water glass = 240 mL • Tea glass = 180 mL • Juice glass = 120 mL • Milk carton = 240 mL	• Coffee cup = 240 mL • Soft drink can = 360 mL • Gelatin = 120 mL • Soup bowl = 180 mL

Located on Meal Tray	Show Subtraction Here	Intake in mL
The resident drank part of his orange juice. The nurse aide measured 45 mL in graduate that resident didn't drink. How many mL of orange juice did the resident drink?		
The resident drank part of his coffee. The nurse aide measured 100 mL in graduate that resident didn't drink. How many mL of coffee did the resident drink?		
The resident drank most of his water. The nurse aide measured 80 mL in graduate that resident didn't drink. How many mL of water did the resident drink?		

Activity #10AA Let's Make a Chart

Using fractions, let's make a chart. The serving sizes of common containers found in health care facilities are listed along the side of the chart. The amounts of fluid drank/eaten are listed across the chart. You will write in the amount in mL that was drank in the appropriate box. I will do the first one for you. 1/4 of 120 mL was drank, which equals 30 mL. I did not include my work in the example, but you need to. Work out your fractions below.

• Water glass = 240 mL • Tea glass = 180 mL • Juice glass = 120 mL • Milk carton = 240 mL	• Coffee cup = 240 mL • Soft drink can = 360 mL • Gelatin = 120 mL • Soup bowl = 180 mL

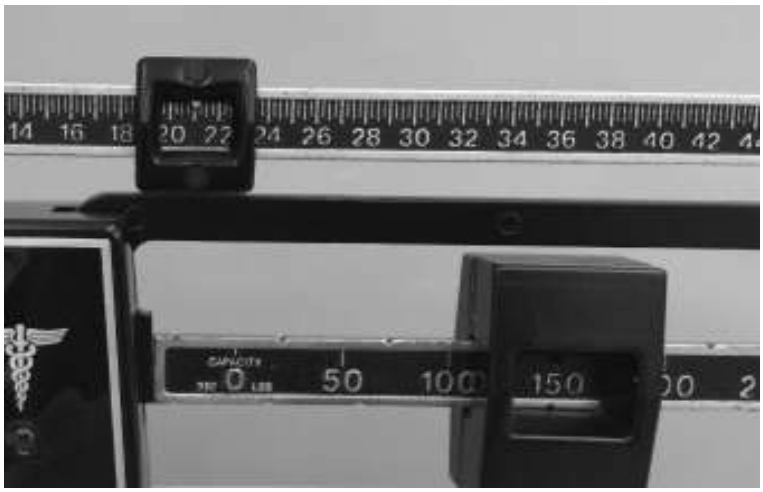
	1/4	1/2	3/4	1/3	2/3
120 mL	30 mL				
180 mL					
240 mL					
360 mL					

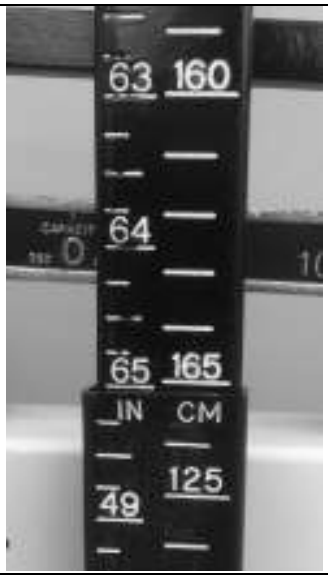
Activity #11AA Urine Output

#1 Urine	#2 Urine
Amount in milliliters	Amount in milliliters
#3 Urine	#4 Urine
Amount in milliliters	Amount in milliliters

Activity #12AA: Weight and Height

#1 Weight
Write the resident's weight in pounds. _____ Show calculation:
#2 Weight
Write the resident's weight in pounds. _____ Show calculation:

#3 Weight
Write the resident's weight in pounds. _____ Show calculation:
#4 Weight

Write the resident's weight in pounds. _____ Show calculation:

#1 Height
Write the resident's height in inches _____ Write the resident's height in feet and inches _____ Show calculation:
#2 Height

Write the resident's height in inches _____ Write the resident's height in feet and inches _____ Show calculation:

#3 Height

Write the resident's height in inches _____

Write the resident's height in feet and inches _____

Show calculation:

#4 Height

Write the resident's height in inches _____

Write the resident's height in feet and inches _____

Show calculation:

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE A
The Nurse Aide I

Student Manual
Version 1. Full Text
2019

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module A – The Nurse Aide I
Definition List

AM Care – personal activities done in the morning that include toileting, face/hand wash, and mouth care before/after breakfast

Activities of Daily Living (ADL) – term used in health care to describe everyday things that a resident routinely does, such as hygiene and grooming, dressing, eating, toileting, and transferring

Basic Nursing Skills – essential skills required of nurse aides to deliver competent care to residents in health care settings

Cognition – the manner in which messages from the five senses are collected, stored in memory, recovered from memory, and later used to answer questions, respond to requests, and perform tasks; the ability to think logically and clearly

Delegation – the process of assigning part of one's responsibility to another qualified person in a specific situation; transferring responsibility for the performance of an activity or task while retaining accountability for the outcome

Grooming – tasks done to maintain the person's appearance, such as caring for fingernails and hair

Hygiene – tasks done to keep bodies clean and healthy, such as bathing and brushing teeth

Interpersonal Skills – in a health care setting, generally refers to a health care provider's ability to get along with others while getting the job done

North Carolina Board of Nursing – regulatory body that provides list of tasks that fall within the range of function for nurse aides in North Carolina

North Carolina Board of Nursing Administrative Code – defines range of function for nurse aides in North Carolina

North Carolina Health Care Personnel Education and Credentialing Section – section of the State of North Carolina that provides services for unlicensed health care workers, their employers, and their instructors and maintains the NC Nurse Aide I Registry

North Carolina Nurse Aide I Registry – a registry of all people who meet state and federal training and testing requirements to perform Nurse Aide I tasks in the State of North Carolina

Nurse Aide I in the State of North Carolina – a valued, unlicensed member of the health care team, responsible for providing delegated nursing tasks, within a

defined range of function, for residents (patients/clients), in a variety of settings, and who is listed on the NC Nurse Aide I Registry

OBRA (Omnibus Budget Reconciliation Act) of 1987 – Federal Law, enacted by Congress, in 1987, to improve quality of life of residents living in a nursing home environment; comprehensive review/update of regulations, effective November 28, 2016

PM Care – personal activities done in the evening that include toileting, face/hand wash, snack, mouth care, and backrub

Personal Care Skills – tasks that deal with a person's body, appearance, and hygiene, typically done on a daily basis

Team – a group of people with a common purpose, assigned tasks, and coordinated effort to get a job done

Work Ethic – is behavior in workplace that includes appearance, communication skills, treatment of others, choices, judgment, and teamwork

Module A – The Nurse Aide I	
(S-1) Title Slide **(S-2 & S-3) Objectives** 1. Describe the North Carolina Nurse Aide I. 2. Explain requirements for initial listing and renewals on the North Carolina Nurse Aide Registry. 3. Describe resources available that outline the range of function of the North Carolina Nurse Aide I. 4. Describe the importance of delegation of tasks to nurse aides. 5. Describe the types of skills performed by nurse aides. 6. Compare basic nursing skills, personal care skills, and interpersonal skills. 7. Describe important characteristics of a competent, caring nurse aide. 8. Explain the differences between an effective team and an ineffective team.	
Content	**Notes**
(S-4) Who is a Nurse Aide I in the State of North Carolina? • A valued, unlicensed member of the health care team, responsible for providing delegated nursing tasks within a defined range of function, for residents (patients/clients) in a variety of settings and who is listed on the N.C. Nurse Aide I Registry • North Carolina Board of Nursing (NCBON) uses the umbrella term, Unlicensed Assistive Personnel (UAP), to describe unlicensed health care assistants who have been trained to provide certain tasks of client care as directed by a licensed health care provider. The Nurse Aide I, Patient Care Aides, Medical Office Assistants, Medication Aides and Medical Assistants are just some of the roles that are termed Unlicensed Assistive Personnel. • Nurse Aide I in NC may also be called nurse aide or nursing assistant	
(S-5) OBRA (Omnibus Budget Reconciliation Act) • Federal Law, enacted by Congress, in 1987; updated in 2016 • Designed to improve quality of life of residents living in a nursing home environment • One component of OBRA defines requirements for nurse aide training and competency evaluation, and the nurse aide registry • OBRA discussions occur throughout the course	
(S-6) Range of Function for Nurse Aides • North Carolina Board of Nursing Administrative Code – defines range of function for nurse aides in North Carolina • North Carolina Board of Nursing – provides list of tasks that fall within the range of function for nurse aides in North Carolina	

Module A – The Nurse Aide I	
• Nurses may delegate other tasks that fall within the range of function for nurse aides if task meets specific criteria before the delegation of task occurs	
(S-7) Regulatory Body • North Carolina Nurse Aide I Registry – a registry of all people who meet state and federal training and testing requirements to perform Nurse Aide I tasks in the State of North Carolina • North Carolina Health Care Personnel Education and Credentialing o Section of the State of North Carolina government that provides services for unlicensed health care workers, their employers, and their instructors o Maintains N.C. Nurse Aide I Registry o Approves Nurse Aide Training Programs	
(S-8) Registry Listing Requirements • Individual is listed on the Nurse Aide I Registry upon passing the National Nurse Aide Assessment Program (NNAAP) o Written/oral examination o Demonstration of five (5) skills • Individual may take the NNAAP exam up to 3 times upon completion of a state-approved Nurse Aide I Training Program	
(S-9) Listing Renewals (1) • Listings are renewed through qualified work experience completed every 24 months • Qualified work experience requires the following: o Work a minimum of eight hours during the 24-month listing period o Receive payment for work experience o Perform nursing or nursing related services o Supervised by an RN • Any nurse aide who does not work during the 24-month listing period will be required to retrain and retake and pass the NNAAP exam	
(S-10) Listing Renewal Form • Both the nurse aide and RN supervisor must complete a designated portion of the renewal listing form • RN and nurse aide must sign form • Nurse aide should send in renewal listing form about 3 months prior to expiration date of listing • Requests for a Replacement Renewal Form may be found at **www.ncnar.org** • Important note: nurse aides cannot work as a nurse aide once the listing expires	

Module A – The Nurse Aide I	
(S-11) Nurse Aide I Renewal Responsibilities • Scannable renewal forms for nurse aides are mailed by the registry to eligible nurse aides 3 months before the listing expiration date • Promptly report changes in name or address to the registry so the forms are mailed to the correct address	
(S-12) Key Web Sites • Two important web sites that every nurse aide should know about o North Carolina Board of Nursing **www.ncbon.com** o N.C. Division of Health Service Regulation **www.ncnar.org**	
(S-13) Job Responsibilities of Nurse Aide • Perform delegated basic nursing skills in a competent, caring manner • Perform delegated personal care skills in a competent, caring manner • Use appropriate interpersonal skills	
(S-14) Delegation • What exactly does delegated mean? • Definition – delegated or delegation is the process of assigning part of one's responsibility to another qualified person in a specific situation (National Council of State Boards of Nursing) • Another definition – transferring responsibility for the performance of an activity or task while retaining accountability for the outcome (ANA) • Nurse uses delegation of skills and legal regulations to assign duties and tasks to others on the health care team • Improves efficiency and shows trust in others (but nurse is still accountable) • Nurse assesses knowledge/skills of the delegate and matches tasks to skills, using the 5 Rights of Delegation – Right Task, Right Circumstance, Right Person, Right Direction and Communication, and Right Supervision and Evaluation • Before accepting a delegated task, the nurse aide must ask self: o Do I have all the information I need to do the task and do I have questions about the task? o Do I believe I can do the task and have the necessary skills to do the task? o Do I have the equipment and supplies I need? o Do I know who my supervisor is and how I can find him/her if needed? o Have I told my supervisor if I need help to do the task?	

Module A – The Nurse Aide I	
(S-15) Delegation – Points to Remember • Nurse maintains accountability and responsibility for delivery of safe and competent care • Decisions regarding delegation of any nurse aide activity are made by nurse on resident-by-resident basis • Never be afraid to ask for help • Always ask if you do not understand a task, need more information, or if not sure about something • If you think you do not have the skills necessary to do the task, talk to your supervisor	
(S-16) Basic Nursing Skills • Essential skills required of nurse aide to deliver competent care to residents in health care settings • Examples include o Monitoring, documenting, and reporting of vital signs o Management of pain as directed by the nursing care plan o Application of warm/cold o Dressing changes • Privacy is key when providing basic nursing skills	
(S-17) Basic Nursing Skills – Importance • Performance of basic nursing skills is important duty of nurse aide • Following resident's plan of care, following directives from supervisors, and reporting important findings are all critical for well-being of residents	
(S-18) Personal Care Skills • Tasks that deal with a person's body, appearance, and hygiene • Privacy is key when providing personal care skills • Done on a daily basis – in the a.m., p.m., and in-between • Each individual has own preferences, such as time of bath, certain soaps, or hairstyles	
(S-19) Personal Care Skills • Hygiene o Tasks performed to keep bodies clean and healthy o Examples include bathing and brushing teeth • Grooming o Tasks performed to maintain the person's appearance while fostering dignity and choice o Examples include caring for fingernails and hair	
(S-20) Personal Care Skills • A.m. Care includes toileting, assisting with face/hand wash, mouth care before/after breakfast • P.m. Care includes toileting, assisting with face/hand wash, snack, mouth care, back rub	

Module A – The Nurse Aide I	
(S-21) Personal Care Skills – Concept of ADLs • Activities of Daily Living (ADLs) is common term • Hygiene and grooming, plus dressing, eating, transferring, and toileting equal activities of daily living (ADLs) • Assisting with ADLs of assigned residents is important duty of nurse aides	
(S-22) When Providing Personal Care • Important to help residents be as independent as possible and encourage residents to do as much of care for self as possible • Residents may feel embarrassed at having to be helped with personal care needs so nurse aides should be professional and provide privacy during care • While assisting with personal care needs, nurse aide can observe resident's skin, mobility, comfort, and cognition	
(S-23) Interpersonal Skills (1) • Essential skills used by a person when working with others • Determined by standards and values, culture and environment, heredity, interests, feelings, expectations others have for us, and past experiences • In a health care setting, generally refers to a health care provider's ability to get along with others while getting the job done	
(S-24) Interpersonal Skills – Importance (2) • Nurse aides interact with a variety of people while on duty and it is important to understand how their own actions and attitudes impact those around them including residents, family members, and co-workers • Nurse aides are a valued member of the health care team and spend the majority of their workday with residents	
(S-25) Interpersonal Skills – Nurse Aide's Role (1) • When caring for residents, nurse aide should o Empathize (view things or events as the resident views them) o Anticipate needs o Treat residents as unique individuals and honor requests when possible o Display patience and tolerance while attempting to understand behavior o Be sensitive to resident's moods and be mindful of your own reactions to their moods	

Module A – The Nurse Aide I	
(S-26) Interpersonal Skills – Nurse Aide's Role (2) • Be respectful to family and understand concerns they may have • Maintain an open, positive, and professional relationship with each member of the health care team • Effectively communicate and work well with others	
(S-27) The Nurse Aide as Employee – Important Qualities • Must act, behave, and function in professional manner while at work • Expected to have an excellent work ethic because of the importance of the position o Work ethic is behavior in workplace o Includes appearance, communication skills, treatment of others, attitude, and teamwork	
(S-28) Appearance (1) • Follows facility dress code for uniform and jewelry • Dresses neatly in modest, clean uniform, without tears or wrinkles, with facility name badge visible at all times • Wears clean, non-skid, closed-toed, comfortable shoes that fit well and offer support • Wears clean undergarments in appropriate color and style	
(S-29) Appearance (2) • Covers permanent body art • Maintains neatly trimmed, short, natural and clean nails without polish • Maintains simple, attractive hairstyle and pulls long hair back away from face • Maintains excellent personal hygiene (bathes daily, free of offensive odors, without perfume/cologne/after-shave)	
(S-30) Appearance (3) • Wears clean stockings or socks that fit well • Wears no jewelry in eyebrows, nose, lips, or tongue • At the most, wears a single pair of stud earrings • Flashes a warm and friendly smile • Wears no heavy make-up	
(S-31) Appearance – First Impression • Just how important is a person's physical appearance? o It takes 15-seconds to make first impression o First impressions are important – whether it be meeting a resident for the first time or showing up for a job interview o Looking good and feeling good about one's self increases self-confidence, which in turn, increases	

Module A – The Nurse Aide I	
likelihood that resident will have confidence in you as a health care provider	
(S-32) Attitude (1) • Patient and understanding • Honest and trustworthy • Conscientious and always tries to do the very best • Enthusiastic and enjoys job • Courteous, considerate, and respectful • Cheerful	
(S-33) Attitude (2) • Dependable and responsible • Accountable and willing to admit mistakes • Tolerant of others and keeps opinions to self • Self-aware • Cares for people equally well, no matter race, age, sex, religion, or sexual orientation • Cares about others and what they are going through	
(S-34) The Nurse Aide as Employee – Nurse Aide's Role • Strive to be the best nurse aide you can be because the residents of North Carolina are depending on you	
(S-35) The Nurse Aide as Employee – Nurse Aide's Role • Understand requirements of being a nurse aide in North Carolina and maintain current listing on Nurse Aide I Registry • Know what nurse aides are legally allowed to do • Have concern for others and help make their lives happier and easier – whether it be residents, families, or co-workers • Maintain excellent appearance, grooming, and hygiene, while at work	
(S-36) The Nurse Aide as Employee – Nurse Aide's Role • Report to work on time and when scheduled • Use sick time for just that – sick time • Perform an honest day's work for an honest day's pay • Show respect to boss and supervisors; don't join in when others are criticizing management • Perform tasks delegated by nurse	
(S-37) The Nurse Aide as Employee – Nurse Aide's Role • Be gentle and kind to residents, families, and co-workers • Be able to put self in the other person's shoes and attempt to understand the person (empathy) • Be pleasant, not moody, bad-tempered, or sad, while at work • Respect others and their possessions • Always try your best	

Module A – The Nurse Aide I	
• Never be afraid to ask when you do not know an answer or how to do something	
(S-38) The Nurse Aide as Employee – Nurse Aide's Role • Treat residents, families, and co-workers with dignity • Be a team player and help others when you are asked and when you have down-time • Be careful and alert to surroundings at work and to resident cues • Be eager and excited about going to work • Do not gossip	
(S-39) The Nurse Aide as Employee – Nurse Aide's Role • Do not lie, cheat, or steal (not even a note pad or ink pen) • Always seek the good in others • Remain loyal to facility and employer • Always take the opportunity to praise others when the chance arises • Do not use profanity or tell off-color jokes	
(S-40) The Nurse Aide as Employee – Nurse Aide's Role • If you are not sure that what you are about to do is right, don't do it – it's your conscience talking!!!!!	
(S-41) The Nurse Aide as Team Member • A team is a group of people, with a common purpose, assigned tasks, and coordinated effort to get a job done	
(S-42) Team Members • Work together and function as interrelated parts of the whole • Communicate with each other • Coordinate work activities and share responsibilities • Receive assignments to ensure that each team member knows what to do, what is expected of them, and how to plan work schedules • Example – a nurse aide is a member of a health care team	
(S-43) Qualities of an Effective Team • Climate – informal, comfortable, and relaxed; members are interested and involved • Communication – open and two-way, ideas and feelings encouraged • Interactions – inclusive and trusting; people like each other and like working with each other • Goals and tasks are appropriate, understood, and modified so that work gets done • Leaders lead and members participate in a respectful and cooperative manner	

Module A – The Nurse Aide I	
• Everyone pulls together – high levels of inclusion, trust, liking, and support • Problem-solving is high – when a problem arises, people consult with appropriate resources and work to resolve problem	
(S-44) Qualities of an Ineffective Team • Climate – tense • Communication – closed and one-way; ideas and feelings are discouraged; members are hesitant to speak up • Interactions – Based on authority only; people with more power dominate and look down on people they feel are unequal and undeserving of their time • Goals – unclear, misunderstood, or forced; may result in not getting the job done • Decision-making – done by the highest authority with minimal group involvement • Trust - distrust among members and members forced to conform • Getting along – disagreements or conflicts are ignored, denied, suppressed • Problem-solving – low; criticism is destructive; members are attacked; job doesn't get done	
(S-45) With a Strong Group Commitment, Members • Feel strong sense of belonging • Enjoy being with each other • Ask each other for advice • Seek and provide support in times of difficulty	
(S-46) With a Strong Group Commitment, Members • Value each other and contribution each makes • Are motivated and want to do a good job • Share good feelings openly • Feel the goals of the group are important and achievable	

Activity #1A
Go Team Worksheet

Instructions: read the following conversations overheard in various health care settings. Decide whether a member of an effective team or ineffective team is talking. Place a checkmark in the correct box.

Conversation	Effective	Ineffective
1. "No, I won't get Mr. James up to the bathroom because he is not my resident."		
2. "I can't wait until the staff Christmas party!"		
3. "Why don't you get Mrs. Smith on the bedpan and I'll turn Mr. Peters."		
4. "If I have to sit in another end-of-shift report with that witch, Mrs. Brown, I'll scream!"		
5. "Don't you think Jackie is a good charge nurse?"		
6. "I really enjoy working with you, Katie."		
7. "Hey Marty, let's go turn all our residents together."		
8. "Cindy, I sure do see why we can't keep any Nurse Aides here. I've been here the longest and I've only been here eight months!"		
9. "That Mary, she looks like a horse whenever she shakes her head, no."		
10. "Guess what I heard about Johnnie? It will really shock you!"		
11. "I am really glad to be a part of the care planning team."		
12. "You are such a good person to work with."		
13. "The infection control nurse said that we only had a 2% infection rate. We did better on our goal than we predicted."		
14. "Sophie, you know Mrs. Atkins better than anyone. Why do you think she seems so unhappy?"		
15. "Gee, Betsy, I sure am glad you and Sam resolved the disagreement about the luncheon date."		
16. "Hey Cecil, can I ask your advice about something?"		
17. "I don't care what you think, Missy. We are not going to do it that way. We are going to do it my way."		
18. "That's a stupid goal. How in the world will we ever achieve that?"		
19. "You will do it now, because I said so!"		
20. "Man, I never seem to get done with all my assigned work."		
21. "Frankly, I don't care what you think."		

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NURSE AIDE I TRAINING PROGRAM

MODULE B
Infection Prevention

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
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Module B – Infection Prevention
Definition List

Aerobic – requires oxygen to survive

Airborne Precautions – a transmission-based precaution that prevents spread of harmful germs that travel in the air at a distance, using Standard Precautions, plus a respirator, depending on specific disease

Anaerobic – does not need oxygen to survive

Aseptic – clean

Bloodborne Pathogens – harmful germs found in human blood and can cause infection and disease

Body Fluids – blood, pus, liquid from sores, urine, stool, tears, spit, droplets from sneezes and coughs, and sputum

Carriers – people who have harmful germs living on or in their body, but are not visibly sick

Centers for Disease Control and Prevention (CDC) – an agency of the federal government oversees the control and prevention of disease, in our country

Chain of Infection – way to explain how infection is passed around from one host to another host by using a picture of a chain

Contact Precautions – a transmission-based precaution that prevents spread of harmful germs by direct contact, using Standard Precautions, plus gown and gloves

Direct Contact – mutual touching of two things, people, or organisms which may cause the spread of harmful germs

Droplet Precautions – a transmission-based precaution that prevents spread of harmful germs that travel by droplets in the air, using Standard Precautions, plus mask and gloves

Droplets – particles of liquids that are sprayed from the nose or mouth when a person sneezes, coughs, sings, talks, or laughs

Goggles – personal protective equipment used to protect eyes from harmful germs

Gloves – personal protective equipment used to protect skin on hands from harmful germs

Gowns – personal protective equipment used to protect skin and clothes from harmful germs

Hand Hygiene – washing hands with soap and water or alcohol-based hand rubs

Healthcare-associated infection (HAI) – an infection that a resident gets while staying or living in a health care setting

Hepatitis B – a disease of the liver caused by a virus

Hepatitis C – a disease of the liver caused by a virus

Host – an animal or a person

Indirect Contact – harmful germs spread by an object that has touched body fluids from infected person

Infection – a disease or condition of the body that occurs when harmful germs get into the body and grow in number

Infection Prevention – all the things that people do to control and prevent the spread of infection

Infectious Agent – a harmful germ that causes an infection

Influenza (flu) – a contagious respiratory illness

Localized Infection – an infection found in one part of the body with symptoms noted at that one part of the body

Masks – personal protective equipment used to protect mouth and nose from harmful germs

Medical Asepsis (clean technique) – practice used to remove or destroy germs and to prevent their spread from one person or place to another person or place

Microorganisms – also called germs that live almost everywhere and may cause problems or diseases

Mode of Transmission – how harmful germs travel or get around from place to place

Mucus Membranes – linings of natural body openings, such as mouth, nose, rectum, genitals and eyes

Non-intact Skin – cuts, scratches, and sores of the skin

Norovirus – a contagious gastrointestinal illness

Outbreak – more illness in more residents than what is expected or what is normal for the facility of a healthcare associated infection

Personal Protective Equipment (PPE) – a group of items used to block harmful germs from getting on skin and clothes

Point of Care – refers to the place where three (3) elements occur together: the resident, the nurse aide, and the care or treatment involving resident contact; most point of care occurs in resident's room

Portal of Entry – a body opening of a person that allows harmful germs to enter the body

Portal of Exit – any way that harmful germs escape from reservoir

Reservoir – place where harmful germs live, grow, and increase in numbers

Sharps – items that have corners, edges, or projections that can cut or pierce the skin, such as needles and razor blades

Sharps Container (needle disposal container or sharps box) – hard and leak-proof biohazard container used only for sharps

Shields – personal protective equipment used to protect the whole face from harmful germs

Sputum – mucous coughed up from lungs

Standard Precautions – the first of two levels to prevent/control infections; the basic tasks that health care workers must do to prevent and control spread of infection, whereby all body fluids, non-intact skin, and mucus membranes are treated as if they were infected

Susceptible Host – person who does not have an infection now, but is at risk for becoming infected from harmful germs

Systemic Infection – an infection that affects an entire body part, or entire body system

Transmission Based Precautions – the second of two levels to prevent/control infections; specific tasks and measures that health care workers must do when caring for residents who are infected or may be infected with specific types of infections

World Health Organization (WHO) – an organization within the United Nations whose purpose is to aid in the achievement of highest level of health for all the world's people

Module B – Infection Prevention	
(S-1) Title Slide **(S-2) Objectives** 1. Relate the chain of infection to the work of a nurse aide in long-term care facilities. 2. Explain the concept of breaking the chain of infection and its importance to infection prevention. 3. Compare Standard Precautions and Transmission-based Precautions. 4. Discuss the use of Personal Protective Equipment by the nurse aide. 5. Explain why residents in long-term care facilities are at risk for infection.	
Content	**Notes**
(S-3) Infection Prevention • Ways to control and prevent the spread of infection	
(S-4) Infection • A disease or condition of the body that occurs when harmful germs get into the body and grow in number • Examples o Urinary tract infection, including bladder infection and kidney infection o Skin infection, including infected wounds and cuts o Respiratory infection, including pneumonia, flu and the common cold o Gastrointestinal infection, including stomach infection, intestinal infection, or food poisoning • Two types of infection are localized and systemic	
(S-5) Localized Infection • An infection found in one part of the body and symptoms are limited to that one part of the body • Example – an infected finger (when a finger becomes infected, it may be red, painful, hot, puffy, with drainage)	
(S-6) Systemic Infection • An infection that affects an entire body part or entire body system • Different types of symptoms including fever, chills, confusion, feeling tired, nausea/vomiting, and possibly symptoms specific to the entire body part or entire body system • Example – respiratory infection	
(S-7) Symptoms of Respiratory Infection • Fever and chills • Sniffling and snorting • Coughing and sneezing • Hacking up globs of green or yellow, slimy mucous	
(S-9) Symptoms of Bladder Infection • Fever and chills	

Module B – Infection Prevention	
• Pain during urination • Bad or strong-smelling urine, with possible blood in it • Resident states “my urine smells and it hurts when I use the bathroom” (may use a different word for urine)	
(S-10) Stomach Infection • Person with a stomach infection will probably have stomach pains and may vomit	
(S-12) Microorganisms • Are also called germs • Live almost everywhere – both inside and outside the body • Some help and others cause problems or diseases • Requirements to survive o Warmth o Moisture o Some need oxygen to live (aerobic) and others do not (anaerobic) o Tissue to feed on • Examples – bacteria, viruses, parasites, fungi • Cause infections	
(S-13) Medical Asepsis • Also called clean technique • Practices used to remove or destroy microorganisms and to prevent their spread from one person or place to another person or place	
(S-14) Chain of Infection • Way to explain how infection is passed around from one host (person or animal) to another host by using picture of a chain • Foundation for spreading and prevention of spreading an infection • Has six (6) links • Each link represents something (or someone) needed to pass on an infection from one to another • For an infection to occur and spread, each of six links must be present • As long as links are joined together, an infection will be passed from one person to another to another, and so on • As long as links are joined together, an infection will be passed from one resident to another, to a staff member, to another resident, and so on • Breaking any link in the chain of infection, can prevent a new infection • Infection prevention practices such as hand washing,	

Module B – Infection Prevention	
cleaning equipment, and using masks will break a link in the chain • Will learn ways to break chain of infection and help keep you, your co-workers, and your residents infection-free; this is one time when breaking something is a good thing!	
(S-15) Link #1 Causative Agent • A harmful germ that causes an infection • Examples – bacteria, a virus, a fungus, or a parasite	
(S-16) Link #2 Reservoir • Place where harmful germs live, grow, and increase in numbers (a home for germs) • When reservoir is a person, harmful germs may live and multiply in: o Blood o The skin o The digestive tract, such as the mouth, stomach, intestines • The respiratory tract, such as the nose, throat or lungs • Examples – a person, an animal, dirt, water, or other places in the environment • Can you look at a person and **ALWAYS** tell if he has an infection that can be given to you, a co-worker, or another resident? • The answer is “NO, not always.”	
(S-17) Link #2 Reservoir • When you think about people being reservoirs for harmful germs, all human beings belong in one of three groups: o 1st group – people not infected, are well and are not a current reservoir for germs o 2nd group – people who are infected, are obviously sick, and you know these people might get you sick o 3rd group – people who are carriers; have the harmful germs living on or in their body, but germs are not making them sick; because they are not sick, you do not know they have infections; are carriers of infection and do not show symptoms of infection, but can still infect others	
(S-18) Link #2 Reservoir • NOW, think about infection in terms of an iceberg • People we know who have infections and can infect us are only the tip of the iceberg • Think about the large number of people who ARE carriers, those we do not know, and who could possibly infect us!	

Module B – Infection Prevention	
• Key to preventing you, your co-workers, and your residents from getting infected is to treat EVERYONE as possible reservoirs or hiding places for harmful germs	
(S-19) Link #3 Portal of Exit • Any way or route that harmful germs escape from the reservoir • Examples o The nose and mouth – harmful germs leave in mucous droplets and saliva (or spit) o The gastrointestinal tract – harmful germs leave in stool or vomit o Skin – harmful germs leave through direct contact or in blood, pus, or other liquids that come from inside of body	
(S-20) Link #4 Mode of Transportation • How harmful germs travel or get around from place to place • Number one way a harmful germ travels from place to place is by our hands • How do our hands provide transportation for germs?	
(S-21) Link #4 Mode of Transportation Harmful germs travel by <u>direct contact</u> with body fluids where germs live, such as o Germs on hands after coughing, sneezing, wiping nose, or using the restroom and then spreading the germs to someone else or to an object that someone else might touch o Touching blood, infected wounds, stool, or vomit of infected person, and do not clean our hands properly before going to the next resident or before touching something that someone else might touch	
(S-22) Link #4 – Mode of Transportation • One way harmful germs travel is by indirect contact with body fluids where germs live, such as o Blood o Sputum (mucous that is coughed up) o Pus or wound fluid (from a cut or sore) o Saliva (or spit) o Stool (or bowel movement) o Vomit • Examples o Needle sticks with blood on the needle o Contact with skin that has a rash, cuts or scratches o Splash or spray of body fluids to the mucus	

Module B – Infection Prevention	
membranes of the eyes, nose and/or mouth	
(S-23) Link #4 Mode of Transportation • Other ways harmful germs get around o Through animal and insect bites; an insect or animal bites an infected person or animal and then bites a new person or animal and shares the infection o By eating or drinking food or water that is infected with harmful germs	
(S-24) Link #5 Portal of Entry • Any opening on a person's body that allows harmful germs to enter • Germs can usually get in the same way they got out • Portals of entry are also portals of exit • Examples of portals of entry include: o Nose and mouth – person breathes in harmful germs o Gastrointestinal tract – when person eats food or drinks liquids that have harmful germs in them o Breaks in skin that allow harmful germs to enter, such as open sore, cut, needle stick, and cracked skin	
(S-25) Link #6 Susceptible Host • Person who does not have an infection now, but is at risk for becoming next person to get infected from harmful germs • Susceptible host is a person whose body for some reason cannot fight off infection • Some of the reasons why a person's body cannot fight off an infection include o Age o Chronic illness o Not having proper vaccinations o Open cuts or skin breakdown o Fatigue o Poor nutrition o Stress	
(S-26) Link #6 Susceptible Host • Residents living in long-term care facilities more likely to get infection than other people who live in the community because o Many have several things wrong with health, such as a resident who may have lung, heart, and kidney problems o Many are elderly More likely to come in contact with harmful germs because they live close together and because they share staff and medical equipment	

Module B – Infection Prevention	

(S-27) Chain of Infection
• How does chain of infection relate to a nurse aide's work in long-term care?
  o As a nurse aide, you will have a huge responsibility to protect self, family, and residents from harm because you will work in environment that encourages infection
  o People who you care for generally are elderly, sickly, and/or susceptible to diseases
  o What is just a cold to most people can be deadly to older adult
  o If you break any link in chain of infection, the occurrence of new infection can be prevented
• You will have many chances at work to break chain of infection	

(S-28, 29) Breaking Chain of Infection at Each Link – Examples
• If **YOU** can break any link in the Chain of Infection, **YOU** can prevent the occurrence of a new infection
• Examples of a very simple way that everyone can break each link of the chain
  o Break 1st link, the infectious agent, by getting an immunization against flu
  o Break 2nd link, the reservoir, by staying home from work when you are sick
  o Break 3rd link, the portal of exit, by covering your mouth and nose when you sneeze
  o Break 4th link, the mode of transmission, by washing your hands
  o Break 5th link, the portal of entry, by covering an open sore with a bandage
  o Break 6th link, the susceptible host, by eating a proper diet	

(S-30) Healthcare-associated infection (HAI) • An infection that a resident gets while staying or living in a health care setting (nosocomial infection)	
(S-31) Centers for Disease Control and Prevention - CDC • Centers for Disease Control and Prevention (CDC) is an agency of the federal government in charge of the control and prevention of disease in our country • Works to protect the public by helping keep members of the public healthy and safe by education • Developed a two-tiered or two-level way to prevent and control infections in health care – Standard Precautions and Transmission-Based (Isolation) Precautions	
(S-32) Standard Precautions	

Module B – Infection Prevention	
• 1st level is to prevent and control infections • Basic tasks that health care workers must do when caring for EACH and EVERY RESIDENT in order to prevent and control the spread of infection • This means that **ALL** body fluids, non-intact skin, and mucus membranes are treated as if they were infected	
(S-33) Review of Terms • Recall body fluids include blood, pus, liquid from sores, urine, stool, tears, saliva, droplets from sneezes and coughs, and sputum coughed up from lungs and emesis • Non-intact skin includes cuts, scratches, sores that may be oozing infected fluids (reminder: non-intact skin is both a portal of exit and portal of entry) • Mucus membranes are the linings of natural body openings, such as eyes, nose, mouth, rectum and genitals	
(S-34) Importance of Standard Precautions • Why must Standard Precautions be used with every resident? o Because there are residents you provide care for who have infections that no one knows about o Yes, a resident may be infected and not show signs or symptoms of being sick o Without practicing Standard Precautions, you can get the infection and pass it along to others o Following Standard Precaution Rules prevents self, visitors, family, co-workers, residents and other members of the health team from getting infections	
(S-35) Hand Hygiene • New term in health care • CDC defines hand hygiene as washing hands with o soap and water or o alcohol-based hand rubs • Washing hands with soap and water is probably a life-long habit but using alcohol-based hand rubs may not be • Alcohol-based hand rubs may be gels, rinses, or foams that do not need water to use	
(S-36) Hand Hygiene • Handwashing is the number one way to stop the transmission of infection! • Therefore, performing hand hygiene is the single most important thing the nurse aide can do to prevent the spread of infection	
(S-37) Hand Hygiene – Where? (Point of Care)	

Module B – Infection Prevention	
• While at work, nurse aide should perform hand hygiene at point of care • Point of care refers to the place where 3 elements occur together o The resident o The nurse aide o The care or treatment involving resident contact o Most point of care occurs in resident's room	
(S-38) Hand Hygiene – When? (5 Essential Times) • World Health Organization (WHO) recommends that during health care delivery, at the point of care, there are 5 essential times or moments that nurse aide must perform hand hygiene 1. Before touching a resident (examples – helping resident move around, helping resident with a.m. or p.m. care, taking vital signs) 2. Before performing a clean or aseptic procedure (examples – before brushing resident's teeth or cleaning dentures, preparing meal tray, feeding resident, getting clean linen) 3. After any body fluid exposure risk (examples – after brushing resident's teeth or providing denture care, feeding resident, caring for skin lesions, cleaning up urine, stool, vomit, blood, and handling soiled linen, urinal, bedpan) 4. After touching a resident (examples – after helping resident move around, helping resident with a.m. or p.m. care, taking vital signs) 5. After touching resident surroundings (examples – after changing bed linen with resident out of bed, raising or lowering bed rail, leaning against a bed or night table, clearing bedside table or over-bed table)	
(S-39) Hand Hygiene • Arrival at work • After using restroom • Before and after eating • Before and after gloving • Before touching clean linen • When your hands are soiled • After handling trash • Touching objects/people	
(S-40) Hand Hygiene • After cleaning a spill of blood or other body fluids • Before and after using shared medical equipment	

Module B – Infection Prevention	
• After changing adult briefs • Leaving work • Returning home • Blowing nose • Sneezing in hand • Touching hair • Touching other body parts • After handling trash	
(S-41) **When to Hand Wash** • There are times when nurse aide should use soap and water, instead of alcohol-based hand rub o If hands are visibly dirty o After using restroom o After blowing nose o After sneezing in hands **When to Hand Rub** • There are times when alcohol-based hand rubs are acceptable choice in hand hygiene o Before and after eating o Before and after handling food o Before and after routine resident care	
(S-42) Personal Protective Equipment (PPE) • A group of items used by a nurse aide to block harmful germs from getting on skin and clothes • This is what nurse aide puts on at work to keep blood, urine, stool, saliva, and other body liquids off skin and clothes • Type of PPE nurse aide wears depends on o What is being done o What kind of contact there will be with blood, body fluids, non-intact skin, and mucus membranes • Whether the person is on Transmission-Based Precautions (will be talking more about later)	
(S-43) Personal Protective Equipment (PPE) • PPE includes gloves that protect skin on hands	
(S-44) Personal Protective Equipment (PPE) • PPE includes gown that protects skin and clothes	
(S-45) Personal Protective Equipment (PPE) • Masks that protect mouth and nose, goggles that protect eyes, face shields that protect whole face	
(S-46, 47, 48) Sharps • Items that have corners, edges, or projections that can cut or pierce the skin, such as needles, needles with	

Module B – Infection Prevention	
syringes, needles with attached tubing, and razor blades • **SAFETY, SAFETY, SAFETY** o Wear gloves and be careful when using or handling anything sharp that could have touched blood or body fluids o Be careful not to cut self or resident during shaves o Be careful not to jab yourself with a sharp • **NEVER, EVER** re-cap a needle or other sharp object because you may jab yourself • **NEVER, EVER** put anything sharp in a regular trashcan	
(S-49) Disposal of Sharps • **ALWAYS** put anything sharp that has been used on a resident in a sharps container (also called – needle disposal container or sharps box), o A special biohazard container used for disposal of sharps o Is hard and leak-proof o Labeled with warning that contents of container are harmful • **SAFETY, SAFETY, SAFETY** o **NEVER, EVER** stick your hand or fingers into a sharps container o **NEVER, EVER** try to cram just one more needle in the sharps container o **NEVER, EVER** over fill a needle disposal box – it should only be filled ¾ full, and then disposed of	
(S-50) Spills on Floor • Clean up spills based on procedures listed in facility's infection prevention policy or notify housekeeping, if necessary (and available) • In general o Put on gloves o Absorb spill o Clean area with correct product, following directions on the product label o Discard waste in appropriate container (a biohazard bag if spill involves body fluids) o Apply disinfectant to area, following directions of product o Place warning cone or sign to warn others if there is wet surface	
(S-51) Spills on Floor • Why are spills on the floor involving body fluids especially dangerous in a long-term care facility? • Spills that involve body fluids are a safety threat in the	

Module B – Infection Prevention	
long-term care facility for two (2) reasons o Falls o Risk of infection	
(S-52) Spills on Surfaces • Any time blood or body fluids get on any surface, you must clean surface with whatever product is provided at the facility • You must follow facility procedures and product instructions very closely • Examples of surfaces that may need to be cleaned include over-bed tables, wheelchairs, counter tops in utility rooms, and shower chairs	
(S-53) Transmission-Based Precautions • 2nd level to prevent and control infections • Specific tasks and measures must be taken when caring for residents who are infected or may be infected with specific types of infections • Nurse aides must follow Standard Precaution rules to protect self, co-workers, and residents from getting infections • 3 types of Transmission-Based Precautions o Contact Precautions o Droplet Precautions o Airborne Precautions	
(S-54) Contact Precautions • Purpose – prevent spread of harmful germs spread by direct contact • PPE – follow Standard Precautions, plus wear gown and gloves • Examples – Methicillin-Resistant Staphylococcus Aureus (MRSA) infection (is the bacteria known for causing skin infections in addition to many other types of infections) and Norovirus (the virus that causes diarrhea and vomiting)	
(S-55) Droplet Precautions • Purpose – prevent spread of harmful germs that travel by droplets in the air • Some harmful germs (like the flu) can be spread or travel by way of droplets o Droplets spread after being sprayed from nose or mouth when infected person sneezes, coughs, sings, talks, or laughs • Droplets might land on another person (direct contact), or might land on doorknob, railing, or other surface that	

Module B – Infection Prevention	

another person might touch (indirect contact)
• Droplets
  o Usually do not go farther than three feet, but could travel farther
  o Spread when an infected resident cough, sings, sneezes, or laughs
• PPE – follow Standard Precautions, plus wear a mask and gloves
• Examples – influenza, meningitis, and whooping cough	

(S-56) Airborne Precautions
• Purpose – prevent spread of harmful germs that travel in the air at a distance
• Harmful germs
  o Float around for a while
  o Can be carried by moisture, air currents and dust
• PPE – Standard Precautions, plus wear a respirator, depending on specific disease
• Examples – tuberculosis (or TB), chicken pox, measles	

(S-57) Outbreaks • More illness in more residents than what is expected or what is normal for the facility • Is a healthcare associated infection • Examples – respiratory illness, such as influenza (flu); and gastrointestinal illness, such as norovirus • Influenza and norovirus are very dangerous for people aged 65 and older	

(S-58) Flu
• Respiratory infection
• Risky for people 65 years and older
  o People 65 years and older are at greater risk of serious complications and death from the flu compared with young, healthy adults
  o 90 percent of flu-related deaths and more than half of flu-related hospitalizations each year occur in people 65 years and older
• Yearly flu vaccination is the first and most important step in protecting against flu
• Healthy adults may be able to infect others 1 day before showing flu symptoms and then 5 to 7 days after becoming sick
• Employees with fever and respiratory symptoms (such as cough or sore throat) should not come to work until fever has been gone for at least 24 hours without the use of fever-reducing medicines like Tylenol or ibuprofen	

Module B – Infection Prevention	
• Encourage EVERYONE (employees, residents, and visitors) to practice good hand hygiene and to cover mouth and nose when coughing or sneezing • Follow Standard Precautions and Transmission-Based Precautions	
(S-59) Norovirus • Gastrointestinal infection • Dehydration can be problem and elderly must replace fluids, when able (sometimes intravenous fluids are needed) • Most people get well in 1 to 2 days, but are contagious until at least 3 days after vomiting and diarrhea have stopped • Nurse aides who have symptoms of norovirus should stay home from work until at least 2 days after symptoms have resolved • Follow hand-hygiene guidelines, and carefully <u>wash hands with soap and water</u> after contact with residents with diarrhea or vomiting • Alcohol-based hand sanitizers are not as effective against norovirus • No vaccination available or specific drug available to prevent or treat norovirus • Follow Standard Precautions and Transmission-Based Precautions	
(S-60) Bloodborne Infections • Harmful germs found in human blood that can cause infection and disease • Three most common bloodborne pathogens are Hepatitis B Virus, Hepatitis C Virus, and the Human Immunodeficiency Virus, or HIV • Resident can get an infection from bloodborne pathogens by o Sharing contaminated needles o Sharing contaminated fingerstick devices o Direct contact with blood from infected person • Nurse aide can get an infection from bloodborne pathogens by o Accidental puncture wounds (jabs) from contaminated sharps o Direct contact with blood from an infected person	
(S-61) Bloodborne Pathogens • Causes Hepatitis B (HBV), a disease of the liver • About 1/3rd of persons infected with Hepatitis B Virus do	

Module B – Infection Prevention	
not show symptoms • Can live outside body on equipment and on surfaces like table tops or blood glucose meters for **7 days**; can infect others during that time • Vaccine is available to prevent you from getting the disease	
(S-62) Bloodborne Pathogens • Causes Hepatitis C (HCV), also transmitted through blood or body fluids • There is no vaccine for hepatitis C	
(S-63) Bloodborne Pathogens – Protect Yourself and Others • Always wear gloves when there is a chance of exposure to blood • Handle used sharps carefully and discard appropriately • Follow facility's exposure plan if any part of body is exposed to blood or stuck with contaminated sharp • Post-exposure o Wash area immediately o Report exposure to nurse o Complete an incident report o Follow procedures for testing and treatment	
(S-64) What is Wrong with this Picture?	
(S-65) What is Wrong with this Picture?	
(S-66) What is Wrong with this Picture?	
(S-67) What is Wrong with this Picture?	
(S-68) What is Wrong with this Picture?	

Activity #1B Instructor's Guide
Chain of Infection Project

Preparation

- Before class, decide how to divide students into groups of 2 to 3 students. Prepare supplies for each group – a sheet of construction paper or a half-sheet of poster paper, and 2 or 3 markers. Assign an infection prevention topic to each group and have them present to the entire class.

ACTIVITY #2B CHAIN OF INFECTION

INFECTIOUS AGENT

1. _____
2. _____
3. _____
4. _____

→

↓

SUSCEPTIBLE HOST

1. _____
2. _____
3. _____
4. _____

RESERVOIR

1. _____
2. _____
3. _____
4. _____

Bacteria
Parasite
Dirt
Person with diabetes
Person with sores
Unwashed Hands
Ticks
Vomit
Respiratory tract
Virus
Skin Tear
Door Knob

Nose (sneezing)
GI tract (vomiting)
Person with poor nutrition
89-year-old person
Skin puncture
Nose (breathing)
Fungi
Mouth (coughing)
Wound (drainage)
Mouth (eating)
GI tract
Sneeze droplets

↑

↓

PORTAL OF ENTRY

1. _____
2. _____
3. _____
4. _____

PORTAL OF EXIT

1. _____
2. _____
3. _____
4. _____

↑

MODE OF TRANSMISSION

1. _____
2. _____
3. _____
4. _____

←

ACTIVITY #2B CHAIN OF INFECTION ANSWERS

INFECTIOUS AGENT

1. Bacteria
2. Parasite
3. Virus
4. Fungi

SUSCEPTIBLE HOST

1. Person with diabetes
2. Person with sores
3. Person with poor nutrition
4. 89-year-old person

RESERVOIR

1. GI tract
2. Dirt
3. Ticks
4. Respiratory Tract

PORTAL OF ENTRY

1. Nose (breathing)
2. Mouth (eating)
3. Skin puncture
4. Skin tear

PORTAL OF EXIT

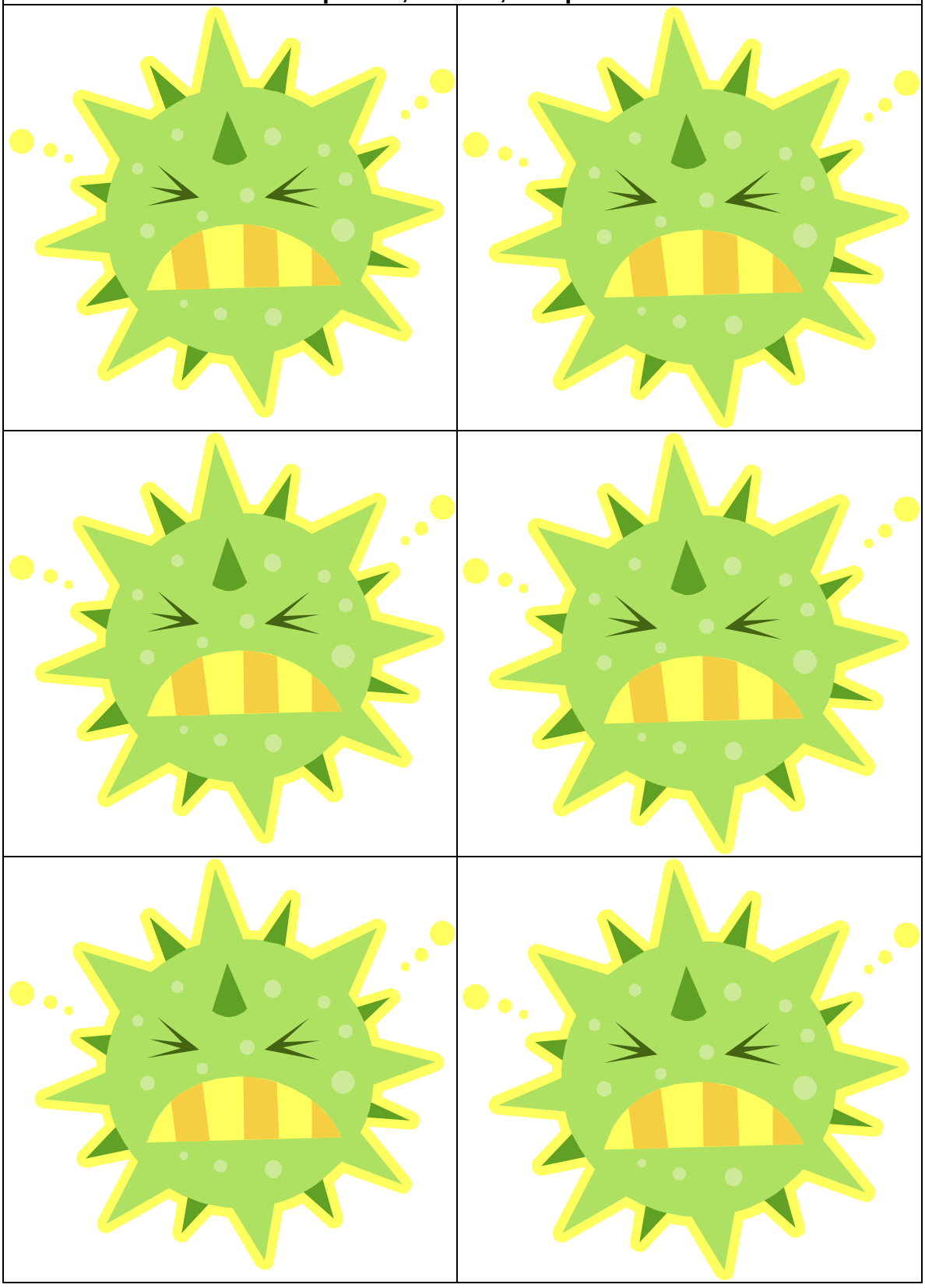
1. Nose (sneezing)
2. GI tract (vomiting)
3. Mouth (coughing)
4. Wound (drainage)

Bacteria
Parasite
Dirt
Person with diabetes
Person with sores
Unwashed Hands
Ticks
Vomit
Respiratory tract
Virus
Skin Tear
Door Knob
Nose (sneezing)
GI tract (vomiting)
Person with poor nutrition
89-year-old person
Skin puncture
Nose (breathing)
Fungi
Mouth (coughing)
Wound (drainage)
Mouth (eating)
GI tract

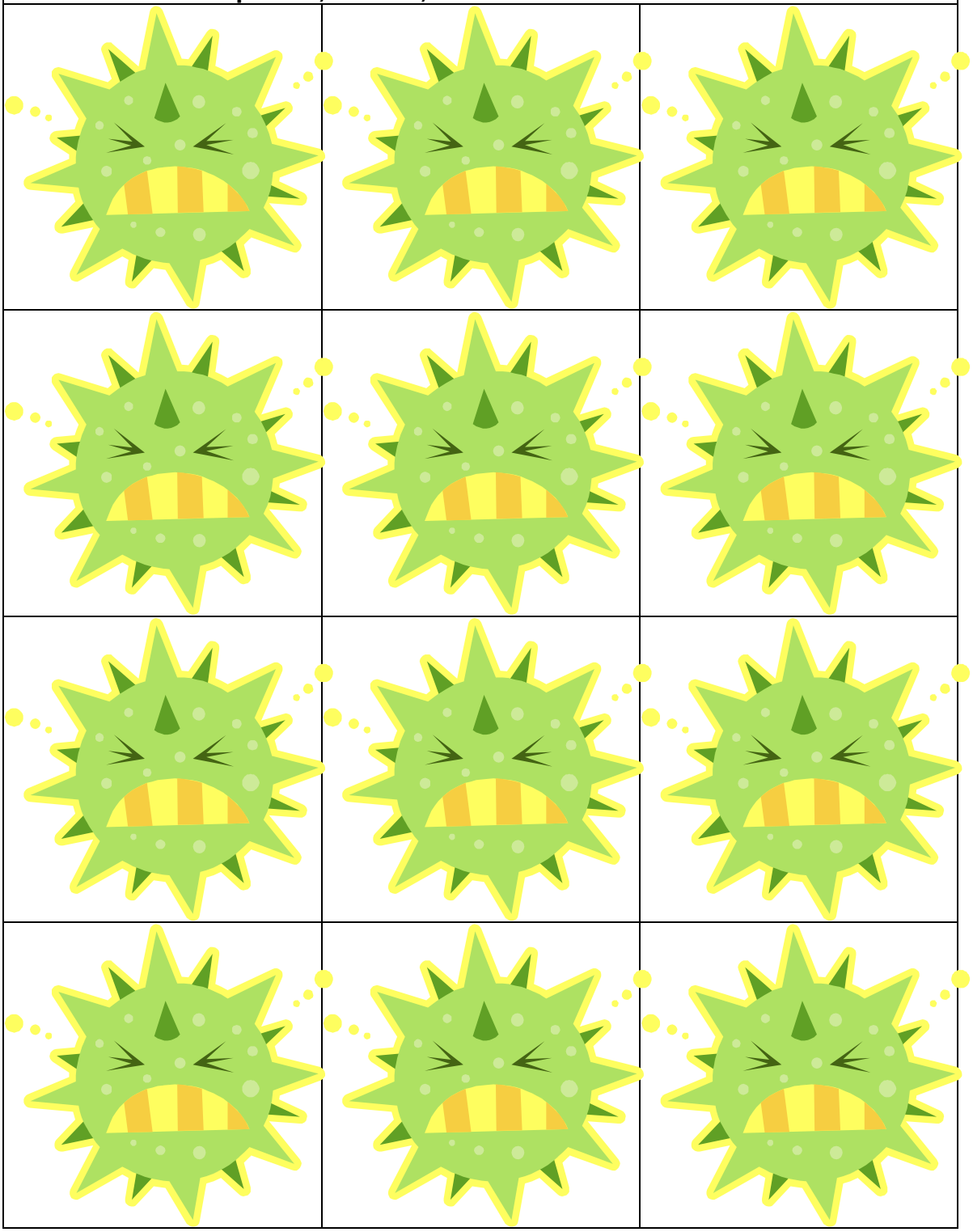
MODE OF TRANSMISSION

1. Unwashed hands
2. Vomit
3. Door knob
4. Sneeze drops

Teaching Tip #12B Hepatitis B Viruses for the classroom
Duplicate, cut-out, and place.



Teaching Tip #12B Hepatitis B Viruses for students
Duplicate, cut-out, and distribute to students.



State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE C
The Resident's Environment: Safety and Emergency

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module C – The Resident's Environment – Safety & Emergency Definition List

BEFAST – acronym to remember sudden signs that stroke is occurring – **B**alance – loss of balance; **E**yes – blurred vision; **F**ace – one side of face is drooping; **A**rms – arm (or leg) weakness; **S**peech – speech difficulty; **T**ime – time to call 911 (or notify nurse if the resident is in a health care facility)

Cerebrovascular Accident (CVA or Stroke) – occurs when blood supply to a part of the brain is blocked or a blood vessel leaks/breaks in a part of the brain

Elopement – when a resident leaves a health care facility without the staff's knowledge

Fall – unintentionally coming to rest on the ground, floor, or other lower level; any sudden, uncontrollable descent from a higher level to a lower level which may result in injury

Hazard – anything in the resident's environment that may cause illness or injury

Medical Emergency – a dire situation when a person's health or life is at risk

PASS – acronym to remember during the use of a fire extinguisher – **P**ull the pin, **A**im at the base of the fire when spraying, **S**queeze the handle, and **S**weep back and forth at the base of the fire

RACE – acronym to remember in case of a fire – **R**emove residents from danger, **A**ctivate alarm, **C**ontain the fire by closing all doors and windows, and if possible, **E**xtinguish the fire (or fire department will extinguish fire)

Resident's Environment – the area of a long-term care center that a resident calls home, designed to provide comfort, safety, and privacy for the resident

Resident Unit – the personal space, furniture, and equipment provided for the resident by the long-term care center

Safety in the Resident's Environment – when a resident has little risk of illness or injury in the environment to which he/she lives

Seizure – involuntary contractions of muscles involving small area or entire body; caused by abnormal electrical activity in the brain

Wandering – walking aimlessly without direction or purpose

Module C – The Resident's Environment: Safety & Emergency	
(S-1) Title Slide **(S-2) Objectives** 1. Explain why residents in long-term care facilities are at risk for injury. 2. Identify the role of the nurse aide in maintaining a safe environment for the resident. 3. Describe the role of the nurse aide in dealing with emergencies in a health care facility.	
Content	**Notes**
(S-3) Safety in the Resident's Environment • Definition – when a resident has little risk of illness or injury in the environment to which he/she lives	
(S-4) Resident's Environment • The area of a long-term care center that a resident calls home, designed to provide comfort, safety, and privacy for the resident • May be a private room or a shared-room with another resident	
(S-5) Resident Unit • Furnished and equipped to meet basic needs of the resident • Personal space, furniture, and equipment provided for the resident by the long-term care center • Closet and/or drawer space • A bed (electric or manual), call system, over-bed table, bedside stand, chair, and privacy curtain • Personal care items (bedpan, wash basin, emesis basin, water pitcher, cups, soap, hair care supplies, deodorant) also located within the resident unit, typically in the bedside stand • May also contain resident's choice of items from home (such as recliner, pictures, bedspread, throw pillows)	
(S-6) Hazard • Anything in the resident's environment that may cause illness or injury • Examples – burns, poisoning, suffocation, equipment, fire, falls	
(S-7) Safety in the Resident's Environment – Importance • OBRA (1997) and regulatory agencies require that long-term care facilities follow safety policies and procedures • The facility is home to the resident and resident should be encouraged and assisted to make room as home-like and safe as possible • Safety is a basic resident need and residents are at great risk for accidents and falls • Goal is to keep resident safe, without limiting independence and mobility	
(S-8) Elderly are at Risk for Injury	

Module C – The Resident's Environment: Safety & Emergency	

• Elderly are at greater risk for injury and rely on health care team to keep them safe
  o Knee joint instability
  o Decreased strength
  o Slower movement
  o Medication side effects, such as dizziness, drowsiness, etc
  o Low blood pressure
• Remember, your residents are relying on you to keep them safe	

(S-9) Elderly are at Risk for Injury
• Elderly are at greater risk for injury and rely on health care team to keep them safe
  o Impaired coordination
  o Hearing impairment
  o Reduced sense of smell and touch
  o Visual impairment
  o Cognitive impairment causing poor judgment and misperceptions
• Remember, your residents are relying on you to keep them safe	

(S-10) Safety in the Resident's Environment – Nurse Aide's Role • Maintain comfortable room temperature and lighting • Be aware that residents may prefer warmer room temperature than employees • Be aware that most residents have poor vision and need bright light, if reading • Keep unit clean and dirty items disposed of properly	
(S-11) Safety in the Resident's Environment – Nurse Aide's Role • Identify and report any unsafe conditions or faulty equipment • Allow resident a choice, if possible, in arrangement of personal items • Check linen for personal items contained in folds prior to sending to the laundry	
(S-12) Nurse Aide's Role when Oxygen is in Use • Post Oxygen in Use signs • Never have open flames or smoking in area • Do not use electrical equipment in room without facility approval	
(S-13) Safety in the Resident's Environment – Points to Remember • Provide care to right resident	

Module C – The Resident's Environment: Safety & Emergency	
• Keep bed in lowest position except when giving bedside care • Keep call signal within easy reach • Arrange resident's room for convenience to the resident; fosters independence • OBRA requires 71^{o} F to 81^{o} F for room temperature	
(S-14) Safety in the Resident's Environment – Points to Remember • Lock wheelchair before moving resident into or out of it • Be careful of feet when transporting residents in wheelchairs • Consider over-bed table a clean area; must be kept clean and free of clutter • Respect the resident's right to full visual privacy	
(S-15) Safety in the Resident's Environment – Points to Remember • Respect that residents can have and use personal items • Always check water temperature prior to bath or shower • Report if water seems too hot • Monitor wandering residents	
(S-16) Definition of a Fall • Unintentionally coming to rest on the ground, floor, or other lower level • Any sudden, uncontrollable descent from a higher level to a lower level which may result in injury	
(S-17) Prevalence of Falls for the Older Adult • One in four Americans aged 65+ falls each year (National Council on Aging) • Every 11 seconds, an older adult is treated in the emergency room for a fall; every 19 minutes, an older adult dies from a fall (National Council on Aging)	
(S-18) Prevalence of Falls for the Older Adult • Falls are leading cause of fatal injury; most common cause of nonfatal trauma-related hospital admissions among older adults (National Council on Aging) • In 2015, the total cost of fall injuries was $50 billion. Medicare and Medicaid paid 75% of these costs (National Council on Aging) • Each year, a typical nursing home reports 100 to 200 falls; numbers possibly higher because many falls not reported (Industrial Safety and Hygiene News) • Of the 1.6 million residents in long-term care facilities, approximately half fall annually (Agency for Healthcare Research and Quality) • About 1 in 3 of those who fall will fall two or more times in a	

Module C – The Resident's Environment: Safety & Emergency	
year (Agency for Healthcare Research and Quality) • One in every 10 residents who fall has a serious related injury and about 65,000 patients suffer a hip fracture each year. (Agency for Healthcare Research and Quality)	
(S-19) Fall Prevention Program • Every facility should have a fall prevention program • Components: o Assessing residents for risk of falling o Identifying/implementing interventions to minimize risk o Identifying/implementing interventions to minimize risk of sustaining an injury as a result of a fall	
(S-20) Fall Risk Factors • Intrinsic – those risk factors that result from the resident's inner being • Extrinsic – those risk factors that result from those things outside of the resident	
(S-21) Intrinsic Risk Factors • Over 65-years old; effects of aging on balance and gait • Medical conditions and diseases • Decline in function due to inactivity • Effects and side-effects of medication	
(S-22) Extrinsic Risk Factors • Hazards of the environment (poor lighting, clutter, wet floor) • Equipment that is unsafe (wheelchair brakes not working) • Unsafe or inaccessible personal items (shoes do not fit correctly)	
(S-23) Preventing Falls – Devices • Assistive devices – gait belts, canes, and walkers • Handrails – located in hallways and stairways • Grab bars – located in bathrooms and shower/tub rooms • Wheel locks – located on beds, wheelchairs and stretchers • Beds that lower to the floor	
(S-24) Preventing Falls – Nurse Aide's Role • Assist with ambulation when necessary • Provide appropriate assistance/supervision • Keep environment free of clutter • Keep all walkways free from rugs, cords, boxes, and equipment • Observe frequently	
(S-25) Preventing Falls – Nurse Aide's Role • Report unsafe conditions immediately • Make sure call signal is always within resident's reach • Answer call signals promptly	

Module C – The Resident's Environment: Safety & Emergency	
• Properly position residents in chairs and/or beds • Wipe up spilled liquids immediately • Pick up litter and place it in the proper container	
(S-26) Elopement • Defined – when a resident leaves a health care facility without the staff's knowledge • At risk for exposure to heat or cold, drowning, getting struck by a car, dehydration • Facility must have a plan in place in case a resident elopes	
(S-27) Preventing Elopement • Identify residents at risk for elopement (example – resident has history of wandering) • Assign a newly admitted resident to a room away from exits and increase staff awareness for risk of elopement; half of elopements occur during the first few days of admission • Technology – locked doors with staff keypads; cameras at exits; combination resident bracelet/door alarm when resident nears the door	
(S-28) Medical Emergency • A dire situation when a person's health or life is at risk	
(S-29) Cerebrovascular Accident (CVA) • Often referred to as a stroke • Occurs when blood supply to a part of the brain is blocked or blood vessel leaks/breaks in a part of the brain • A true emergency because a quick response is critical to reduce severity of the stroke	
(S-30) Cerebrovascular Accident (CVA) • Acronym BEFAST can be used to remember sudden signs that stroke is occurring o **B**alance – loss of balance; dizziness o **E**yes – blurred vision o **F**ace – one side of face is drooping o **A**rms – arm (or leg) weakness o **S**peech – speech difficulty o **T**ime – time to call 911 (or notify supervisor if the resident in a health care facility)	
(S-31) Seizure • Defined – involuntary contractions of muscles; small area or entire body; caused by abnormal electrical activity in the brain • Main goal – keep resident safe	
(S-32) Nurse Aide's Role During a Seizure • Note time of start and stop of seizure • Send for supervisor, but do not leave resident alone • Put on gloves	

Module C – The Resident's Environment: Safety & Emergency	
• Cradle head to protect it • Loosen clothing to assist with breathing	
(S-33) Nurse Aide's Role During a Seizure • Do not attempt to restrain resident • Do not force anything in resident's mouth between teeth • Do not give resident food or liquids • If no injuries are suspected (head, neck, spine), turn resident on side when seizure is over to prevent aspiration (choking on saliva or vomitus)	
(S-34) Conscious Choking Resident • A common sign that residents are choking is when they put their hands around their throats	
(S-35) Conscious Choking Resident • Encourage resident to cough as forcefully as possible • Ask someone to get nurse • Stay with person • Follow facility's procedure for clearing an obstructed airway	
(S-36) Nurse Aide's Role in Preventing Choking • Sit resident upright to eat • Provide assistance at mealtime to prevent spilling hot liquids • Encourage resident to use dentures when eating • Assist resident by cutting food in small pieces • Report any difficulty in chewing or swallowing	
(S-37) Fire • A fire needs three things to start o Heat o Fuel o Oxygen • Can be prevented or doused by removing one of these	
(S-38) Facility Fire Safety Plan • All employees must know the plan before needed o In-services about fires and evacuation o Evacuation routes posted o Fire extinguishers throughout the facility • Important for nurse aide to review fire safety plan often and understand role in the event of a fire	
(S-39) In the Event of a Fire • Keep calm • Follow facility's Fire Safety Plan • Never use elevator • Remember two important acronyms – RACE and PASS	
(S-40) RACE • **R**emove residents from danger • **A**ctivate alarm	

Module C – The Resident's Environment: Safety & Emergency	
• **C**ontain the fire by closing all doors and windows, if possible • **E**xtinguish the fire, or fire department will extinguish	
(S-41) PASS • Use fire extinguisher, only if trained in PASS o **P**ull the pin o **A**im at the base of the fire when spraying o **S**queeze the handle o **S**weep back and forth at the base of the fire	

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE D
Communication

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module D – Communication
Definition List

Belittle – to speak slightingly of; to cause a person to seem little or less

Cliché – a phrase or expression that has become overly familiar or commonplace

Communication – is the process of exchanging information through sending and receiving messages using signs, symbols, words, drawings and pictures

Cultural sensitivity - being aware of, recognizing, acknowledging, and valuing that behavior patterns differ between and within different cultures

Culture – the characteristics of a group of people – language, values, beliefs, habits, likes, dislikes, customs - passed from one generation to the next

Demeanor - behavior toward others; outward manner

Gait - a manner of walking or moving on foot

Liaison - a person who establishes and maintains communication for mutual understanding and cooperation

Non-verbal Communication (also called body language) – body positions and actions that send an unspoken message along with the spoken message; the conscious or unconscious signals that a person's body sends

Paraphrase – to re-state a person's message in your own words

Prejudice - an adverse opinion formed without just grounds or before sufficient knowledge; preconceived judgment or opinion

Slang – language peculiar to a particular group; an informal nonstandard vocabulary

Therapeutic Communication – a type of communication that health care providers consciously use when talking with residents in order to influence residents or help residents to a better understanding

Verbal Communication – the act of sending/receiving the spoken message

Module D – Communication	
(S-1) Title Slide **(S-2) Objectives** 1. Describe components of therapeutic and non-therapeutic communication 2. Discuss the importance of appropriate communication skills 3. Describe barriers to communication 4. Explore how culture and religion impact communication 5. Discuss the NA's role and responsibilities for effectively communicating with a variety of individuals	
Content	**Notes**
(S-3) Communication – Definition • Successfully sending and receiving messages using signs, symbols, words, drawings and pictures o Explore the meaning behind certain symbols o Locate drawings/pictures that convey a universal message	
(S-4) Communication – Appropriate methods • Appropriate communication includes: o Use words that mean the same to the sender and receiver o Use words that are familiar o Be concise o State information in an organized, logical order o State facts and be specific	
(S-5) Communication – Three-way process • Simplest form is a three-way process o Sender communicates the message o Receiver receives the message o Feedback allows sender and receiver to respond to each other in some way	
(S-6) Communication – Verbal • Using written or spoken words, pictures or symbols to send a message • Involves active listening skills and silence • Includes paraphrasing, clarifying and focusing • Asking direct, open-ended questions	
(S-7) Communication – Non-Verbal (1) • Using body language such as movements, facial expressions, gestures, posture, gait, eye contact and appearance to send a message • Can be used to support or oppose spoken or written communication o Smiling reinforces the statement, "I am happy today!" while frowning or smirking opposes the statement. • Is often an unconscious gesture, movement or facial	

Module D – Communication	
expression that blocks effective communication • Can be perceived in different ways by different individuals	
(S-8) Communication – Non-Verbal (2) • Examples of non-verbal communication include: o Positive – face the resident while speaking, stand up straight, smile, nod with approval, place arms at sides, show relaxed movements o Negative – turn your back during communication, slouch, avoid eye contact, eye roll, frown, cross arms across chest, show tense movements	
(S-9) Communication – Importance • Learn about the resident in order to provide care that meets individual needs • Be a source of encouragement to the resident and family members • Establish trust • Build meaningful relationships that benefit the resident	
(S-10) Communication – Importance (2) • Serve as a liaison between the resident and healthcare team. • Provide information and respond to questions appropriately. • Listen, observe, report and record details accurately o Discuss the importance of being a liaison and patient advocate.	
(S-11) Communication – Barriers (1) • Language • Using inappropriate words, clichés or slang • Giving responses that cause confusion or frustration • Talking too fast • Giving advice or offering a personal opinion or point of view • Ignoring or belittling the resident	
(S-12) Communication – Barriers (2) • Using non-verbal communication skills when verbal communication is more appropriate • Prejudices and attitudes • Different life experiences • Age • Cultural differences • Noise and lack of privacy • Mental or physical impairments	
(S-13) Culture	

Module D – Communication	
• Is the characteristics of a group of people that are passed from one generation to the next • Varies from one group to another, and encompasses different races and nationalities • Tend to share biological and physiological characteristics	
(S-14) Culture – Characteristics • Includes language, values, beliefs, habits, likes, dislikes and customs • Not all individuals accept all characteristics of the group	
(S-15) Culture – Knowledge (1) • People react differently based on their beliefs and values • Emotions – weakness; strength o Impact others in positive and negative ways. o Can prevent emotional healing o Should be acknowledged in a positive manner • Personal space – standing close, touching, gestures, eye contact o Should allow communication to occur comfortably	
(S-16) Culture – Knowledge (2) • Family o Living together in one unit o Living in separate locations (other cities, states or countries) o Being isolated • Can be supportive/destructive during illness	
(S-17) Culture – Knowledge (3) • Hygiene o Bathing is not viewed the same by all cultures o Clothing styles and colors vary among cultures o Often impacts a person's feeling of self-worth • Illness o Impacts self-image and lowers self-worth o Treatments are impacted/dictated in some cultures o Acceptance/denial is a sign of strength/weakness o Becoming familiar with various illnesses helps provide improved or alternative means of care • Asking questions and researching treatment options opens doors for discussion and helps ease fear.	
(S-18) Religions • Are recognized throughout the world o Buddhism, Christian, Hindu, Islam, Jehovah's Witness, Jewish, Mormon (these are only a few) • Play a vital role in the resident's life • Impact whether a resident accepts or rejects medical treatments and care	

Module D – Communication	
• Are misunderstood due to lack of knowledge	
(S-19) Communication – NA's Role (1) • Develop skills that enhance effective communication o Use appropriate verbal and non-verbal communication skills o Listen to what is being said o Ask questions for clarification and acknowledge understanding o Avoid interrupting	
(S-20) Communication – NA's Role (2) o Do not express personal opinions or disapproval o Develop patience o Reduce or eliminate environmental distractions o Understand and use silence appropriately and in a supportive manner	
(S-21) Culture and Communication – NA's Role • Accept each resident as an individual • Follow the nursing care plan that incorporates cultural and religious beliefs • Demonstrate respect o Greet the resident using his/her title such as Mr., Mrs., Miss and their last name o Do not refer to the resident as *sweetie, honey, dearie, gramps* or *sugar.* These terms are disrespectful and degrading. o Attempt to pronounce the name correctly, speak slowly and ask for clarification. • Follow appropriate cultural preferences (eye contact, distance) • Communicate in a non-threatening, therapeutic manner	
(S-22) Communication - Special Approaches • When a resident speaks a different language • Use a caring tone of voice and facial/body expression • Speak slowly and distinctly, but not loudly • Keep messages simple • Repeat the message in different ways as needed • Focus on a single idea or experience	
(S-23) Communication - Special Approaches • Avoid medical terms and abbreviations • Allow silence • Pay close attention to non-verbal behavior • Note and use words the resident seems to understand • Reference a language dictionary as needed	
(S-24) Communication - Health Care System • Has its own culture	

Module D – Communication	
• Beliefs - standardized definitions of health and illness, believes in the power of technology • Practices - encourages maintenance of health (annual physical examination/routine diagnostic procedures) and prevention of illness • Rituals - limiting visitors and specific visiting hours • Expectations – punctuality such as arriving for appointments on time	
(S-25) Communication • Listen more and speak less to improve communication.	

Handout #1D: Types of Conversation / Goals

Type of Conversation	Goal
Social Conversation	To create a comfortable, relaxed atmosphere to enjoy conversation with others. Share information about things that are of mutual interest. Not to discuss problems or complaints. To learn new things and get fresh information.
Interview	To ask questions with kindness and provide information in a way that does not scare the resident. To demonstrate sincere interest and create trust. To identify the resident's personal preferences, likes and dislikes. To help determine ways to plan and improve nursing care and assist with scheduling activities of daily living. To reinforce your interest and concern in the well-being of the resident.
Teaching	To show and tell the resident something that he or she may not already know. To offer an explanation of why something is done and how it can benefit quality of care.
Reporting	To report accurate information through observation and interaction with the resident. To communicate facts to the nurse, not assumptions or personal opinions.
Problem Solving	To help meet the resident's needs. To focus on the resident's wants or preferences. To find a way to meet the requests while following the nursing care plan. To offer alternative/creative ways to meet the resident's expectations.
Therapeutic Communication	To encourage/allow the resident to discuss feelings openly. To gain insight and be receptive to the resident's thoughts and feelings. To not be judgmental, belittle or degrade the resident. To respond with kindness using supportive verbal and non-verbal communication skills and acknowledge understanding of the resident's feelings.

Handout #2D: Communication Techniques

Successful Techniques

- Accepting – “Yes, I understand.”
- Offering Self – “I’ll sit with you a while.”
- Giving Broad Openings – “Where would you like to begin?”
- Giving General Leads – “Tell me about it.”
- Making Observations – “I notice you are crying.”
- Encouraging – “What does the voice seem to be saying?”
- Reflecting – “So, this causes you to feel angry?”
- Exploring – “Tell me more about that.”
- Presenting Reality – “I see no one else in the room.”
- Summarizing – “So, let’s see, do I have this correct?”

Non-successful Techniques

- Rejecting – “Oh, you don’t want to talk about that.”
- Disapproving – “You shouldn’t talk that way.”
- Challenging – “How do you know that?”
- Requesting an Explanation – “What makes you think that way?”
- Belittling – “Everybody gets down in the dumps.”
- Stereotyping – “Everybody who works here does that.”
- Interrupting – “Wait, what you really mean is. . .”
- Changing the Subject – “Let’s talk about something different.”

Handout #3D: Communication Techniques

Getting to Know You

Spend time talking to a resident about the items below.

Name resident likes to be called: _____

Where were you born?
Where did you grow up?
Favorite parts of childhood?
High school days?
College/Secondary Ed/Service?
Married?
Children?
Career/Life Role/Spouse's career?
Moves?
Retirement?
Grandchildren?
Favorite pastime?
Favorite hobbies?
Favorite leisure activity?
Favorite spectator sport?
Favorite active sport?
Favorite music?
Play an instrument?
Have what you need to enjoy your music?
Favorite intellectual activity?
Favorite games?
Favorite arts/crafts?
Favorite outdoor activity?
Favorite drinks?
Favorite baked goods?

Favorite meals?
Favorite snacks?
Favorite restaurant?
Morning routine?
Afternoon routine?
Evening routine?
Sleep routine?
Daily pleasure?
Birthday tradition?
Special holiday traditions?
Ethnic culture/culture traditions?
Volunteer work/community service?
Psychosocial needs (see list)
Spiritual/Religious beliefs/traditions?
Is there something you would like to learn?
If you could do anything, what would it be?
What is something you never got to do you wanted to?
What things around you bring comfort?
What can we do to make you feel more comfortable here?

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MODULE E
Law and Ethics

Student Manual
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Module E – Laws and Ethics
Definition List

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

Assault – act of threatening to touch, or attempting to touch a person, without proper consent

Basic Human Rights – protected by the Constitution of the United States and state that a person has the right to be treated with respect, live in dignity, pursue a meaningful life and be free of fear

Battery – touching a person without consent

Civil Law – law that deals with relationships between people

Code of Ethics – rules of conduct for particular group, may differ from one facility to another, but revolves around idea that resident is valuable person who deserves ethical care

Confidentiality – not disclosing or telling information that is personal or private about a resident, except to authorized people

Consent – the right to decide what will be done to the body and who can touch the body, may be written consent, verbal consent, or implied consent

Criminal Law – offenses against the public and society

Defamation – false statement made to a third person that causes a person shame or ridicule, or ruins their reputation; written is called libel; verbal is called slander

Disclosure – making known to the public

Diversion of Drugs – unauthorized taking or use of any drug

Exploitation – Exploitation means taking advantage of a resident for personal gain using manipulation, intimidation, threats, or coercion.

False Imprisonment – unlawful restraining or restricting a person's movement

Fraud – an intentional deception or misrepresentation made by a person with knowledge that deception could result in some unauthorized benefit to self or some other person

Invasion of Privacy – violation of right to control personal information or the right to be left alone

Laws – rules made by government to help protect public

Malpractice – giving care for which you are not allowed legally to perform

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

Neglect – a failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress

Negligence – actions or failure to act or give proper care resulting in injury

Nondisclosure – not making known to the public

Privacy – the personal responsibility and activities done to prevent the intrusion of one person onto another

Resident's Rights – rights that have been written into Federal law (OBRA) that identify how a resident must be treated while living in a long-term care facility

Sexual abuse – non-consensual sexual contact of any type with a resident

Vulnerable Adults – adults who are at risk for abuse or mistreatment because they are not able to protect selves from harm due to mental, emotional, developmental disability; or brain damage; or changes from aging

Module E – Laws and Ethics	
(S-1) Title Slide **(S-2) Objectives** 1. Describe ethical conduct. 2. Describe a resident's rights in the nursing home. 3. Give examples of abuse, neglect, and misappropriation of property. 4. Explain the role of the Health Care Personnel Registry. 5. Explain the role of the nurse aide in securing informed consent prior to providing care to the resident.	
Content	**Notes**
(S-3) Laws • Are rules made by government to help protect public • Person liable if laws not obeyed and may be fined or jailed • Two types o Criminal – offenses against the public o Civil – deal with relationships between people	
(S-4) Legal – Key Terms (1) • Tort – a wrong committed against a person or property o Unintentional – did not mean to cause harm o Intentional – did mean to cause harm • Malpractice o Giving care for which you are not allowed legally to perform o Example – nurse aide performing treatment only allowed by nurses, such as starting a blood transfusion • Negligence o Actions or failure to act or give proper care, resulting in injury o Examples – brakes on wheelchair not locked and resident falls, failure to provide water if permitted and resident requests	
(S-5) Assault and Battery • Assault o Act of threatening to touch, or attempting to touch a person, without proper consent (key is consent) o Example – threatening to "tie a resident down" • Battery o Touching a person without consent o Example – hitting a resident o Example – performing a procedure that resident refused	
(S-6) Consent • The right to decide what will be done to the body and who can touch the body	

Module E – Laws and Ethics	
• Example of written consent – signs a form (nurse aide does not obtain this) • Example of verbal consent – a verbal “yes” or “ok” (nurse aide can obtain this) • Example of implied consent – resident extends arm after nurse aide asks to check blood pressure (nurse aide can obtain this)	
(S-7) Invasion of Privacy • Violation of right to control personal information or the right to be left alone • Example – gossiping in the hall about a resident’s medical condition and others hear the conversation • Example – picture taken of resident and put on a social network, without consent	
(S-8) Legal – Key Terms (2) • False imprisonment o Unlawful restraining or restricting a person’s movement o Example – restraining a person, without authorization or justification o Example – not allowing a person to leave a facility • Defamation o False statement made to a third person that causes a person shame or ridicule, or ruins the reputation o Written is libel o Verbal is slander o Example – saying or writing that a resident is insane	
(S-9) Legal – Key Terms (3) • Diversion of drugs – unauthorized taking or use of any drug • Fraud – an intentional deception or misrepresentation made by a person with knowledge that deception could result in some unauthorized benefit to self or some other person	
(S-10) Importance of Laws • Laws tell people what they can and cannot do • Laws are written to protect the public and society from harm	
(S-11) Legal – Nurse Aide’s Role • Understand range of function and know what he/she can legally perform, while on duty • Keep skills and knowledge current • Keep resident’s safety and well-being in mind • Understand directions for use when using equipment, materials, supplies	

Module E – Laws and Ethics	
• Follow long-term care facility's policy and procedures, regarding care of resident • Do no harm to resident or belongings • Report questionable practices by others to the nurse • Review legal key terms and understand examples of each	
(S-12) Who are Vulnerable Adults? • Adults who are at risk for abuse or mistreatment because they are not able to protect selves from harm due to mental, emotional, developmental disability; or brain damage; or changes from aging	
(S-13) We Must Protect our Vulnerable Adults From… • Neglect – a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness • Misappropriation of property – illegal or improper use of resident's money, property, assets; by another, without consent, for personal gain • Abuse – willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish • Exploitation – taking advantage of a resident for personal gain by manipulation, intimidation, threats, or coercion.	
(S-14) Role of the Nurse Aide in Regards to Prevention of the Mistreatment of Vulnerable Adult • Care of personal property o Handle possessions carefully o Report observed theft o Add any new possessions to list of resident belongings, per facility policy o Mark items with resident's name o Do not accept tips or ask for tips • Review key terms and understand what must be reported to nurse • Recognize signs/symptoms of various types of abuse, neglect, and misappropriation of funds • If abuse is observed by another health care provider, stop abuse and report immediately to nurse • Report questionable practices by others to nurse	
(S-15) Signs, Symptoms, and Examples of Neglect • Dehydration, malnutrition, untreated pressure ulcers, and poor personal hygiene • Unsanitary and unclean conditions, such as being dirty, having to lie in feces or urine, inadequate clothing • Resident's report of neglect	

Module E – Laws and Ethics	
(S-16) Misappropriation of Property • Signs and Symptoms o The sudden appearance of a staff member's name on a bank signature card o The discovery of a forged version of the resident's name o The sudden and unauthorized withdrawal of money using an ATM card or other means o Unexplained disappearance of the resident's personal property or money from the resident's room o Resident's report of missing personal property, assets, or money • Examples o Cashing a resident's checks without permission o Forging a resident's name on documents o Misusing or stealing a resident's money or personal property	
(S-17) Physical Abuse • Signs and Symptoms o Sprains, dislocations, broken bones, skull fractures o Bruises of face, upper arms, upper thighs, abdomen o Fearfulness o Withdrawn, paranoid behavior o Bruises, black eyes, welts, lacerations o Rope marks, restraint marks o Open wounds, cuts, punctures o Internal injuries/bleeding o Repeated "unexplained" injuries o Sudden change in resident's behavior o Resident's report of physical abuse • Examples o Hitting, beating, pushing, kicking, slapping, pinching, shaking o Burning o Handling or moving the resident roughly o Withholding personal or medical care o Inappropriate use of drugs and physical restraints o Force-feeding	
(S-18) Emotional or Psychological Abuse • Signs and Symptoms o Emotionally upset or agitated o Extremely withdrawn, will not talk, or is non-responsive o Deferent, passive, acting shamed o Depressed, voices feelings of helplessness and hopelessness o Trembling, clinging, cowering, minimal eye contact	

Module E – Laws and Ethics	
o Unusual behavior (sucking, biting, rocking) that may be mistakenly attributed to dementia o Resident's report of emotional or psychological abuse • Examples o Instilling fear through intimidation o Not answering call signal o Mocking or making mean remarks to resident o Sexual harassment o Demands to perform demeaning acts o Verbal threats of harm, insults, threats o Humiliation o Harassment o Treating resident like a baby o Enforced social isolation	
(S-19) Exploitation • Signs and symptoms o Resident inconsistent with longstanding values/beliefs o Wills, living wills, trusts, income flow altered with new caretaker or friend as beneficiary/executor o Begins using new bankers, physician, attorneys o Increasingly helpless, frightened, despondent, feeling only caretaker or friend can prevent further decline o Resident does not see true nature of the caretaker or friend • Examples o New friend or caretaker appears to have restrictive control and dominance over resident o Visitors are denied access to resident o New friend or caretakers makes all decisions for resident o Resident mistrusts family members and long-time friends	
(S-20) Health Care Personnel Registry (HCPR) • Lists pending allegations and substantiated findings of nurse aides and other unlicensed personnel • HCPR listings can lead to negative consequences for the nurse aide • Substantiated finding of abuse, neglect and misappropriation of resident property will cause a finding on the HCPR • Nurse aides cannot be employed in a nursing home with a substantiated finding on the HCPR	
(S-21) Mistreatment of Vulnerable Adult – Points to Remember	

Module E – Laws and Ethics	
• Abuse is cause for immediate dismissal of the perpetrator and posted on Nurse Aide Registry, if substantiated • Not reporting abuse is aiding and abetting	
(S-22) Ethics and Code of Ethics • Ethics o Is knowledge of what is right conduct and wrong conduct, or knowing right from wrong o Inner knowledge that assists us in making choices or judgments • Code of Ethics o Rules of conduct for particular group o May differ from one facility to another, but revolves around idea that resident is valuable person who deserves ethical care o Helps employees deal with issues of right and wrong • Confidentiality – not disclosing or telling information that is personal or private about a resident, except to authorized people • Privacy o The personal responsibility and activities that prevent the intrusion of one person onto another o Example – pulling suspended curtains completely around a resident's bed during care provides physical barrier from others o Example – lowering one's voice when talking in the hall about a resident's condition	
(S-23) Basic Human Rights • Are protected by the Constitution of the United States • Right to be treated with respect, live in dignity, pursue a meaningful life and be free of fear • Examples of infringement of these rights – addressing residents as children, using demeaning nicknames for residents, leaving door open during bath, threatening a resident with harm	

Module E – Laws and Ethics	

(S-24) Resident's Rights
• Defined
  o Residents have same legal rights as all citizens of the United States plus legally protected Resident's Rights
  o Rights that have been written into federal law (OBRA) that identify how a resident must be treated while living in a long-term care facility
  o Provides a code of ethics for health care providers
  o Posted in long-term care facility and given to resident/legal representative on admission
• Ombudsman – every resident living in a North Carolina long-term care facility has access to a person assigned to their district who supports or promotes their interests
  o District assignments of NC long term care ombudsman – located at https://files.nc.gov/ncdhhs/Ombudsman-Contact%20List_2.pdf	

(S-25) Ethics – Importance • Knowledge of right and wrong guides sense of duty and conduct of all health care providers • Guides all health care providers in providing quality care • Governs actions of health care providers • Vital to safety and well-being of residents	
(S-26) Ethics – Nurse Aide's Role (1) • Use good judgment • Keep staff and resident information confidential • Document accurately • Follow plan of care as outlined • Be honest and trustworthy at all times • Report abuse or suspected abuse • Understand and respect Resident's Rights	
(S-27) Ethics – Nurse Aide's Role (2) • Report all resident observations and incidents • Show empathy for residents • Respect all residents equally • Provide high quality of resident care • Protect residents' privacy • Treat all residents professionally • Avoid stereotyping due to residents beliefs or culture • Respect values and beliefs that differ from your own • Safeguard the resident's property	
(S-27) Ethics – Points to Remember (3) • Ethical behavior – always being accountable for actions • When do nurse aides use ethical behavior? Always!	

Module E – Laws and Ethics	
• Ethical behavior can vary with different cultures and social backgrounds • We are all individuals who think differently	
(S-28) Ethics – Points to Remember (4) • End of life decision making usually follow resident's individual ethical principles • Nurse aides must respect fact that resident has right to make own self-determination regarding end of life decisions and may differ from nurse aide's own personal ethics • Resident has o Right to refuse medical intervention at end of life o Right to request everything possible in order to prolong life	

Handout #1E: Mistreatment of the Vulnerable Adult

Who Are Vulnerable Adults?

Adults who are at risk for abuse or mistreatment because they are not able to protect selves from harm due to mental, emotional, developmental disability; or brain damage; or changes from aging

We Must Protect Them From…

- Abuse – willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish
- Neglect – a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness
- Misappropriation – illegal or improper use of resident's money, property, assets; by another, without consent, for personal gain
- Exploitation – taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion

What is the Role of the Nurse Aide in Regards to Prevention of the Mistreatment of Vulnerable Adult?

- Personal property
  - Handle possessions carefully
  - Report observed theft
  - Add any new possessions to list of resident belongings, per facility policy
  - Mark items with resident's name
  - Do not accept tips or ask for tips
- Report questionable practices by others to nurse
- If abuse is observed by another health care provider, stop abuse and report immediately to nurse
- Review key terms and understand what must be reported to nurse
- Recognize signs/symptoms of various types of abuse, neglect, misappropriation and exploitation

Signs, Symptoms, and Examples of Neglect

- Dehydration, malnutrition, untreated pressure ulcers, and poor personal hygiene
- Unsanitary and unclean conditions, such as being dirty, having to lie in feces or urine, inadequate clothing
- Resident's report of neglect

Chart of Abuse

Misappropriation of Property	
Signs/Symptoms	**Examples**
• Sudden appearance of staff member's name on a bank signature card • Discovery of forged version of the resident's name • Sudden and unauthorized withdrawal of money using an ATM card or other means • Unexplained disappearance of the resident's personal property or money from the resident's room • Resident's report of missing personal property, assets, or money	• Cashing a resident's checks without permission • Forging a resident's name on documents • Misusing or stealing a resident's money or personal property
Physical Abuse	
Signs/Symptoms	**Examples**
• Repeated "unexplained" injuries • Internal injuries/bleeding • Sprains, dislocations, broken bones, skull fractures • Bruises of face, upper arms, upper thighs, abdomen • Black eyes, welts, lacerations • Rope marks, restraint marks • Open wounds, cuts, punctures • Sudden change in resident's behavior • Fearfulness, withdrawn, paranoid behavior • Resident's report of physical abuse	• Hitting, beating, pushing, kicking, slapping, pinching, shaking • Burning • Handling or moving the resident roughly • Withholding personal or medical care • Inappropriate use of drugs and physical restraints • Force-feeding
Emotional or Psychological Abuse	
Signs/Symptoms	**Examples**
• Emotionally upset or agitated • Extremely withdrawn, will not talk, or is non-responsive • Deferent, passive, acting shamed • Depressed, voices feelings of helplessness and hopelessness • Trembling, clinging, cowering, minimal eye contact • Unusual behavior (sucking, biting, rocking) that may be mistakenly attributed to dementia • Resident's report of emotional or psychological abuse	• Instilling fear through intimidation • Not answering call signal • Mocking or making mean remarks to resident • Sexual harassment • Demands to perform demeaning acts • Verbal threats of harm, insults • Humiliation • Harassment • Treating resident like a baby • Enforced social isolation
Exploitation	
Signs/Symptoms	**Examples**
• Inconsistent with longstanding values/beliefs • Wills, living wills, trusts, income flow altered with new caretaker or friend as beneficiary/executor • Begins using new bankers, physician, attorneys • Increasingly helpless, frightened, despondent, feeling only caretaker or friend can prevent further decline • Resident does not see true nature of the caretaker or friend	• New friend or caretaker appears to have restrictive control and dominance over resident • Visitors are denied access to resident • New friend or caretakers makes all decisions for resident • Resident mistrusts family members and long-time friends

Handout #2E: North Carolina's Bill of Rights for Nursing Home Residents
(Condensed Version)

EVERY RESIDENT SHALL HAVE THE FOLLOWING RIGHTS:

(1) To be treated with consideration, respect, and full recognition of personal dignity and individuality.

(2) To receive care, treatment, and services that are adequate and appropriate, and in compliance with relevant federal and State statutes and rules.

(3) To receive at the time of admission and during stay, a written statement of services provided by the facility, including those required to be offered on an as needed basis, and of related charges. Charges for services not covered under Medicare and Medicaid shall be specified. The patient will sign a written receipt upon receiving the above information.

(4) To have on file physician's orders with proposed schedule of medical treatment. Written, signed evidence of prior informed consent to participation in experimental research shall be in patient's file.

(5) To receive respect and privacy in his medical care program. All personal and medical records are confidential.

(6) To be free of mental and physical abuse. Except in emergencies, to be free of chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.

(7) To receive from the administration or staff of the facility a reasonable response to all requests.

(8) To associate and communicate privately and without restriction with persons and groups of the patient's choice at any reasonable hour. To send and receive mail promptly and unopened. To have access to a telephone where the patient may speak privately. To have access to writing instruments, stationary and postage.

(9) To manage his/her own financial affairs unless other legal arrangements have been implemented. The facility may also assist the patient but is required to follow stringent guidelines.

(10) To have privacy in visits by the patient's spouse, and if both are patients in the same facility, they shall be given the opportunity, where feasible, to share a room.

(11) To enjoy privacy in his/her room.

(12) To present grievances and recommend changes in policies and services personally, through other persons or in combination with others, without fear of reprisal, restraint, interference, coercion, or discrimination.

(13) To not be required to perform services for the facility without personal consent and the written approval of the attending physician.

(14) To retain, to secure storage for, and to use his personal clothing and possessions, where reasonable.

(15) To not be transferred or discharged from a facility except for medical, financial, or their own or other patient's welfare, nonpayment for the stay or when mandated by Medicare or Medicaid. Any such transfer shall require at least five days' notice, unless the attending physician orders immediate transfer, which shall be documented in the patient's medical record.

(16) To be notified within ten days after the facility's license is revoked or made provisional. The responsible party or guardian must be notified as well.

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE F
Dignity

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
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Module F – Dignity
Definition List

Dignity – quality or state of being worthy of esteem or self-respect

Empathy – identifying with and understanding the feelings of another without feeling sorry for the person

Module F – Dignity	
(S-1) Title Slide **(S-2) Objectives** 1. Identify caring behaviors consistent with treating a resident with dignity	
Content	**Notes**
(S-3) Dignity • Dignity is our inborn (inherent) value and worth as human beings; everyone is born with it. All people have the right to be recognized for their inherent humanity and treated ethically • After people learn about dignity, a remarkable thing happens. Everyone recognizes that we all have a deep, human desire to be treated as something of value • Dignity has the potential to change the world. Nurse aides have the potential to change the world where they work by treating each individual, both residents and members of the health care team, with dignity	
(S-4) Dignity – Definition (of Dignity) • Quality or state of being worthy of esteem or self-respect • An important component in OBRA's Residents' Rights **Dignity – Key Terms** • Empathy – identifying with and understanding the feelings of another without feeling sorry for the person • Resident's Rights – are included in OBRA (1987 and 2016) and spell out how residents MUST be treated while living in a long-term care facility	
(S-5) Dignity (1) – Importance • Promotes sense of self-importance • Promotes quality of life • Promotes feelings of positive self-worth • Guides nurse aide in giving care	
(S-6) Dignity (2) – Nurse Aide's Role • Meet resident's physical, social, emotional, intellectual, and spiritual needs • Explain procedure to resident before beginning task • Respect resident's room and personal items • Be patient and do not rush resident • Encourage resident to make as many decisions as possible	
(S-7) Dignity (3) – Nurse Aide's Role • Refrain from judging the resident • Be positive, supportive, and encouraging • Be familiar with preferences • Be empathetic	

Module F – Dignity	
• Listen carefully and be aware of unusual gestures	
(S-8) Dignity (4) – Nurse Aide's Role • During interactions with resident, assist resident to maintain and enhance self-esteem and self-worth by o Respecting resident's social status, speaking respectfully, listening carefully, treating residents with respect o Focusing on residents as individuals when talking with them and addressing residents as individuals when providing care o Assisting residents to attend activities of own choosing o Respecting resident's private space and property – HOW?	
(S-9) Dignity (5) – Nurse Aide's Role • How can a nurse aide demonstrate respectful behaviors toward a resident's private space and property? o By not changing the radio or television station without the resident's permission o By knocking on doors and requesting permission to enter o By closing doors as requested by resident o By not moving or inspecting resident's personal possessions without permission	
(S-10) Dignity – Points to Remember • Promotion of dignity is constant and on-going • Should always be respectful – whether in communication or in performance of resident skills • Essential for every nurse aide activity • Resident's dignity is valued if nurse aide gives appropriate, compassionate and effective care	

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NURSE AIDE I TRAINING PROGRAM

MODULE G
Basic Restorative Care

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
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Module G – Basic Restorative
Definition List

Adaptive Devices (assistive devices) – special equipment that helps a disabled or ill resident perform activities of daily living (ADLs)

Amputation – surgical removal of a body part

Basic Restorative Care – care provided after resident's highest possible functioning is restored (rehabilitation) following illness or injury

Bladder/Bowel Training – measures taken to restore function of voiding and defecating by resident, with ultimate goal of continence

Defecation – process of emptying the rectum of feces

Empathy – being able to identify with and understand how a resident feels

Enema – the introduction of fluid into the colon to eliminate stool or feces or stimulate bowel activity

Functional Loss – partial or complete loss of the function of a body part

Incontinence – the inability to control urination or defecation

Orthotic Device – device that helps support and align a limb and improve its functioning

Prosthetic Device – artificial replacement device for body part that is missing or deformed; improves person's function and/or appearance

Rehabilitation – restoration of a resident's highest possible functioning following illness or injury

Supportive Device – special equipment that helps a disabled or ill resident with movement

Urination (or voiding) – process of emptying the bladder

Module G – Basic Restorative Care	
(S-1) Title Slide **(S-2) Objectives** 1. Explain the role of the nurse aide in basic restorative care. 2. Describe the processes involved with bowel and bladder training.	
Content	**Notes**
(S-3) Basic Restorative Care • Care provided after rehabilitation when the resident's highest possible functioning has been restored following illness or injury • Goals are to maintain function that has been restored through rehabilitation and to increase independence	
(S-4) Basic Restorative Care – Importance • Emphasis on maintaining and/or improving existing abilities • Important to prevent any further complications • Aimed at moving individual toward independence as much as possible and to encourage residents do as much as they can, as long as they can, as often as they can • Team effort to assist resident to develop a productive lifestyle • Important to assist individual to accept or adapt to limitations that cannot be overcome	
(S-5) Basic Restorative Care – Nurse Aide's Role • Nurse aides are often the first health care provider to recognize signs that resident is feeling a loss in independence and should be reported to supervisor o Negative self-image o Anger directed toward others o Feelings of helplessness, sadness, hopelessness o Feelings of being useless o Increased dependence o Depression • Encourage the resident and support the family when functional loss (partial or complete loss of the function of a body part) and loss of independence causes these feelings • Be sensitive to resident's needs. Some may be embarrassed, need more encouragement than others, and need to be more involved in planning for activities	
(S-6) Basic Restorative Care – Nurse Aide's Role • Be positive and supportive • Emphasize abilities	

Module G – Basic Restorative Care	

• Explain planned activities and how nurse aide will help
• Treat with respect
• Allow for expression of feelings
• Develop empathy for situation
• Praise accomplishments
  o Assist resident to do as much as possible
  o Be realistic though, and never give false hope	

(S-7) Basic Restorative Care – Nurse Aide's Role • Review skills that will be needed to assist with restorative activities • Focus on small tasks and accomplishments • Recognize that setbacks will occur • Inform individual that setbacks occur and are to be expected • Encourage to continue with planned care in the face of setbacks • Explain that setbacks are an opportunity to improve the next attempt	
(S-8) Basic Restorative Care – Nurse Aide's Role • Give resident control • Allow some choice on when activities are performed • Encourage selection of appropriate clothing • Show patience when preparing for activity	
(S-9) Basic Restorative Care – Nurse Aide's Role • Provide for rest periods • Encourage as much as possible independence during activity • Encourage use of any prescribed adaptive devices • Consider involving family in activity, with resident's permission	

(S-10) Prosthetic Device
• Definition - replacement for loss of body part, specifically fitted to one person
• Examples are implanted lens, cochlear implant, hip prosthesis, artificial body part such as a leg or hand
• Nurse aide's role
  o Devices are usually expensive and should be handled with care
  o A nurse or a therapist should demonstrate application before this is attempted by the nurse aide
  o Expect some specific instructions for areas of prosthetic attachment
  o Observe skin under and near the prosthetic device frequently for signs of skin breakdown cause by	

Module G – Basic Restorative Care	
pressure and abrasion o Keep any skin under the prosthetic device clean and dry o Provide good skin care to all areas at risk for rubbing by any prosthetic device o Be emphatic or able to identify with and understand how a resident feels; remember the psychological toll the need for a prosthetic device takes on the individual and always support the use of the device	
(S-11) Orthotic Device • Definition - artificial device that replaces a body part and helps with function and/or appearance • Examples include artificial eye, eyeglasses, contact lenses, hearing aid, artificial breast, fitted brace for weak body part, device for use with amputation – surgical removal of a body part • Nurse aide's role o Devices are usually specific to the resident and should only be used with that resident o If there are wheels, lock them when moving the individual in or out of device o Always be alert for devices that might rub a bony prominence and report immediately o If trained to do so, pad between bony prominence and device	
(S-12) Supportive Device • Special equipment that helps a disabled or ill resident with movement • Examples include canes, walkers, crutches, wheelchairs, and motorized chairs	
(S-13) Assistive (Adaptive) Devices • Special equipment that helps a disabled or ill resident perform activities of daily living (ADLs) o Promote independence o Successful use of adaptive devices depends on resident's attitude, acceptance, motivation, support from others	
(S-14) Assistive (Adaptive) Devices for Positioning • Include regular pillows or wedge-shaped foam pillows (pictured)	
(S-15) Assistive (Adaptive) Devices for Positioning • Bed cradles – keep bed covers off legs and feet (pictured) • Footboards – help prevent foot drop	

Module G – Basic Restorative Care	
• Heel protectors – help with foot alignment	
(S-16) Assistive (Adaptive) Devices for Eating • Angled utensils – for limited arm or wrist movement (pictured) • Sipper cup (pictured) • Large grip handled utensils (pictured) • Plate with lip around the edge – keeps food on plate • Snap on food guard – keeps food on plate	
(S-17) Assistive (Adaptive) Devices for Dressing • Shirt and jacket pull (pictured) • Zipper pull (pictured) • Button fastener (pictured)	
(S-18) Assistive (Adaptive) Devices for Dressing • Long-handled shoe horn (pictured) • Socks and stocking aid (pictured)	
(S-19) Assistive (Adaptive) Devices for Hygiene • Electric toothbrush (pictured) • Denture care kit (pictured) • Fingernail brush (pictured)	
(S-20) Assistive (Adaptive) Devices for Hygiene • Extra-long sponge (pictured)	
(S-21) Assistive (Adaptive) Devices for Hygiene • Device used by residents with diabetes o To examine heels for abrasions and sores o To wash feet	
(S-22) Assistive (Adaptive) Devices for Reaching • (Pictured)	
(S-23) Assistive (Adaptive) Devices – Recording and Reporting • What activity was attempted • What assistive devices were used • How successful was the activity as this relates to the activity goal • Any increase/decrease in ability noted • Any changes in attitude or motivation, both positive and negative • Any changes in health as evidenced by skin color, respirations, energy level, etc.	
(S-24) Basic Restorative Care – ALWAYS REMEMBER • Sometimes you may think it is easier and quicker to do something for a resident, rather than encouraging the resident to do the task independently – important, though, to be patient and encourage resident to do as much of the task as possible, regardless of how long it	

Module G – Basic Restorative Care	
takes or how poorly the resident performs the task • Independence helps with the resident's self-esteem and speeds up recovery	
(S-25) Bowel and Bladder Training • Measures taken to restore function of urination and defecation by resident, with ultimate goal of continence o Urination (or voiding) – process of emptying the bladder o Defecation – process of emptying the rectum of feces o Continence – ability to control urination or defecation o Incontinence – the inability to control urination or defecation	
(S-26) Bowel and Bladder Training – Importance • Incontinence embarrassing for resident • Resident will limit lifestyle because of incontinence • Odors can cause family and friends to shun individual • Infections can develop • Residents may find it difficult to discuss and ask for help	
(S-27) Bowel and Bladder Training – Nurse Aide's Role • Nurse aide valued member of health care team (that also includes resident and family) and is involved with bowel and bladder retraining plan • Support explanation by doctor or nurse of bowel training schedule to resident, so others cannot hear	
(S-28) Bowel and Bladder Training – Nurse Aide's Role • Keep an accurate record of bladder/bowel pattern and amounts • Answers call lights promptly • Do not rush resident; be patient • Be positive • Don't scold if there are accidents • Assist to bathroom, if requested • Provide privacy, either in bed or in the bathroom • Provide encouragement; be supportive and sensitive	
(S-29) Bowel and Bladder Training – Nurse Aide's Role • Offer fluids per the schedule; encourage plenty of fluids • Encourage fiber foods – fruits, vegetables, breads and cereals • Encourage regular exercise • Teach good pericare • Keep bedding clean and odor-free	
(S-30) Bladder Training – Nurse Aide's Role • Attempts to void are scheduled and resident is	

Module G – Basic Restorative Care	
encouraged to void o When resident awakens o One hour before meals o Every two hours between meals o Before going to bed o During night as needed	
(S-31) Bladder Training – Nurse Aide's Role • Attempts to void are scheduled and resident is encouraged to void o Running water in the sink o Have resident lean forward, putting pressure on the bladder o Put resident's hands in warm water o Offer fluids to drink o Pour warm water over perineum area	
(S-32) Bowel Training • During bowel training, enemas, laxatives, suppositories, and stool softeners may be ordered • Enemas involve the introduction of fluid into the colon to eliminate stool or feces or stimulate bowel activity o Enemas will be ordered by the doctor o The order for an enema may be found on the nursing care plan o Common varieties of enemas include: tap water, saline, soapsuds o Usually contains approximately 500 ml of the ordered fluid. o Commercially prepared enemas usually have about 120 ml of fluid that contains additives designed to soften the stool so it can be more easily passed o Hiring facilities will train the nurse aide to administer an enema before the nurse aide is delegated the task	
(S-33) Bowel and Bladder Training – Points to Remember • Bowel and bladder retraining can be accomplished • Staff must be consistent and follow the plan • Recording and reporting vital to success of both bowel and bladder retraining • Success can take 8 to 10 weeks	

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MODULE H
Body Systems

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Module H – Body Systems
Definition List

Cell Theory

Benign tumor – a non-life-threatening, non-cancerous tumor that does not spread to other body parts

Cell Theory – basic unit of all living tissues or organisms, all living organisms made of cells, and cellular function is essential process of living things

Cells – are building blocks of the human body and when combined, are said to form tissue

Chemotherapy (or chemo) – a medical treatment that uses medications given orally or intravenously to kill cancer cells

Connective tissue – tissue that anchors, connects, and supports other tissues; located in every part of the body; bones, tendons, ligaments, and cartilage; blood is a form of connective tissue

Epithelial tissue – tissue that covers internal and external body surfaces; lines nose, mouth, respiratory tract, stomach, and intestines; skin, hair, nails, and glands

Malignant tumor – a cancerous tumor that invades and destroys nearby tissues and can spread to other parts of the body

Metastasis – when a cancer spreads to other parts of the body by breaking off and travelling to other parts of the body

Muscle tissue – tissue that stretches and contracts to let body move

Nerve tissue – tissue that receives and carries impulses to the brain

Organ – made of tissue, may be several different types of tissue, that carry on a special function, and combine to form a system

Organelle – carry on work of cell

Organism – made up of systems functioning together to perform activities of daily living needed for continued life

Radiation – a medical treatment that kills cancer cells using X-ray beams aimed at the tumor, or radioactive material implanted at or near the tumor

System – made of groups of several organs functioning together for a specific purpose or purposes

Tissue – cells grouped together to carry out a particular activity or function; when grouped together, tissues become organs

Tumor – growth of abnormal cells which may be benign or malignant

Integumentary System

Avoidable pressure injury – one that develops from improper use of the nursing process

Bedfast – confined to bed

Bony Prominences – areas of body where bone is close to the skin, such as elbows, shoulder blades, sacrum

Deep tissue pressure injury – purple or deep red localized area of discolored intact skin or blood-filled blister; usually due to damage of underlying soft tissue from pressure and/or shear

Dermatitis – inflammation of skin

Dermis – layer of skin under the epidermis

Eczema – red, itchy areas on the surface of skin

Epidermis – outer layer of skin

Friction – rubbing of one surface against another; skin is dragged across a surface

Integumentary System – the skin; the largest organ and system in the body, responsible for providing a natural protective covering of the body

Pressure injury (or pressure ulcer) – any lesion caused by unrelieved pressure that results in damage to underlying tissues

Pressure injury stage 1 – intact skin; redness over bony prominence

Pressure injury stage 2 – skin loss (partial-thickness); may see a blister or shallow reddish-pink ulcer; the blister may be intact or open

Pressure injury stage 3 – skin loss (full-thickness); skin gone; may see subcutaneous fat; slough (dead soft tissue, often moist and varies in color – white, yellow, green, or tan) may be present; could be attached or stringy loose

Pressure injury stage 4 – full-thickness skin and tissue loss with muscle, tendon, and bone exposure; slough and eschar (thick, leathery dead tissue that may be loose or attached to skin); often black or brown

Shear – when layers of skin rub up against each other; or it could be when skin remains in place, but tissues underneath move and stretch causing damage to capillaries and blood vessels

Shingles (or Herpes Zoster) – a disease caused by a virus, most common in people over 50, with signs that include a rash or blisters on one side of the body, burning pain, numbness, and itching

Stasis Dermatitis – a skin condition affecting lower legs and ankles that occurs from a buildup of fluid under the skin and causes problems with circulation

The 30^{o} lateral position – position of a resident when the bed is not raised more than 30^{o} and pillows are placed under the head, shoulder, and leg to lift up the hip at about a 30^{o} angle to avoid pressure on the hip

Unavoidable pressure injury – a pressure injury occurs despite efforts to prevent one through proper use of the nursing process

Unstageable pressure injury – full-thickness tissue loss with injury covered by slough and/or eschar

Musculoskeletal System

Abduction – moving a body part away from the midline

Adduction – moving a body part toward the midline

Amputation – removal of all or part of a limb because of a disease or an accident

Arthritis – Inflammation or swelling of the joints causing stiffness, pain, and decreased mobility

Ball-and-socket joint – a joint that allows movement in all directions, made up of the rounded end of one bone fitted into the hollow end of another bone, for example, the hip and the shoulder

Bone Marrow – soft and spongy tissue located in the inside part of the bone

Bones – hard and rigid structures that make up the skeleton and together form the framework of the body

Cardiac Muscle – striated, involuntary muscle of the heart

Cartilage – connective tissue that cushions bones at the joints and keeps them from rubbing together

Closed fracture – a broken bone that does not break the skin

Contracture – permanent shortening of muscle resulting in immovable joints

Dorsiflexion – bending the toes and foot upward at the ankle

Extension – straightening a body part

External Rotation – turning the joint outward

Flexion – bending a body part

Fracture – break in the bone caused by an accident or osteoporosis

Hinge joint – a joint that allows movement in one direction, for example, the elbow and knee

Hip Fracture – a serious condition involving a break in the hip bone due to an accidental fall or a fall from weakened bones

Internal Rotation – turning the joint inward

Involuntary muscle – a muscle that works automatically and cannot be controlled

Joints – the point where bones meet, made up of connective tissue called cartilage that cushions bones and keeps them from rubbing together during movement

Ligaments – connect bone to bone

Muscle atrophy – the wasting away of a muscle due to disuse, causing a decrease in size and increase in weakness of the muscle

Muscle Strain – damage of the muscle caused by trauma

Muscles – structure of the body that powers movement of skeleton and helps body stay erect

Musculoskeletal System – system of the body that provides structure and movement for the body

Open fracture (or compound fracture) – a broken bone that breaks through the skin

Opposition – touching the thumb to a finger of the same hand

Osteoarthritis – degenerative joint disease affecting the elderly and may occur with aging or joint injury, usually involving weight-bearing hips and knees

Osteoporosis – loss of bone density causing bones to become porous and brittle, resulting in bones breaking easily

Phantom pain – pain experienced in the area that a body part has been amputated possibly due to damaged nerve endings

Phantom sensation – the feeling that an amputated body part is still there

Pivot joint – a joint that allows turning from side to side, for example, the skull connected to the spine

Plantar Flexion – bending the foot downward at the ankle

Pronation – turning downward

Prosthesis – device that replaces body part that is missing or deformed

Rheumatoid Arthritis – systemic, crippling disease-causing deformities, with stiff, painful, swollen joints

Skeletal muscle – striated voluntary muscles attached to the bones that powers movement of the skeleton

Smooth Muscle – involuntary muscle of the inner linings of organs, such as the stomach, intestines, blood vessels, and others

Sprain – stretched or torn ligaments or tendons

Supination – turning upward

Synovial membrane – lining of the joints that secretes synovial fluid that acts as lubricant allowing joints to move smoothly

Tendons – connect muscle to bone

Total Knee Replacement (or TKR) – surgical replacement of the knee with a prosthesis performed to relieve pain and restore mobility, damaged by arthritis or injury

Voluntary muscle – a muscle that can be controlled

Nervous System

Brain – located in the skull and consists of three parts – cerebrum, cerebellum, and the brainstem

Brainstem – part of the brain that controls breathing, opening and closing of blood vessels, heart rate, swallowing, gagging, and coughing

Central nervous system (or CNS) – one of the two divisions of the nervous system that includes the brain and spinal cord

Cerebral cortex – outer layer of the cerebrum where ideas, thinking, analysis, judgment, emotions, and memory occurs; also guides speech, interprets messages from senses, and controls voluntary muscle movement

Cerebrovascular accident (or CVA or stroke) – damage to part of the brain due to blood clot or hemorrhage cutting blood supply off

Cerebellum – part of the brain located just below the cerebrum that controls balance and regulates movement

Cerebrum – center of the brain where thought and intelligence occur and is divided into two hemispheres and four lobes

Cognitive impairment – poor judgment, memory loss, inability to solve problems, confusion

Dysphagia – difficulty swallowing

Emotional lability – inappropriate or uncalled for laughing, crying, or expressions of anger

Expressive aphasia – trouble communicating thoughts by speech or writing

Frontal lobe – lobe of the cerebrum important for cognitive functions and control of voluntary movement or activity

Head and spinal cord injuries – injuries resulting from diving accidents, sports injuries, motor vehicle accidents, and war injuries, resulting in mild concussion to coma, paralysis, and death

Hemiparesis – weakness on one side of body

Hemiplegia – paralysis on one side of body

Left hemisphere of the cerebrum – the half of the cerebrum that controls the right side of the body

Nerves – structures that are made up of nerve cells or neurons that carry messages to and from the brain and to and from the rest of the body

Nervous System – the control and message center of the body

Neurons – nerve cells and basic unit of the nervous system

Occipital lobe – lobe of the cerebrum primarily responsible for vision

Paraplegia – complete loss of function occurs to the lower body

Parietal lobe – lobe of the cerebrum that processes information about temperature, taste, touch and movement

Paresis – loss of use of muscle function affecting only part of body

Parkinson's Disease – progressive, incurable disease that causes a part of the brain to degenerate, resulting in stiffening muscles, shuffling gait, and bent posture

Peripheral nervous system – one of the two divisions of the nervous system that includes nerves that travel throughout the body

Quadriplegia – complete loss of function occurs to lower and upper body, plus trunk

Receptive aphasia – difficulty understanding spoken or written words

Right hemisphere of the cerebrum – the half of the cerebrum that controls the left side of the body

Sensory Organs - receive impulses from environment and relay impulses to brain including skin, tongue, nose, eyes, and ears

Spinal Cord – located within the spine, connected to the brain and conducts messages between the brain and the body by pathways

Temporal lobe – lobe of the cerebrum that processes memories, integrating them with sensations of taste, sound, sight and touch

Cardiovascular System

Angina pectoris (or angina) – chest pain occurring when the heart muscle is not getting enough oxygen due to narrowed blood vessels, brought about by exercise, stress, excitement, or digesting a big meal

Arteries – blood vessels that carry blood with oxygen and nutrients away from the heart and to the cells

Atherosclerosis – arteries harden due to plaque build-up from fatty deposits; what lay people refer to as “hardening of the arteries”

Cardiovascular System – also called the circulatory system and is the continuous movement of blood though the body

Congestive Heart Failure (or CHF) – when one or both sides of the heart stop pumping effectively

Coronary Artery Disease (or CAD) – a condition in which blood vessels in the coronary arteries narrow, lowering blood supply to the heart and depriving it of oxygen

Hypertension – high blood pressure

Myocardial Infarction (or heart attack or MI) – a condition where the heart muscle does not receive enough blood and lacks oxygen, causing damage or death to that area of the heart

Peripheral Vascular Disease (or PVD) – poor circulation of legs, feet, arms, hands due to fatty deposits that harden in blood vessels

Varicose Veins – enlarged, twisted veins usually in the legs

Veins – blood vessels that carry blood with waste products away from the cells and to the heart

Respiratory System

Asthma – chronic inflammatory disease occurring when the respiratory system reacts quickly and strongly to irritants, such as pollen and dust, characterized by

difficulty breathing, wheezing, and a sense of tightness or constriction in the chest due to spasm of the muscles

Chronic bronchitis – chronic irritation and inflammation of bronchi usually caused by smoking

Chronic Obstructive Pulmonary Disease (or COPD) – chronic, progressive disease of the lungs causing trouble breathing, particularly getting air out of lungs; includes chronic bronchitis and emphysema

Cyanosis – changes in skin color, pale or bluish color of lips and extremities

Dyspnea – difficulty breathing

Emphysema – chronic, progressive disease of the lungs causing irreversible damage, usually resulting from chronic bronchitis and smoking

Exhale – when carbon dioxide is expelled out of the nose and the mouth from the lungs

Expiration – involves the breathing out of carbon dioxide

Inhale – when air (or oxygen) is pulled in through the nose and down into the lungs

Inspiration – involves the breathing in of oxygen

Lobes – segments or areas of the lung

Lower Respiratory Tract – consists of lower trachea, bronchi, and lungs

Lungs – elastic, spongy, cone-shaped air-filled structures involved in respiration

Pneumonia – acute (sudden onset) infection of the lung or lungs caused by bacteria, virus, or fungus

Pursed-lip breathing – an assistive breathing pattern for residents with chronic lung disease that requires inhaling slowly through nose and exhaling slowly through pursed lips (as if about to whistle)

Respiratory System – involves the breathing in of oxygen (inspiration) and the breathing out of carbon dioxide (expiration)

Thorax – closed cavity of the body that contain the structures needed for respiration, extending from the base of the neck to the diaphragm

Upper Respiratory Infection (or URI or a cold) – viral or bacterial infection of nose, sinuses, and throat with nasal drainage, sneezing, sore throat, fever, and tiredness

Upper Respiratory Tract – consists of nose, mouth, sinuses, pharynx, larynx, and top of trachea

Digestive System

Bowel Movement (or feces or stool or BM) – semi-solid material made of water, solid waste, bacteria, and mucus that is eliminated via the anus

Colostomy – a surgically created opening (stoma) through the abdomen into large intestine to allow stool to be expelled into a bag affixed to the abdomen

Constipation – inability to have a stool or infrequent, difficult, and possibly painful elimination of a hard, dry stool

Defecation (bowel elimination) – the passage of the bowel movement from the large intestines out of the body through the anus

Diarrhea – liquid stool

Digestive System – also known as the digestive system, extends from the mouth to the anus, and responsible for digestion and elimination

Enema – specific amount of water that may or may not have an additive and is inserted into the colon to stimulate passage of stool

Esophagus – the food tube of the body between the throat and the stomach

Fecal Impaction – hard stool stuck in the rectum and cannot be expelled, resulting in ongoing constipation

Feces – tubular shaped stool passed from the rectum

Flatulence – gas

Gastritis – inflammation of the stomach lining

Gastric ulcer (or peptic ulcer) – raw sores in stomach caused by excessive acid secretion

Gastroesophageal reflux disease (or GERD) – chronic condition when liquid contents of the stomach back up into the esophagus and that can damage the lining of the esophagus

Incontinence of stool – not able to control bowel movements, leading to an unintentional, spontaneous passage of stool

Intestines (small and large) – lower GI structures

Peristalsis – involuntary contractions that move food through the digestive system

Ulcerative Colitis – chronic inflammatory disease of large intestine; serious condition that can result in a colostomy

Urinary System

Benign Prostatic Hypertrophy (or BPH) – enlargement of prostate gland, a donut-shaped structure around the male urethra, leading to urinary dysfunction

Chronic Kidney Disease (or CKD) – damage of the kidneys that worsens gradually

Cystitis – inflammation of bladder due to infection

Dysuria – painful urination

Functional incontinence – loss of urine caused by cognitive, physical, or environment reasons

Hematuria – blood in the urine

Kidney Stones (or renal calculi) – jagged stones formed when urine crystallizes in the kidneys that can block kidneys and ureters causing excruciating pain

Kidneys – paired organs responsible for filtering waste products from the blood and producing urine

Nephritis – inflammation of kidney due to infection

Overflow incontinence – loss of urine due to bladder overflow or distention

Retention – inability to completely empty the bladder

Stress incontinence – loss of urine with sneezing or coughing

Ureters – narrow tubes that connect the kidneys to the urinary bladder

Urethra – a tube located between the urinary bladder to the outside of the body

Urge incontinence – involuntary loss of urine from a sudden urge to void

Urinary Bladder – muscular sac that stores the urine until it passes from the body

Urinary Incontinence – inability to control the bladder leading to an involuntary loss of urine

Urinary System – the filtering system of the body, responsible for ridding body of waste products from blood

Urinary Tract Infection (or UTI) – an infection of urethra, bladder, ureter, or kidney typically caused by E. coli, a bacteria found in the digestive system

Urination (or micturition or voiding) – the passing of urine from the bladder through the urethra to the outside of the body

Urine – made up of water, salt, and waste substances filtered from the blood by the kidneys that passes out of the body via the urethra

Urine straining – process of pouring urine into a fine filter strainer to catch any particles, particularly kidney stones

Reproductive System

Cystocele – weakening of the wall between the urethra and the vagina causing the bladder to drop down into the vaginal canal

Prolapse – when a pelvic organ drops into the vaginal canal

Rectocele – occurs when the wall of tissue separating the rectum from the vagina weakens causing the rectum to shift downward into the vagina canal

Reproductive System – system that allows human beings to create a new human life and may be subdivided into two categories (1) the female reproductive system and (2) the male reproductive system

Uterine prolapse – when the pelvic floor muscles weaken resulting in the uterus shifting downward into the vaginal canal

Endocrine System

Diabetes Mellitus (or DM or diabetes) – the most common disorder of the endocrine system and occurs when the pancreas produces too little insulin or does not use insulin properly causing sugar build up in the blood

Endocrine System – system of glands that secrete chemicals directly into the bloodstream to regulate body functions

Gestational diabetes – a type of diabetes that occurs during pregnancy

Glands – an organ that secretes chemicals, called hormones that regulate bodily function

Hyperglycemia – high blood sugar

Hypoglycemia – low blood sugar

Pancreas – organ of the body that produces insulin

Type 1 diabetes – a lifelong condition typically beginning during childhood and early adult when the pancreas does not produce insulin

Type 2 diabetes – a type of diabetes that develops after about age 35 when the pancreas secretes insulin, but does not use it well

Immune System

Acquired Immune Deficiency Syndrome (or AIDS) – disease caused by a virus and attacks the immune system and destroys infection-fighting and cancer-fighting cells of the body

Graves Disease – immune system attacks thyroid gland which causes it to secrete more thyroid hormone

Immune System – system defends threats both inside and outside the body

Lupus – when immune system attacks tissues causing redness, pain, swelling, and damage

Module H – Body Systems (Cell Theory)	
(S-1) Title Slide **(S-2, 3 & 4) Objectives** 1. Identify the structure and function of the cell and the integumentary, musculoskeletal, nervous, cardiovascular, respiratory, digestive, urinary, reproductive, endocrine, and immune systems. 2. Describe the nurse aide's role in the provision of care for a resident with cancer. 3. Discuss changes in the integumentary, musculoskeletal, nervous, cardiovascular, respiratory, digestive, urinary, reproductive, endocrine, and immune systems due to aging. 4. Compare and contrast normal findings and variation of normal findings of the integumentary, musculoskeletal, nervous, cardiovascular, respiratory, digestive, urinary, reproductive, endocrine, and immune systems. 5. Describe common disorders of the integumentary, musculoskeletal, nervous, cardiovascular, respiratory, digestive, urinary, reproductive, endocrine, and immune systems. 6. Describe the nurse aide's role related to a resident's integumentary, musculoskeletal, nervous, cardiovascular, respiratory, digestive, urinary, reproductive, endocrine, and immune systems.	
Content	**Notes**
(S-5) Title Slide	
(S-6) Cell Theory – Overview • Basic unit of all living tissues or organisms • All living organisms made of cells • Cellular function is essential process of living things • Cells have several functioning structures called organelles, that carry on work of cell	
(S-7) Cells – Structure and Function • Are building blocks of the human body • Have same basic structure; function, size, and shape may differ • Need food, water, and oxygen to live and function • Microscopic in size • Divide, grow, and die, renewing tissues and organs • Reproduce for tissue growth and repair in an orderly manner • Combine to form tissue	
(S-8) Tissue – Structure and Function • Grouped together and carry out a particular function • Types o Epithelial – covers internal and external body surfaces; lines nose, mouth, respiratory tract, stomach, and intestines; skin, hair, nails, and glands o Connective – anchors, connects, and supports other	

Module H – Body Systems (Cell Theory)	
tissues; located in every part of the body; bones, tendons, ligaments, and cartilage; blood is a form of connective tissue o Muscle – stretches and contracts to let body move o Nerve – receives and carries impulses to the brain • Combine to form organs	
(S-9) Organ – Structure and Function • Made of tissue, may be several types of tissues • Carries on a special function; examples are heart, stomach, bladder • Some are paired; examples are kidneys, lungs • Combine to form a system	
(S-10) System – Structure and Function • Made of groups of several organs functioning together for a specific purpose or purposes • Combine to form an organism • Systems of the body include urinary, musculoskeletal, nervous, respiratory, cardiovascular, digestive, integumentary, endocrine, and reproductive	
(S-11) In Summary, Organization of the Body • Cells, the basic unit of body structure; then tissue, then organ, then system	
(S-12) Organism – Structure and Function • Made up of systems functioning together to perform activities of daily living needed for continued life	
(S-13) Cells – Normal Findings • Reproduce for tissue growth and repair in a controlled and orderly manner	
(S-14) Cells – Variation of Normal • Cell division and growth are out of control developing into a mass or clump of cells • Tumor – growth of abnormal cells; may be benign or malignant o Benign (non-cancerous) – do not spread to other body parts; may grow large, but nonlife-threatening; do not grow back when removed o Malignant (cancerous) – invade and destroy nearby tissues; can also spread to other parts of body (metastasis) by breaking off and travelling; may be life-threatening; may grow back when removed; can occur almost anywhere in or on the body, but commonly occurs on skin and in the lung, colon, breast, prostate, uterus, ovary, bladder, and kidney	
(S-15) Cancer (CA) – Risk Factors	

Module H – Body Systems (Cell Theory)	
• Second largest cause of death; National Cancer Institute describes risk factors o Age – getting older most important risk factor o Tobacco – actual use (smoke, chew, dip) and second-hand (being around it) o Radiation – sunlight, x-rays, and radon gas o Infections – certain viruses and bacteria	
(S-16) Cancer – Risk Factors • Immuno-suppressive drugs – lower body's natural defense of stopping cancer from forming (organ transplant) • Alcohol • Diet – high in fat, protein, calories, and red meat (colon and rectal); fruits and vegetables are great	
(S-17) Cancer – Risk Factors • Hormones – female hormones • Obesity • Environment – air pollution, second-hand smoke, and asbestos	
(S-18) Cancer – Seven Warning Signs • **C**hange in bowel or bladder habits • **A** sore that does not heal • **U**nusual bleeding or discharge from any body opening • **T**hickening or lump in breast or elsewhere • **I**ndigestion or difficulty swallowing • **O**bvious change in a wart or mole • **N**agging cough or hoarseness	
(S-19) Cancer – Treatment • Goals – cure (removal from body and kill cancer cells); control (help resident live longer); reduce signs and symptoms from disease and treatment • Key is to find cancer early • Includes – surgery, radiation, chemotherapy, others (hormone, stem cell transplants, alternative) • Dependent on type, site, size, and if it has spread • May need 1 or several types of treatment • Can damage healthy cells and tissues nearby cancer • Side effects depend on type and extent of treatment	
(S-20) Cancer Treatment – Radiation • Kills cancer cells using X-ray beams aimed at tumor or radioactive material implanted at or near the tumor	
(S-21) Cancer Treatment – Radiation • Side effects o At site – sore, irritated, redness, and blistering	

Module H – Body Systems (Cell Theory)	
o Head and neck – dry mouth and sore throat o Tiredness o Discomfort, nausea, vomiting, diarrhea, and loss of appetite • Be aware of safety needs for health care providers and visitors; follow directives from care plan and nurse • Nurse aide care directed at minimizing side effects and providing emotional support	
(S-22) Cancer Treatment – Chemotherapy (or Chemo) • Affects whole body; cancer cells and normal cells affected • Targeted therapy may be given that can tell the difference between cancer cells and normal cells • May be given orally or intravenously, which may require a port (implanted device in a vein allowing for medications and/or IV fluids to be given and blood drawn) • Be aware of safety needs for health care providers and visitors, specifically handling body fluids; follow directives from care plan and nurse	
(S-23) Cancer Treatment – Chemotherapy (or Chemo) • Side effects depend on drugs used o Hair loss (alopecia) o Digestive disturbances, such as poor appetite, nausea, vomiting, diarrhea, and loss of appetite o Stomatitis – inflammation of the mouth o Decreased blood cell production, resulting in potential for bleeding and infection; weakness and tiredness o Changes in thinking and memory o Emotional changes • Targeting chemotherapy can also raise blood pressure • Nurse aide care directed at minimizing side effects and providing emotional support	
(S-24) The Resident with Cancer – Nurse Aide's Role • Resident's needs include pain relief or control, rest and exercise, fluids and nutrition, prevention of skin breakdown, prevention of bowel problems, dealing with side effects of treatment, psychologic and social needs, and spiritual needs	
(S-25) The Resident with Cancer – Nurse Aide's Role • Understand that each case is different; the residents you care for may live several months or many years; treatment effects each resident differently; never make assumptions about the resident or the resident's treatment	

Module H – Body Systems (Cell Theory)	
• Social interaction – resident may want to talk or not; listen if resident wants to share feelings or experiences; never push resident to express self; be honest, sensitive; be positive, comment if resident is eating more of diet or seems stronger • Proper nutrition – follow care plan; encourage a variety of foods with small portions if appetite is poor; for nausea or swallowing complaints, soups or gelatin may be tolerated; use plastic utensils if resident is receiving chemo (food tastes better) • Pain control – watch for signs and report to nurse; provide comfort measures, such as repositioning and distraction • Assist with comfort and circulation – try a variety of positioning devices, assist to chair if care plan directs, reposition at least every 2 hours if weak or immobile • Skin care – watch for signs of pressure injury, keep skin clean and dry; never wash off markings; avoid applying lotion to radiation site; follow skin care directives on care plan • Mouth care – understand that chemo, nausea, vomiting, mouth infections can cause pain and bad taste in mouth; soft toothbrush, mouth care cleaning per care plan but avoid mouthwash with alcohol (can increase irritation); and gentle swabbing with oral swabs dipped in a rinse for mouth sores	
(S-26) The Resident with Cancer – Nurse Aide's Role • Observe for and report to the nurse the following – increased weakness, tiredness fainting; nausea, vomiting, diarrhea, weight loss, change in appetite; depression, confusion, change in mental state; blood in mouth, urine, or bowel movement; changes in skin, new lumps, sores, rash; and increase in pain or pain that is not relieved by medication	
(S-27) The Resident with Cancer – Nurse Aide's Role • Self-image – may be an issue if weakened and has had change in appearance; hair loss common side effect, assist with grooming, show concern and interest	
(S-28) The Resident with Cancer – Nurse Aide's Role • Visitors and family – if visit is positive one, do not intrude; check with nurse about support groups in community if requested by visitors; watch for and report negative interactions to the nurse during visits	

Module H – Body Systems (Integumentary)	
Content	**Notes**
(S-29) Title Slide	
(S-30) Integumentary System – Overview • The skin • Largest organ and system in the body • Accessory structures include hair and nails • Responsible for providing a natural protective covering of the body	
(S-31) Integumentary System – Structure • Three layers o Epidermis – the outer layer; has living and dead cells; living cells push dead cells up as they divide and dead cells flake off; living cells contain pigment that give the skin its color; does not have blood vessels and only few nerve cells o Dermis – inner layer; made up of connective tissue; blood vessels, nerves, sweat glands, oil glands, and hair roots located there o Subcutaneous (fatty) tissue – thick layer of fat and connective tissue	
(S-32) Integumentary System – Function • Protects body from injury and pathogens • Regulates body temperature • Eliminates waste through perspiration • Contains nerve endings for cold, heat, pain, pressure and pleasure • Stores fat and vitamins	
(S-33) Integumentary System – Normal Findings • Warm, dry • Absence of breaks, rash, discoloration, swelling	
(S-34) Integumentary System – Changes Due to Aging • Skin is thinner, drier, more fragile • Skin loses elasticity • Fatty layer decreases so person feels colder • Hair thins and may gray	
(S-35) Integumentary System – Changes Due to Aging • Folds, lines, wrinkles and brown spots may appear • Nails harden and become more brittle • Reduced circulation to skin, leading to dryness and itching • Development of skin tags, warts and moles	
(S-36) Integumentary System – Variation of Normal • Breaks in skin	

Module H – Body Systems (Integumentary)	
• Pale, white or reddened areas • Black and blue areas • Changes in scalp or hair	
(S-37) Integumentary System – Variation of Normal • Rash, itching or skin discoloration • Abnormal temperature • Swelling	
(S-38) Integumentary System – Variation of Normal • Ulcers, sores, or lesions • Dry or flaking skin • Fluid or bloody drainage	
(S-39) Shingles (Herpes Zoster) • Caused by a virus; same virus that causes chicken pox; virus is inactive in nerve tissue and can become active years later; most common in people over 50 • Signs – rash or blisters on one side of body, burning pain, numbness, and itching; lasts about 3 to 5 weeks; Centers for Disease Control (CDC) states that the following should avoid contact with infected resident: never had chicken pox or immunization, have a weakened immune system, is pregnant never had chicken pox or immunization • Infectious until lesions are crusty • Nurse aide's role – per directive of care plan, keep rash covered until crusty, remind resident to wash hands often and avoid scratching or touching rash; vaccine recommended for people 60 years or older who have had chicken pox	
(S-40) Stasis Dermatitis • Skin condition affecting lower legs and ankles • Occurs from buildup of fluid under skin • Problems with circulation resulting in fragile skin • Can lead to open ulcers and wounds • Early signs – scaly, red, itchy areas; later signs – swelling of legs, ankles, or other areas; thin skin; darkening skin, leg pain • Nurse aide's role – report signs; note too tight stockings and shoes and report to nurse; follow directives of care plan which may include anti-embolism stockings and elevation of feet	
(S-41) The Pressure Injury • The Centers for Medicare and Medicaid Services (CMS) defines the pressure ulcer (injury) as "any lesion caused by unrelieved pressure that results in damage to	

Module H – Body Systems (Integumentary)	
underlying tissues; friction and shear are factors” • The CMS requires that long term care facilities identify residents at risk for pressure ulcers • Many pressure ulcers occur within first 4 weeks of admission to the facility	
(S-42) Pressure Injury – Key Terms • Bony prominence – an area where bone sticks out or projects from flat surface of the body; back of head, shoulder blades, elbows, hips, spine, sacrum, knees, ankles, heels, and toes	
(S-43) Pressure Injury – Key Terms • Shear – when layers of skin rub up against each other; or it could be when skin remains in place, but tissues underneath move and stretch causing damage to capillaries and blood vessels • Friction – rubbing of one surface against another; skin is dragged across a surface • CMS has defined two other terms o Unavoidable pressure injury – a pressure injury occurs despite efforts to prevent one through proper use of the nursing process o Avoidable pressure injury – one that develops from improper use of the nursing process	
(S-44) Pressure Injury – At Risk Factors • Pressure is major cause of pressure injuries; shearing and friction are contributing factors; all contribute to skin breakdown • Risk factors – immobility, breaks in skin, poor circulation to area, moisture, dry skin, and urine and feces irritation • Older residents and disabled residents are at risk due to skin changes due to age, chronic disease, and frailty	
(S-45) Pressure Injury – Residents at Risk • Bedfast (confined to bed) residents • Requires some or total help moving (coma, paralysis, hip fracture) • Agitated or have involuntary muscle movement • Urinary or fecal incontinence • Exposed to moisture • Poor nutrition; poor fluid balance • Lowered mental awareness • Problems sensing pain or pressure • Have circulatory problems • Are older • Are obese or very thin	

Module H – Body Systems (Integumentary)	
• Refuse care • History of pressure injuries	
(S-46) Pressure Injury Stages • Stage 1 – intact skin; redness over bony prominence • Stage 2 – Skin loss (partial-thickness); may see a blister or shallow reddish-pink ulcer; the blister may be intact or open • Stage 3 – Skin loss (full-thickness); skin gone; may see subcutaneous fat; slough (dead soft tissue, often moist and varies in color – white, yellow, green, or tan) may be present; could be attached or stringy loose • Stage 4 – Full-thickness skin and tissue loss with muscle, tendon, and bone exposure; slough and eschar (thick, leathery dead tissue that may be loose or attached to skin); often black or brown • Unstageable – Full-thickness tissue loss with injury covered by slough and/or eschar • Deep tissue injury – purple or deep red localized area of discolored intact skin or blood-filled blister; usually due to damage of underlying soft tissue from pressure and/or shear	
(S-47) Pressure Injury – Pressure Points • Occur over bony areas, called pressure points and include back of head, ears, shoulder blades, elbows, hips, spine, sacrum, knees, ankles, heels, and toes; sacrum being the most common site	
(S-48) Pressure Injury - Sites • Objects can contribute to pressure injury – eye glasses, oxygen tubing, tubes, casts, braces • Obese people can have pressure areas occur where skin is in contact with skin, such as abdominal folds, legs, buttocks, thighs, and under breasts	
(S-49) Prevention is Key • Identify residents at risk • Measures directed at 1) handling, moving, and positioning of the resident and 2) providing skin care	
(S-50) Handling, Moving, and Positioning of Resident • Refer to care plan for directives • Follow repositioning schedule • Use assistive devices (pillows, foam wedges); support feet properly • Do not position on red area, pressure injury, on tubes or other medical devices • Prevent bed friction (powdered sheets are an example)	

Module H – Body Systems (Integumentary)	
• Prevent shearing (do not raise the head more than 30º) • Keep feet and heels off bed	
(S-51) The 30º Lateral Position • Bed is not raised more than 30º • Pillows are placed under head, shoulder, and leg • Position lifts up the hip to avoid pressure on the hip at about a 30º angle • Person does not lie on hip as with the side-lying position	
(S-52) Providing Skin Care • Inspect skin every time care is provided • Follow care plan for bathing schedule; do not use hot water; use cleansing agent (soap can dry and irritate skin) • Prevent incontinence • Check for perspiration or wound drainage • Apply moisturizer to dry areas • Give a back rub when repositioning; do not rub over boney prominences • Keep linen clean, dry, and free of wrinkles • Avoid scrubbing vigorously when bathing or drying • Avoid skin-to-skin contact by using pillow or blanket placement • No heat directly on pressure injury	

Module H – Body Systems (Musculoskeletal)	
Content	**Notes**
(S-53) Title Slide	
(S-54) Musculoskeletal System – Overview • Provides structure and movement for the body • Protects and gives the body shape	
(S-55) Muscles – Structure • Muscles o Body has over 600 muscles made up of elastic tissue o Some are connected to bones by tendons • May be involuntary (cardiac or smooth) or voluntary (skeletal) • Involuntary – work automatically; cannot control o Cardiac – in the heart; striated o Smooth – control action of organs, such as stomach, intestines, blood vessels, and others; smooth • Voluntary – can be controlled o Skeletal – attached to the skeleton; include the arm and the legs; striated	
(S-56) Muscles – Function • Power movement of skeleton – tendons that connect muscles to bone and move bones when muscles contract (shorten) • Give body form (or posture) • Produce most of body heat – when muscles contract, food is burned for energy producing heat; more muscle activity, greater amount of heat; when body is cold, rapid muscle contractions occur producing heat, called shivering	
(S-57) Skeletal (Bones) – Structure • The skeleton o Has 206 bones o Framework • Bones o Outside is hard and rigid o Covered with periosteum, which contains blood vessels o Bone marrow, located inside, is soft and spongy o Connected to other bones by ligaments o Connected to muscles by tendons	
(S-58) Skeleton (Bones) – Function • The skeleton o Provides framework for body o Protects organs of the body	

Module H – Body Systems (Musculoskeletal)	
• Bones o Allows body to move o Stores calcium o Make and store blood cells (in bone marrow)	
(S-59) Joints – Structure • Point where bones meet • Made up of connective tissue called cartilage that cushions bones; keeps them from rubbing together • Synovial membrane lines joints and secretes synovial fluid that acts as lubricant so joints move smoothly • May be movable (ankle), slightly movable (backbone), or immovable (skull) • Ligaments located here hold bones together • Types – ball-and-socket, hinge, and pivot	
(S-60) Types of Joints – Function • Ball-and-socket – allows movement in all directions; made up of rounded end of one bone fitted into the hollow end of another bone; examples – hips and shoulders • Hinge – allows movement in one direction; example – elbow and knee • Pivot – allows turning from side to side; example – skull connected to spine	
(S-61) Musculoskeletal System – Normal Findings • Ability to perform routine movements and activities of daily living • Ability to perform full range of motion exercises bilaterally, without pain • Able to perform the following movements	
(S-62) Musculoskeletal System – Normal Findings • Abduction bilaterally without pain	
(S-63) Musculoskeletal System – Normal Findings • Adduction bilaterally without pain	
(S-64) Musculoskeletal System – Normal Findings • Extension of arm bilaterally without pain	
(S-65) Musculoskeletal System – Normal Findings • Flexion of arm bilaterally without pain	
(S-66) Musculoskeletal System – Normal Findings • Extension of leg bilaterally without pain	
(S-67) Musculoskeletal System – Normal Findings • Flexion of leg bilaterally without pain	
(S-68) Musculoskeletal System – Normal Findings • Pronation	
(S-69) Musculoskeletal System – Normal Findings	

Module H – Body Systems (Musculoskeletal)	
• Supination	
(S-70) Musculoskeletal System – Normal Findings • Dorsiflexion	
(S-71) Musculoskeletal System – Normal Findings • Plantar flexion	
(S-72) Musculoskeletal System – Normal Findings • Opposition	
(S-73) Musculoskeletal System – Changes Due to Aging • Muscles weaken and lose tone • Bones lose density and become brittle • Slower muscle and nerve interaction • Joints stiffen, become less flexible, and become painful causing decrease in range of motion and flexibility	
(S-74) Musculoskeletal System – Changes Due to Aging • Height decreases from 1 to 2 inches, between age 20 and 70 • Slowed recovery from position changes and sudden movement • Pain when moving • Reaction time, movement speed, agility, and endurance decrease • Poorer response to stimuli	
(S-75) Musculoskeletal System – Variation of Normal • History of falls • Difficulty with holding or lifting objects • Loss of muscle strength and tone • Generalized weakness and tiredness • Bruising • Slow and unsteady body movement	
(S-76) Musculoskeletal System – Variation of Normal • White, shiny, red, or warm areas over a joint • Complaints of pain in joints or muscles • Swelling, redness, and warmth of joints • Complaints of pain with movement • Inability to move joints	
(S-77) Arthritis • Inflammation or swelling of the joints; causes stiffness, pain, and decreased mobility; two common types: o Osteoarthritis (degenerative joint disease); affects the elderly and may occur with aging or joint injury; usually weight-bearing hips and knees involved, but may also include fingers, thumbs, and spine; pain and stiffness typically increase with damp, cold weather o Rheumatoid arthritis – affects any age; starting with	

Module H – Body Systems (Musculoskeletal)	
smaller joints then progressing to larger ones; joints become red, swollen, and very painful, fever, tiredness, and weight loss occur; severe and painful deformities can result with eventual movement restricted; considered an autoimmune disease when normal tissue is attacked by the immune system	
(S-78) Arthritis – Nurse Aide's Role • Encourage activity, follow care plan, canes, safety rails helpful; • Encourage independence by assisting with use of devices that help with bathing, dressing, and feeding; offer clothing choices that are easy to put on and fasten; treat each resident individually; • Help maintain self-esteem by encouraging self-care as much as possible, listen • Watch for and report stomach upset and heartburn, due to medicine	
(S-79) Osteoporosis • Bones lose density causing them to become porous and brittle; bones break easily • Caused by lack of calcium in diet, lack of regular exercise, decrease in mobility, decrease in female hormones • Signs – low back pain, stooped posture, becoming shorter, and broken bones • Nurse aide's role – to prevent or slow progress, encourage walking and simple exercise per care plan or nurse's directive; move resident carefully	
(S-80) Fracture • Broken bone caused by an accident or osteoporosis • Closed (does not break the skin) or open (also called compound and breaks through the skin); • Most common – fractures of arms, wrists, elbows, legs and hips • Goal is to put bone back in alignment, so it can heal; bone tissue grows and fuses area together, but must be allowed to do so by not moving area by typical use of a cast • Signs – pain, swelling, bruising, limited mobility • Nurse aide's role – prevention in falls crucial, follow fall prevention concepts; cast – elevate arm or leg slightly higher than level of heart; observe circulation of fingers or toes (warmth, color, movement of fingers or toes); report swelling, tightness of cast, sores, cool fingers or	

Module H – Body Systems (Musculoskeletal)	
toes, drainage or bleeding; report irritation from edges of cast; keep cast dry and assist with personal care per directive of care plan or; nurse; monitor and report if resident sticks objects in the cast	
(S-81) Hip Fracture • A break in the hip bone, serious condition requiring months of recovery; older resident heals slowly, and complications may occur – secondary illnesses and disability • Results from falling and breaking the hip, OR a broken hip due to weakened bones that causes a fall • Most require surgery and total hip replacement; goals of care include – healing of incision, slow strengthening of muscles of the hip region, mobility, gait and endurance increase • Nurse aide's role – prevention in falls crucial, follow fall prevention concepts; after surgery and during rehabilitation, follow care plan carefully as it will provide guidance on weight bearing limitation, how much resident can do, and which assistive devices may be used; following and understanding directives about weight-bearing limitations (how much weight the resident can support – non, partial, or full); do not perform range of motion until directed to do so; be very aware of limitations of leg and hip movements, use abduction pillow (special foam pillow placed in between legs that immobilizes and positions hips and legs using straps) as directed by care plan and nurse; report the following to the nurse – incision redness, drainage, bleeding; increased pain; numbness or tingling of feet and legs; tenderness or swelling in calves of legs; shortening or rotation outward of affected leg; abnormal vital signs; resident is being non-compliant with limitations; decrease in appetite; and improvements that are noted	
(S-82) Total Knee Replacement (TKR) • Surgical replacement of knee with a prosthesis; prosthesis – device that replaces body part that is missing or deformed • Performed to relieve pain and restore mobility, damaged by arthritis or injury • Post-op care is similar to hip replacement; resident does have greater ability to do self-care though • Goals – prevent blood clots, special stockings and machines used; speed up recovery, decrease stiffness, increase range of motion,	

Module H – Body Systems (Musculoskeletal)	
• Nurse aide's role – follow care plan and nurse's directive regarding mobility; encourage fluids to reduce urinary infections; report pain and redness, swelling, heat, or tenderness in calves	
(S-83) Amputation • Surgical removal of some or all of a body part; occurs – arm, hand, leg, foot; caused – disease or accident • Phantom sensation – person feels the body part is still there; phantom pain – person experiences pain in the area that has been amputated; do not ignore either; possibly results from damaged nerve endings; report to nurse • Nurse aide's role – per care plan and nurse directive, provide assistance with activities of daily living; provide support if phantom statements are made and do not argue with resident, report to nurse; assist with position changes and range of motion exercises per directive; follow care plan regarding prosthetic care	
(S-84) Contracture and Muscle Atrophy • Contracture – the muscle or tendon shortens, freezes, becomes inflexible; causes permanent disability • Muscle atrophy – the muscle wastes away, decreases in size, and becomes weak, from disuse • Prevention of these two conditions critical; perform range of motion exercises; use positioning and supportive devices to maintain structure and function of extremities	
(S-85) Musculoskeletal – Nurse Aide's Role • Prevention, prevention, prevention! • Most falls are preventable in the long-term care facility; answer call lights immediately, keep pathways clear, clean up spills, and do not move furniture; keep walkers and canes nearby so resident can reach them; resident should wear correctly fitted, non-skid footwear that is secured correctly to the feet • Encourage regular movement, activity, self-care with ADLs • Encourage resident to walk, do light exercise, and active range of motion	

Module H – Body Systems (Nervous)	
Content	**Notes**
(S-86) Title Slide	
(S-87) Nervous System – Overview • Control and coordinate all body functions • Reflex centers for heartbeat and respiration • Senses and interprets information from outside the body and responds to needed changes both inside and outside the body	
(S-88) Nervous System – Overview • Consists of two main divisions o Central nervous system (CNS) – brain and spinal cord o Peripheral nervous system – includes nerves that travel throughout the body	
(S-89) The Neuron (Nerve Cell) • Neuron – basic unit of the nervous system • Carry messages or impulses through spinal cord to and from the brain o Fragile and take long time to heal if injured; o Some are covered and insulated with a protective fiber, called the myelin sheath; also allows for speed of conduction of impulses	
(S-90) The Brain • 3 Parts o Cerebrum o Cerebellum o Brainstem • Protected by the skull	
(S-91) Brain – The Cerebrum • Divided into right and left hemispheres o Right hemisphere controls movement and function of left side o Left hemisphere controls movement and function of right side o Any illness or injury to right hemisphere affects function of left side; any illness or injury to left hemisphere affects function of right side • Cerebral cortex – outer layer; ideas, thinking, analysis, judgment, emotions, memory occurs, guides speech, interprets messages from senses, controls voluntary muscle movement	
(S-92) Brain – The Cerebrum • Each side of your brain contains four lobes.	

Module H – Body Systems (Nervous)	
o The frontal lobe is important for cognitive functions and control of voluntary movement or activity o The parietal lobe processes information about temperature, taste, touch and movement o The occipital lobe is primarily responsible for vision o The temporal lobe processes memories, integrating them with sensations of taste, sound, sight and touch	
(S-93) The Brain – Cerebellum and Brain Stem • Cerebellum o Controls balance and regulates voluntary muscles o Produces and coordinates smooth movements • Brain Stem o Regulatory center o Controls heart rate, breathing, swallowing, opening/closing blood vessels	
(S-94) Spinal Cord and Sensory Organs • Spinal cord o Located within the spine o Connected to the brain o Conducts messages between the brain and the body by pathways • Sensory Organs o Include skin, tongue, nose, eyes, and ears o Receive impulses from environment and relay impulses to brain	
(S-95) Nervous – Normal Findings • Alert and oriented, with clear short-term/long-term memory • Sensory function intact • Ability to sense heat, cold, pain • Straight gait; coordination of limbs • Reflexes present	
(S-96) Nervous – Changes Due to Aging • Some hearing loss occurs • Appetite decreases • Less tear production • Vision decreases • Problems seeing blue and green • Pupils less responsive to light • Changes in memory, most likely with short-term memory	
(S-97) Nervous – Changes Due to Aging • Loss of nerve/brain cells • Slowed response and reflex time • Jerking motions or tremors	

Module H – Body Systems (Nervous)	
• Reduced sense of touch and sensitivity to pain • Reduced blood flow to the brain • Forgetfulness • Each of the senses decrease in function • Sensitivity to heat and cold decreases	
(S-98) Nervous – Variation of Normal • Changes in gait or movement • Complaint of loss of feeling or inability to move one side of the body • Paralysis • Seizures • Confusion • Speech, vision, or hearing changes • Complaints of numbness, dizziness, nausea	
(S-99) Stroke (CVA, Cerebrovascular Accident) • Talked about or will talk about the signs of a stroke in the emergency component of the curriculum and importance of seeking emergency care immediately • Caused when (1) a blood vessel leaks or breaks in the brain; or (2) when oxygen to an area is disrupted, brain cells die • Can be mild or severe	
(S-100) Stroke • Recall that cerebrum is divided into right and left hemispheres; right controls movement and function of left side; left controls movement and function of right side; illness or injury to right hemisphere affects function of left side; illness or injury to left hemisphere affects function of right side • Further recall that each side of your brain contains four lobes with important functions • The area of the brain and the size of the area affected by the injury will impact the severity of the stroke, signs and symptoms the resident will exhibit, extent of disability, and prognosis	
(S-101) Stroke • After the stroke, the resident may experience: o Hemiplegia – paralysis on one side of body o Hemiparesis – weakness on one side of body o Expressive aphasia – trouble communicating thoughts by speech or writing o Receptive aphasia – difficulty understanding spoken or written words o Emotional lability – inappropriate or uncalled for	

Module H – Body Systems (Nervous)	
laughing, crying, or expressions of anger o Loss of sensations (temperature, touch) o Loss of bowel/bladder control o Cognitive impairment (poor judgment, memory loss, inability to solve problems, confusion) o Dysphagia (difficulty swallowing)	
(S-102) Stroke – Nurse Aide's Role • Will vary depending on severity of stroke and region of the brain involved • In general, to assist team to strengthen muscles and keep joints mobile, provide range of motion; maintain correct body alignment and support extremities with pillows and other measures; maintain positive attitude, use non-verbal and verbal communication to do so, never refer to the weak side as the "bad leg or bad arm", assist with communication using techniques recommended by speech therapist or nurse; • Understand that confusion and/or memory loss can be frightening and frustrating to the resident, may cry for no reason, again maintain a positive attitude when caring for resident, smiles and simple gestures may be helpful • Encourage independence and self-esteem by letting resident do as much care whenever possible, celebrate small victories, make tasks as easy as possible • Be very observant for changes in skin condition especially those areas at risk for pressure injury development; this resident may be at increased risk for pressure injury if loss of sensation is present or resident cannot move a side of the body; report changes immediately to nurse • Be aware with bath water temperature and shaving if the resident has loss of touch or sensation • Adapt self-care activities to limitations of the resident's condition by having them use assistive devices for eating and dressing; remember to put items the resident will need – call signal, water pitcher, glasses on the resident's unaffected side	
(S-103) Parkinson's Disease • Progressive, incurable disease that causes a part of the brain to degenerate; causes muscles to stiffen, gait shuffling, bent posture, pin-rolling with finger and thumb, tremors, and shaking; mask-like facial expression may develop • Nurse aide's role – protect resident and keep out of unsafe areas, assist with ambulation because resident is	

Module H – Body Systems (Nervous)	
at high risk for falls and running into things, due to changes in mobility and visual impairments; assist with activities of daily living and assist resident with self-care	
(S-104) Head and Spinal Cord Injuries • Result from diving accidents, sports injuries, motor vehicle accidents, and war injuries; injuries range from mild concussion to coma, paralysis, and death	
(S-105) Head and Spinal Cord Injuries • Head injuries may cause permanent brain damage; disabilities are related to the part of brain injured and may include personality changes, seizures, memory loss, paresis (loss of use of muscle function affecting only part of body), and full-blown paralysis • Severity of spinal cord injuries depend on the level and force of injury regarding the spinal cord; the higher the injury to the spinal cord, the greater loss of function: paraplegia – complete loss of function occurs to lower body; quadriplegia – complete loss of function occurs to lower and upper body, plus trunk	
(S-106) Head and Spinal Cord Injuries • Nurse aide's role – provide emotional support and realize that the resident may exhibit feelings of anger and frustration; encourage resident to participate in much of self-care as possible; crucial for position changes at a minimum of every two hours due to loss of function; range of motion per directives of care plan; immobility may lead to constipation, so encourage fluids and intake of fiber, if ordered; due to nature of disability, urinary catheter may be necessary, which increases occurrence of urinary tract infection, so provide catheter care and encourage fluids; immobility may lead to poor circulation, offer rest periods during care and apply stockings per directive; encourage deep breathing and coughing, per order, to prevent pneumonia	

Module H – Body Systems (Cardiovascular)	
Content	**Notes**
(S-107) Title Slide	
(S-108) Cardiovascular – Overview • Also called the circulatory system • The continuous movement of blood through the body	
(S-109) Cardiovascular – Changes Due to Aging • Heart muscle less efficient • Blood pumps with less force • Arteries lose elasticity and become narrow • Blood pressure increases	
(S-110) Cardiovascular – Variation of Normal • Shortness of breath, changes in or difficulty breathing • Change in pulse rate and rhythm • Loss of ability to perform ADLs • Chest pain	
(S-111) Cardiovascular System – Variation of Normal • Swelling of hands and feet • Pale or bluish lips, hands, or feet • Weakness and tiredness • Weight gain	
(S-112) Hypertension (High Blood Pressure) • Major cause is atherosclerosis, or what lay people refer to as “hardening of the arteries” • Arteries harden due to plaque build-up from fatty deposits • May complain of headache, blurred vision, and dizziness	
(S-113) Coronary Artery Disease (CAD) • A condition in which blood vessels in the coronary arteries narrow, lowering blood supply to the heart and depriving it of oxygen • Along time, fatty deposits block arteries, which may result in a myocardial infarction (MI or heart attack) • If artery is blocked in brain, a stroke results	
(S-114) Angina Pectoris (Angina) • Occurs when heart muscle is not getting enough oxygen • Causes chest pain, pressure or tightness of chest, pain radiating up the jaw, and/or down the left arm, may sweat and get short of breath • Exercise, stress, excitement, or digesting a big meal require additional oxygen; with coronary artery disease, the narrowed blood vessels keep heart muscle from getting enough oxygen	
(S-115) Myocardial Infarction (MI, Heart Attack)	

Module H – Body Systems (Cardiovascular)	
• An emergency situation when all or part of the blood flow to the heart muscle is blocked and oxygen and nutrients cannot reach cells in the area • Waste products are not removed; muscle cells in the area die • Area may be small or large, depending on which artery is involved • If resident survives, cardiac rehabilitation is ordered	
(S-116) Peripheral Vascular Disease (PVD) • Poor circulation of legs, feet, arms, hands due to fatty deposits that harden in blood vessels • Signs – nail beds and feet pale or blue, swelling in hands and feet, ulcers of legs and feet, pain while walking • Follow care plane directive regarding elastic stockings	
(S-117) Congestive Heart Failure (CHF) • When one or both sides of heart stop pumping blood effectively • All the conditions listed can cause severe damage to the heart muscle, resulting in heart not being able to pump effectively • Left side damage causes blood to back up into lungs; right side damage causes blood to back up into legs, feet, or abdomen • Signs and symptoms – tiredness, weakness, dizziness, rapid or irregular heartbeat, shortness of breath, edema (swelling of feet and ankles), increased urination at night, weight gain • Nurse aide's role – assist to bathroom; respond to call signal promptly; rest periods; intake and output; elastic stockings per order; extra pillows; HOB elevated; weigh resident; range of motion	
(S-118) Cardiovascular System – Nurse Aide's Role • Per directive of care plan or nurse, monitor vital signs (BP and P) and report abnormal values • Assist with special diet needs (low fat, low sodium) • Measure intake and output if resident receives special medication • Provide rest periods at intervals; rest reduces need for extra oxygen • Prevent resident from tiring • Layer clothing to help with warmth • Report complaints of chest pain immediately to the nurse; stay with resident and use call signal for assistance	

Module H – Body Systems (Cardiovascular)	
• Avoid extremes in temperature, particularly a cold room • Reduce stressful situations; be aware of interactions between resident and visitors; notify nurse if resident becomes upset	

Module H – Body Systems (Respiratory)	
Content	**Notes**
(S-119) Title Slide	

(S-120) Respiratory System – Structure and Function
• Thorax
  o Closed cavity of the body that contains the structures needed for respiration
  o Extends from the base of the neck to the diaphragm, and surrounded by muscles and ribs
• Upper Respiratory Tract
  o Consists of nose, mouth, sinuses, pharynx, larynx, and top of trachea
• Lower Respiratory Tract
  o Consists of lower trachea, bronchi, and lungs
• Function – involves the breathing in of oxygen (inspiration) and the breathing out of carbon dioxide (expiration)	

(S-121) Respiratory System – Changes Due to Aging • Respiratory muscles weaken • Lung tissue gradually becomes less elastic • Shortness of breath upon exertion • Lung capacity decreases • Oxygen in the blood decreases • Muscles of the diaphragm become weaker • Limited expansion of the chest due to changes in posture	
(S-122) Respiratory System – Variation of Normal • Shallow breathing or breathing through pursed lips • Coughing or wheezing • Nasal congestion or discharge, or productive cough • Noisy respirations • Gasping for breaths • Too slow or too fast respiratory rate	
(S-123) Respiratory System – Variation of Normal • Cyanosis – changes in skin color, pale or bluish color of lips and extremities • Dyspnea – difficulty breathing • Changes in rate and rhythm of breathing • Need to sit after mild exertion • Pain in the chest	
(S-124) Chronic Obstructive Pulmonary Disease • Chronic, progressive disease-causing trouble breathing, particularly getting air out of lungs; include chronic bronchitis and emphysema o Chronic bronchitis – irritation and inflammation of	

Module H – Body Systems (Respiratory)	
bronchi usually caused by smoking; signs – productive cough that brings up sputum (phlegm) and mucus, breathlessness, and wheezing o Emphysema – chronic disease of lungs usually results from chronic bronchitis and smoking; signs – problems breathing, coughing, breathlessness, and rapid heartbeat; no cure and irreversible; is usually on oxygen	
(S-125) COPD • When lungs do not get enough oxygen, all body systems affected; resident with chronic lung disease may live in constant fear of not being able to breathe causing them to sit upright in attempt to improve lung expansion; have poor appetites, do not sleep well, leading to further weakness and poor health; feel out of control; fear suffocation	
(S-126) Lung of Smoker With COPD • COPD signs – chronic cough or wheeze, difficulty breathing, sob during exertion, pale cyanotic reddish-purple skin, confusion, weakness, difficulty in finishing meal because of sob, fear and anxiety	
(S-127) COPD – Nurse Aide's Role • Help sit up or forward leaning supported with pillows • Offer fluids and small, frequent meals • Support pursed-lip breathing taught by nurse – inhaling slowly through nose and exhaling slowly through pursed lips (as if about to whistle) • Observe oxygen in use (NEVER adjust) • Be supportive of fears, carefully • Follow infection prevention principles during care • Encourage rest period	
(S-128) COPD Resident Report to Nurse • Signs/symptoms of colds or illness (make COPD worse) • Changes in breathing and changes in lung secretions • Changes in mental state • Excessive weight gain • Increasing dependency on staff and family	
(S-129) Pneumonia • Acute infection of tissue of lung or lungs that may be caused by bacteria, virus, or fungus • Signs – high fever, chills, cough, greenish or yellow sputum, chest pains, and rapid pulse • Resident with COPD at great risk for developing pneumonia, especially if weakened; recovery longer for	

Module H – Body Systems (Respiratory)	
older residents and residents with COPD	
(S-130) A Person with Asthma • Picture of healthy (blue) and unhealthy (red) bronchial tubes of a resident having an asthma attack • Unhealthy one results in constricted breathing	
(S-131) Asthma • Chronic inflammatory disease occurs when respiratory system is hyperreactive (reacts quickly and strongly) to irritants, such as pollen and dust • Exercise and stress can worsen • When bronchi become irritated from the irritants, they constrict, making it difficult to breathe • Responding to irritation and inflammation, mucus membranes produce thick mucus; further inhibiting breathing because air gets trapped in lungs causing coughing and wheezing • Residents with asthma should avoid triggers (irritants)	
(S-132) Upper Respiratory Infection (URI, a Cold) • Viral or bacterial infection of nose, sinuses, and throat • Signs – nasal drainage, sneezing, sore throat, fever, and tiredness • Remedy – body's immune system, fluids, and rest; stay away from smoke; may be more comfortable sitting up; stay away from residents with COPD	
(S-133) Respiratory System – Nurse Aide's Role • Provide rest periods at intervals • Encourage exercise and regular movement • Encourage and assist with deep breathing exercises • Limit exposure to smoke, polluted air, or noxious odors by residents with respiratory conditions • Position residents in a manner to maximize lung expansion	

Module H – Body Systems (Digestive System)	
Content	**Notes**
(S-134) Title Slide	
(S-135) Digestive – Overview • Also known as the gastrointestinal (GI) system • Extends from the mouth to the anus • Has 2 functions: digestion and elimination	
(S-136) Digestive System – Structure and Function • Upper GI structures include the mouth, pharynx, esophagus and stomach • Lower GI structures include the small intestines and large intestines • Accessory structures include the teeth, tongue, salivary glands, liver, gall bladder, and pancreas • GI System digests food, absorbs nutrients, and eliminates waste	
(S-137) Peristalsis • Involuntary contractions that move food through the digestive system	
(S-138) Bowel Movement • Bowel movement is called feces or stool or simply, BM • The passage is called defecation or bowel elimination and involves the movement of the feces from the large intestines out of the body through the anus • Semi-solid material made of water, solid waste, bacteria, and mucus • Number of bowel movements a person has dependent upon age and what the person has eaten • Iron supplements can cause a dark black color; red food coloring, beets, and tomato juice can cause a red color • Descriptors o Diarrhea – liquid stool o Constipation – inability to have a stool or infrequent, difficult, and possibly painful elimination of a hard, dry stool o Flatulence – gas o Incontinence (of stool) – not able to control bowels, leading to an unintentional, spontaneous passage of stool	
(S-139) Digestive – Normal Findings • Adequate intake of a well-balanced diet, with fluids • Passage of a brown, soft, formed, tubular shaped stool (feces), without pain • Flat abdomen	

Module H – Body Systems (Digestive System)	
• Active bowel sounds	
(S-140) Digestive – Changes Due to Aging • Decreased number of taste buds • Slowing of peristalsis causing constipation • Slower absorption of nutrients • Loss of bowel muscle tone • Loss of sphincter muscle tone • Digestion takes longer and less efficient • Thinning of stomach lining	
(S-141) Digestive – Changes Due to Aging • Decrease in saliva causing difficulty chewing and swallowing • Decrease in amounts of digestive enzymes and saliva production • Decrease in appetite • Loss of teeth • Altered taste and smell • Proteins, vitamins, and minerals not absorbed as well	
(S-142) Digestive – Variation of Normal • Difficulty swallowing or chewing • Poor intake of diet and fluids • Weight gain or loss • Loss of appetite • Abdominal pain and cramping • Blood, pus, mucus, or other discharge in stool • Incontinence	
(S-143) Digestive – Variation of Normal • Nausea and vomiting • Heartburn • Liquid stool (diarrhea) or hard stool/inability to pass a stool (constipation) • Pain when having a bowel movement • Whitish, black, or red colored stool (unless food or iron supplement related)	
(S-144) Gastric Ulcer and Gastritis • Gastric (peptic ulcer) – raw sores in stomach caused by excessive acid secretion; signs – burning pain 1 to 3 hours after eating, belching, and vomiting; can cause bleeding resulting in black, tarry stool; nurse aide's role – report abnormal stools to nurse; do not flush in case nurse would like to assess stool; encourage resident to follow prescribed diet • Gastritis – inflammation of the lining of the stomach; risk factors – use of certain pain relievers, older adults	

Module H – Body Systems (Digestive System)	
increased risk of gastritis because the stomach lining tends to thin with age, excessive alcohol use, and stress	
(S-145) Ulcerative Colitis • Chronic inflammatory disease of large intestine; serious condition that can result in a colostomy • Colostomy – a surgically created opening (stoma) through the abdomen into large intestine to allow stool to be expelled into a bag affixed to the abdomen	
(S-146) Gastroesophageal Reflux Disease (GERD) • Chronic condition when liquid contents of stomach back up into esophagus; very inflammatory and can damage the lining of esophagus • Heartburn most common symptom caused by weakening of sphincter muscle joining esophagus to stomach; if untreated, cause ulceration • Nurse aide's role – follow care plan; evening meal eaten 3 to 4 hours before bedtime; should remain upright 2 to 3 hours after eating; provide extra pillows; dietary modifications may also help	
(S-147) Constipation • Occurs when stool moves too slowly through the intestine; • Signs – abdominal swelling, gas, irritability, and verbalizing of resident that no recent bowel movement • Can result from decreased fluid intake, poor diet, inactivity, medications, aging, certain diseases, or not taking the time to have a bowel movement	
(S-148) Fecal Impaction • Hard stool stuck in the rectum and cannot be expelled, resulting in ongoing constipation • Signs – no stool for several days, oozing of liquid stool, cramping, abdominal distention (swelling), and pain in rectum • Nurse aides <u>are not allowed</u> to remove fecal impactions	
(S-149) The Enema • Specific amount of water that may or may not have an additive and is inserted into the colon to stimulate passage of stool • Doctor will write order for type and amount of fluid; four different types – tap water, soapsuds, saline, commercially- prepared and pre-packaged • Follow facility's procedure for administering enemas	
(S-150) Digestive System – Nurse Aide's Role • Make sure dentures are in place and fit properly	

Module H – Body Systems (Digestive System)	
• Observe for choking if there is a history of trouble with chewing and swallowing • Provide fluids with meals • Encourage daily bowel movements • Residents with fecal incontinence must be kept clean and dry; follow infection prevention concept of wiping from front to back; assist resident with handwashing • Important for nurse aide to provide privacy when attending to elimination needs of resident; should not be rushed or interrupted • Fiber and drink plenty of fluids; should offer fluids each time nurse aide enters room (unless fluid restricted); healthy resident should drink about 64 ounces of fluid each day • Regular physical activity is very beneficial to elimination; strengthens muscles of abdomen and pelvic which help with peristalsis; immobility and lack of exercise weakens these muscles slowing down peristalsis and elimination; encourage regular activity as tolerated and assist if needed • Understand bowel habits for each resident is individual and personal; determine bowel habits of resident; preferred time or times of day; typically, though elimination usually happens after meals • Ideal position for elimination is in a leaning forward, squatting position; if resident cannot get out of bed, assist with positioning so that resident is sitting up and by doing so allows for the resident to contract muscles and to work with gravity	

Module H – Body Systems (Urinary System)	
Content	**Notes**
(S-151) Title Slide	
(S-152) Urinary – Overview • The filtering system of the body • Responsible for ridding body of waste products from blood	
(S-153) Urinary – Structure and Function • Kidneys o Bean-shaped paired organs o Located at the back of abdominal cavity, slightly above the waist o About four or five inches long and an inch thick o Filter waste from the blood and produces urine o Help maintain water balance and blood pressure in the body o Regulate amounts of electrolytes in the body	
(S-154) Urinary – Structure and Function • Ureters o Narrow tubes o Connect the kidneys to the urinary bladder o About a foot long • Urinary bladder o Muscular sac o Stores the urine until it passes from the body	
(S-155) Urinary – Structure and Function • Urethra o A tube o Located between the urinary bladder to the outside of the body o About seven or eight inches long in males and about one and a half inches long in females	
(S-156) Urethra – Male Versus Female • Think about the anatomy of the female urethra and the male urethra in terms of length • Note the difference between one and a half inches versus seven/eight inches and how the male and female genitalia differ	
(S-156) Urethra – Male Versus Female • Think about the anatomy of the female urethra and the male urethra in terms of length • Note the difference between one and a half inches versus seven/eight inches and how the male and female genitalia differ	

Module H – Body Systems (Urinary System)	
(S-157) Urination and Urine • The passing of urine from the bladder through the urethra to the outside of the body is called urination or micturition or voiding • Made up of water and waste products filtered from blood by kidneys • Many factors can change color of urine, such as medications, certain food and dyes and vitamins and supplements • B vitamins can cause urine to become bright yellow; beets can cause a pink or red color	
(S-158) Urine – Normal Findings • Light yellow to amber in color • Clear or transparent when freshly voided, with a faint smell • About 1000 to 1500 milliliters per day	
(S-159) Urinary – Changes Due to Aging • Decreased kidney size and ability to filter blood • Decreased capacity, elasticity, muscle tone of bladder • Decreased ability to concentrate urine • Difficulty or incomplete emptying of urinary bladder • Enlargement of prostate in males • Many awaken several times at night to urinate • Sense of thirst lessens, resulting in less intake, resulting in less output which may lead to dehydration	
(S-160) Urinary System – Variation of Normal • Changes in urine o Color, cloudiness, odor, amount, frequency may indicate infection o Presence of sugar, acetone, blood, sediment in urine • Weight loss or gain • Swelling in arms or legs • Dysuria – pain or burning during urination • Swelling in bladder or abdomen • Pain in kidney or back • Incontinence • Fever	
(S-161) Urinary Tract Infection (UTI) • Recall the differences in the female and male urethras; more common in females than males • An infection of urethra, bladder, ureter, or kidney typically caused by E. coli, a bacteria found in the digestive system • Signs include frequency, urgency, voiding in small	

Module H – Body Systems (Urinary System)	
amounts, pain, burning • Nurse aide's role – always wipe/wash from front to back (both resident and nurse aide); provide careful perineal care when changing adult briefs; encourage fluids; offer toileting opportunity at least every 2 hours; answer call lights promptly showers are preferable to baths; report abnormal urine signs to nurse	
(S-162) Kidney Stones • Also called renal calculi • Form when urine crystallizes in kidneys • Can block kidneys and ureters causing excruciating pain • Signs include – abdominal pain, flank or back pain, painful urination, frequent urination, blood in urine, nausea, vomiting, chills, fever • Urine straining – process of pouring urine into a fine filter strainer to catch any particles; if found, save, and report to nurse	
(S-163) Benign Prostatic Hypertrophy (BPH) • Disorder common in men over age of 60 • Prostate gland enlarges and causes pressure on urethra • Signs – frequent urination, dribbling of urine and difficulty beginning to urinate • Urinary retention (when urine remains in bladder) may occur, which can cause urinary tract infection; urine can further back up into the ureters and kidneys creating damage to structures • Nurse aide's role – report signs of infection in urine and elevated temperature to nurse; provide perineal care or assist with care as needed	
(S-164) Chronic Kidney Disease (CKD) • Lasting damage of kidneys that worsens gradually; 5 stages; with the latter stages resulting in the need for dialysis • CKD can be prevented from advancing into further stages by controlling diabetes, maintain healthy blood pressure, exercise, and maintain a healthy weight	
(S-165) Urinary Incontinence • Inability to control bladder leading to an involuntary loss of urine; not normal part of aging • Can occur in residents who are dependent, confined to bed, paralyzed, elderly, or diseases of the nervous or circulatory system o Stress incontinence – loss of urine with sneezing or coughing	

Module H – Body Systems (Urinary System)	
o Urge incontinence – involuntary loss of urine from a sudden urge to void o Functional incontinence – loss of urine caused by cognitive, physical, or environment reasons o Overflow incontinence – loss of urine to bladder overflow or distention • Nurse aide's role – answer call lights promptly, check on resident for need to void frequently; keep resident clean and dry, urine can be irritating to the skin and a risk factor for pressure injuries; change wet clothing and linen immediately; encourage residents to drink fluids; be respectful and provide reassurance to residents, never refer to adult briefs as a diaper	
(S-166) Urination – Nurse Aide's Role • Residents with incontinence must be kept clean and dry; follow infection prevention concept of wiping from front to back; assist resident with handwashing • Important for nurse aide to provide privacy when attending to elimination needs of resident; should not be rushed or interrupted • To promote normal urination, nurse aide should encourage residents to drink fluids often and should offer fluids each time nurse aide enters room (unless fluid restricted) • Ideal position for urination for men is standing; for women is a sitting position; if resident cannot get out of bed, assist with positioning so that resident is sitting up and by doing so allows for the process to work with gravity	

Module H – Body Systems (Reproductive System)	
Content	**Notes**
(S-167) Title Slide	
(S-168) Reproductive System	
(S-169) Reproductive – Overview • This system allows human beings to create a new human life and may be subdivided into two categories (1) the female reproductive system and (2) the male reproductive system	
(S-170) Reproductive – Structure and Function • Female reproductive structures include the uterus, fallopian tubes, ovaries, and vagina • Male reproductive structures include the penis, testicles, scrotum, and urethra • Responsible for production of reproductive cells, produce hormones responsible for sex characteristics, and reproduction	
(S-171) Reproductive – Normal Findings • Absence of bleeding (other than menses) and vaginal discharge/penile discharge • Absence of pain and itching • Absence of enlargement of prostate gland	
(S-172) Reproductive System – Changes Due to Aging • Decreased size and function of reproductive structures • Enlargement of prostate • Sagging breasts • Loss of hair in vulva area • Weakened muscles that hold female reproductive organs in place	
(S-173) Reproductive System – Variation of Normal • Bleeding other than menses • Pain • Vaginal/penile discharge • Itching	
(S-174) Pelvic Organ Prolapse • Female reproductive organs held in place by muscles and connective tissue; pelvic organs may drop down (prolapse) into vaginal canal o Cystocele – when bladder drops down o Rectocele – when rectum shifts downward o Uterine prolapse – when uterus shifts downward • Incontinence may occur • Conditions range from mild to severe • Women may have tried Kegel exercises to attempt to	

Module H – Body Systems (Reproductive System)	
tighten pelvic muscles • Nurse aide's role – provide perineal care as needed and report abnormal observations to nurse	

Module H – Body Systems (Endocrine System)	
Content	**Notes**
(S-175) Title Slide	
(S-176) Endocrine – Overview • Is a system of glands that secrete chemicals directly into the bloodstream to regulate body functions • Different types of glands are pictured on slide	
(S-177) Endocrine – Structure and Function • Structure – glands located throughout the body that secrete chemicals, called hormones that regulate bodily function • Function o Maintains homeostasis (balance) o Influences growth and development o Regulates sugar in the blood and calcium in the bones o Regulates reproduction o Regulates how fast cells burn food	
(S-178) Endocrine • Normal Findings o Skin warm/dry o No variation of weight, appetite o Awake, alert, oriented • Changes Due to Aging o Levels of hormones decrease o Insulin production decreases o Body is less capable to deal with stress	
(S-179) Endocrine • Blurred vision	
(S-180) Endocrine System – Variation of Normal • Headache • Blurred vision • Dizziness • Weakness • Hunger • Irritability • Sweating • Dry skin	
(S-181) Endocrine System – Variation of Normal • Confusion • Weight gain/loss • Appetite increase/decrease • Tiredness • Increase thirst	

Module H – Body Systems (Endocrine System)	
• Increase urination	
(S-182) Diabetes Mellitus (Diabetes) • Most common disorder of endocrine system • Occurs when pancreas produces too little insulin or does not use insulin properly • Insulin needed for glucose to move from blood into cells; cells need glucose for energy • Without enough insulin, sugar builds up in blood; causing blood glucose levels to rise • Three types – Type 1, Type 2, and Gestational	
(S-183) Diabetes – Three Types • Type 1 – onset typically during childhood and early adult; pancreas does not produce insulin; lifelong condition; managed with daily doses on insulin, a special diet, and regular blood glucose testing • Type 2 – develops after about age 35; pancreas secretes insulin, but does not use it well; develops slowly; usually controlled by diet and oral medicine • 3rd type is gestational diabetes; occurs during pregnancy	
(S-184) Nurse Aide's Role • Follow care plan directives closely; ensure meals are served and resident eats his diet, report to nurse if resident refuses a meal, observe intake of meal and document carefully; if meal is delayed for lab or other reason, retrieve meal as soon as resident is allowed to eat • Encourage resident to follow exercise program which assists with circulation • Observe for signs of low blood sugar (hypoglycemia) and high blood sugar (hyperglycemia); low blood sugar may result from refusal of meal, delay of meal, increase in exercise; report immediately to nurse • Signs of hypoglycemia – hunger, vomiting, weakness, shakiness, sweating, headache, dizziness, fast pulse, low blood pressure, fast respirations, confusion, cool and clammy skin, convulsions, unconsciousness (do not let it get that far) • Signs of hyperglycemia – weakness, drowsiness, thirst, dry mouth, hunger, frequent urination, flushed face, sweet breath odor, respirations rapid and deep, blood pressure low, skin dry, headache, blurred vision, convulsions, coma (do not let it get that far • Provide for foot care as directed and observe for irritation or sores, report immediately to nurse	

Module H – Body Systems (Immune System)	
Content	**Notes**
(S-185) Title Slide	
(S-186) Immune System • Overview – this system defends threats both inside and outside the body • Structure – antibodies and white blood cells • Function o Protects the body from harmful infection-causing germs, such as bacteria and viruses o Provides immunity from certain diseases • Normal findings – body can fight infection • Changes due to aging o Immune system weakens and person more prone to getting infections o Person's immune system may attack itself causing disease	
(S-187) Immune – Variation of Normal o Signs of infection – fever, redness, swelling o Anxiety o Nausea and vomiting o Stiff, swollen, painful joints	
(S-188) Acquired Immune Deficiency Syndrome (AIDS) • Disease caused by a virus, HIV and attacks the immune system and destroys infection-fighting and cancer-fighting cells of the body • Spread through body fluids including blood, semen, vaginal secretions, and breast milk	
(S-189) AIDS – Nurse Aide's Role • Follow Standard Precautions and Blood Borne Pathogen Standard as nurse aide cares for resident • Assist with activities of daily living as needed • Provide fluids as ordered • Measure and record I&O and obtain weights • Encourage deep-breathing and coughing exercises as directed • Encourage self-care as tolerated • Observe for and report signs of infection • Provide emotional support	
(S-190) Other Common Disorders • Lupus – when immune system attacks tissues causing redness, pain, swelling, and damage • Graves disease – immune system attacks thyroid gland which causes it to secrete more thyroid hormone	

Module H – Body Systems (Immune System)	
• Nurse aide's role o Observe for and report signs of infection o Follow standard precautions o Provide for nutrition, hydration, and rest for the resident	

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE I
Body Mechanics

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module I – Body Mechanics
Definition List

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

Angle – when two lines meet

Base of Support – foundation that supports an object

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

Center of Gravity – point where most weight is concentrated for an object or body

Fowler's Position – resident reclined in a sitting position, at 45 to 60 degrees

Full-sling Mechanical Lift – mechanical device that uses a sling and used to transfer residents who cannot assist or are too heavy for the staff to transfer themselves

High Fowler's Position – resident sitting up almost straight, at 60 to 90 degrees

Lateral Position – resident positioned on right or left

Logrolling – turning the resident as a unit, while maintaining the head, back, and legs in a straight line

Mechanical Lift – mechanical devices used to transfer residents from one area to another, such as to and from bed, to and from chairs

Prone Position – resident positioned on abdomen

Protractor – a measurement device used to measure angles

Sims Position – resident positioned in left side lying position

Stand-assist lift – mechanical device used to transfer residents, who can bear some weight, follow directions, can sit on the side of the bed, and can bend hips, knees, and ankles

Supine Position – resident positioned flat on back

Module I – Body Mechanics	
(S-1) Title Slide **(S-2) Objectives** 1. Describe principles of body mechanics that help prevent injury. 2. Identify measures to safely assist a falling person to the floor. 3. Describe correct positioning of residents.	
Content	**Notes**
(S-3) Body Mechanics • Efficient and safe use of the body by the coordination of body alignment, balance, and movement	
(S-4) Body Mechanics – Importance • Due to nature of their duties, nurse aides are subject to back and other injuries to the body so practicing correct body mechanics is critically important	
(S-5) Body Mechanics – Importance • Maximizes strength, minimizes fatigue, avoids muscle strain and injury, and assures personal and resident safety • Job requirements for nurse aide include lifting, moving and carrying objects • Reduces costs to resident and facility • Reduces employee absences due to back injuries • Reduces liability for the facility due to workman's compensation • By not using proper body mechanics, even picking up piece of paper from the floor can cause back injury	
(S-6) Body Mechanics – ABC's • Follow the ABC's of correct body mechanics o Alignment o Base of Support o Coordination	
(S-7) ABC's of Correct Body Mechanics – Alignment • Also known as posture • How the head, trunk, arms, and legs are aligned with one another, when the back is straight	
(S-8) ABC's of Correct Body Mechanics – Alignment • Correct body alignment allows the body to move and function efficiently and with strength • When you stand up straight, a line can be drawn straight down through the center of your body and the two sides of body are mirror images of each other, with body parts lined up naturally, arms at the side, palms directed forward, and feet pointed forward and slightly apart (also called anatomic position) • Important to maintain correct body alignment when sitting and lying down	
(S-9) ABC's of Correct Body Mechanics – Alignment	

Module I – Body Mechanics	
• Maintain correct body alignment when lifting/carrying an object o Keep object close to the body o Point feet and body in direction you are moving o Do not twist at waist	
(S-10) ABC's of Correct Body Mechanics – Base of Support • Foundation that supports an object • Good base of support needed for balance • Wide base of support more stable than narrow base of support • For a person, the feet are the base of support (legs shoulder-length apart is ideal)	
(S-11) ABC's of Correct Body Mechanics – Center of Gravity • Point where most weight is concentrated for an object or body • For a standing person, pelvis is center of gravity • A low center of gravity gives you a more stable base of support and balance is increased	
(S-12) ABC's of Correct Body Mechanics – Center of Gravity • By bending knees to lift an object, instead of at the waist o Center of gravity lowered o Stability increases o Less likely to strain muscles • When moving or transferring resident, center of gravity includes the resident, so resident needs to be close to your body as possible	
(S-13) Points to Remember When Lifting • When given a choice, push or slide objects rather than lifting them • Use large muscles of upper arms and thighs to lift • Keep movements smooth when lifting and do not twist or make jerky movements • Face object or person when moving • Use both arms and hands when lifting, pushing or carrying objects	
(S-14) Body Mechanics – Changing Linen • Raise bed to about waist height when changing linen	
(S-15) Lifting an Object off the Floor • Bend hips/knees and get close to object before lifting • Face object • Grip object firmly with both hands	
S-16) Lifting an Object off the Floor • Move smoothly and not jerky • Lift by pushing up with strong leg muscles	

Module I – Body Mechanics	
• Use wide base of support Get help when needed	
(S-17) A Resident is About to Fall • Simply control direction of fall by easing resident to floor, protecting head • Keep resident still until nurse can check for injuries • DO NOT try to hold the resident up because it can hurt nurse aide and resident • DO NOT try to hold the resident up because the nurse aide may lose balance and both land on floor	
(S-18) Angles • An angle is formed when 2 lines meet • Angles are measured in degrees or abbreviated, ^{o} • The bed frame and head of bed are the 2 lines used to determine the angle of the bed	
(S-19) Measuring Bed Angles • Angles used to describe positions in a bed are measured in degrees ranging from 0^{o} – 90^{o} o 0^{o} = supine and prone positions (or a flat bed) o 45^{o} – 60^{o} = Fowler's position o 60^{o} – 90^{o} = High Fowler's position • As the head of the bed is being raised, the angle area is the area between the bottom of the mattress at the head end of the bed and the bed frame • As the head of the bed is raised, the angle increases	
(S-20) Measuring Bed Angles • A protractor is a measurement device that is used to measure angles o If the head of the bed is facing the right (you're right), use the bottom numbers to illustrate angles of bed positions o If the head of the bed is facing the left (you're left), use the top numbers to illustrate angles of bed positions	
(S-21) Positioning the Resident • Resident must always be properly positioned and correctly aligned	
(S-22) Positioning the Resident – Importance • Regular position changes and correct alignment o Promote well-being and comfort o Promote easier breathing o Promote circulation o Prevent pressure ulcers and contractures	
(S-23) Positioning the Resident • Reposition in bed or chair at least every two hours (or more frequently per care plan) • Use good body mechanics	

Module I – Body Mechanics	
• Ask a co-worker for assistance as needed • Use pillows for support and correct alignment • Understand correct placement for variety of positions while resident is in bed	
(S-24) Positioning the Resident (Supine) • Lies flat on back with arms and hands at the side • Use pillows for support under the head and shoulders to maintain correct body position • Use pillows, rolled towels or washcloths to support arms or hands • To create floating (or elevated) heels, place pillow under calves • Place pillows or a padded board (footboard) against the feet to keep the feet positioned correctly • Remember – facing UP (sUPine)	
(S-25) Positioning the Resident (Prone) • Lying on abdomen • Not a comfortable position for many people • Never leave resident in prone position very long	
(S-26) Positioning the Resident (Fowler's) • Reclined sitting position • 45 to 60 degrees	
(S-27) Positioning the Resident (High Fowler's) • Sitting up almost straight • 60 to 90 degrees	
(S-28) Positioning the Resident (Lateral) • Lying on right or left-side	
(S-29) Positioning the Resident (Sims) • Left side-lying position	
(S-30) Logrolling • Positioning a resident on the side with problems with the neck or back, spinal cord injury, or surgery of the back or hip requires a special technique called logrolling • As the resident is being turned, the resident must be turned as a unit; the head, back, and legs must remain in a straight line • It is best to have two people perform the logroll together using a draw sheet and a count of three	
(S-31) Mechanical Lifts • Helps prevent injury to staff and residents • Used to transfer residents to/from beds, chairs, wheelchairs, stretchers, tubs, shower chairs, and commodes • Use requires special training • Never use if unsure of the operation of the lift; always ask questions if further explanation is needed	
(S-32) Mechanical Lifts	

Module I – Body Mechanics	

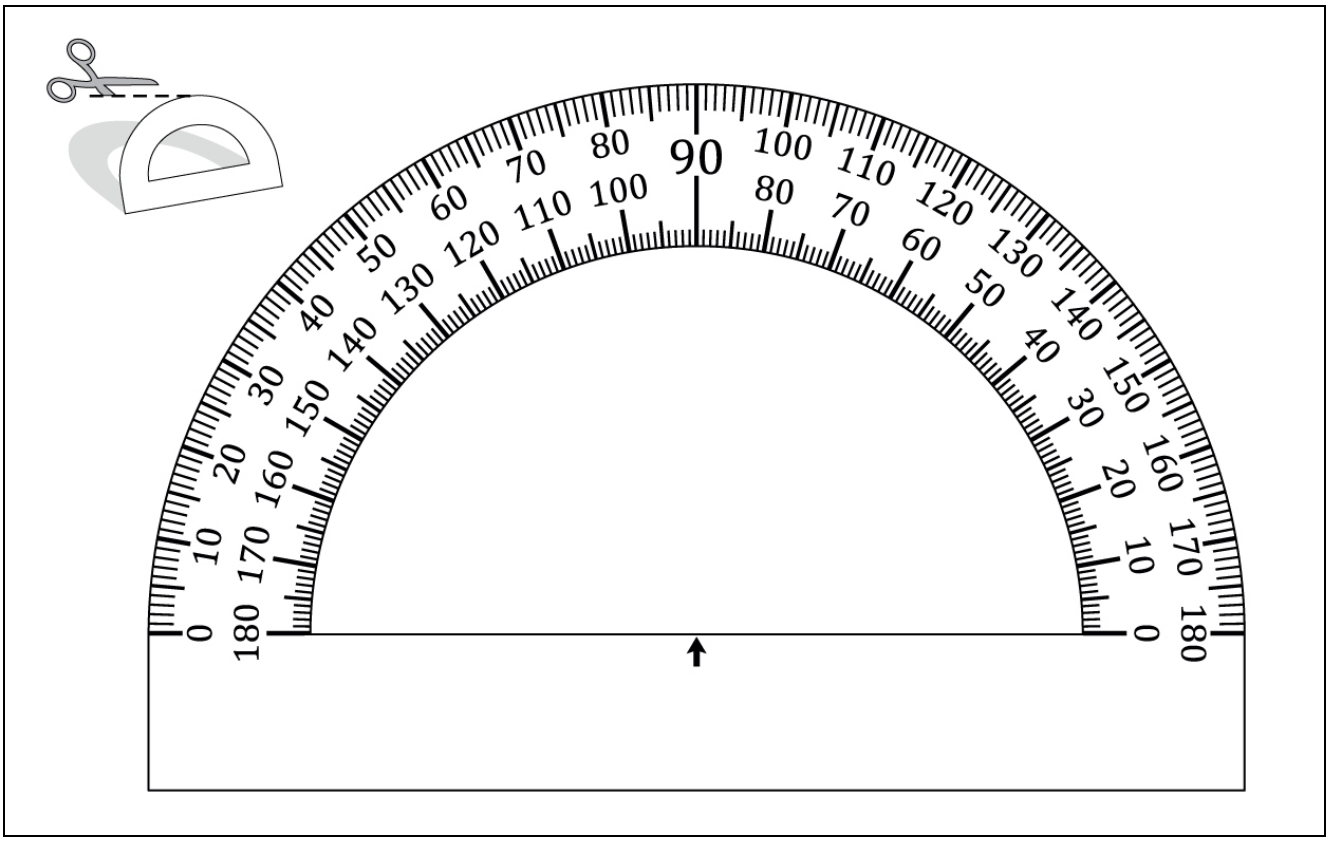
• Different types of lifts available
  o Those used to lift dependent residents
  o Those used with residents who have some weight-bearing capability
• Use may be mandatory if the facility has a “no lift” policy
• Follow care plan and supervisor’s directive regarding which mechanical lift to use and how many people are required
• Notify supervisor if the lift is not working right or needs repair
• Remember to explain the procedure to the resident and what is happening throughout the procedure
• The nurse aide must be at least 18-years old to use the lift
• Realize that just because the nurse aide knows how to use one type of lift does not mean the nurse aide knows how to use all types of lifts	

(S-33) Mechanical Lifts • Realize that just because the nurse aide knows how to use one type of lift does not mean the nurse aide knows how to use all types of lifts	

(S-34) Full-sling Mechanical Lift
• Used for residents who
  o Cannot assist during transfers
  o Are heavy
  o Have physical limits which do not allow for other methods of transfer
• Before use, nurse aide needs to know the following from the care plan or supervisor
  o Resident’s level of function or dependency
  o What type and size of sling to use	

(S-35) Stand-assist Lift
• Used when resident can
  o Bear some weight on legs, is able to stand, has some arm strength
  o Can bend hips, knees, and ankles
  o Can sit on side of bed
  o Can follow directions	

Teaching Tip #6I Measuring Bed Angles Using a Protractor Duplicate and cut out protractors.



State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE J
Nutrition and Fluid

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
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Module J – Nutrition
Definition List

Advancing a Diet – food is gradually reintroduced to the resident due to surgery, in preparation for a procedure, or illness

Aspiration – accidental breathing in of food, fluid, vomit, or other object into lungs

Calcium – a mineral that keep bones and teeth strong

Calorie – energy value of a food or a beverage

Carbohydrates – a nutrient that supplies energy and helps body use fats

Dehydration – serious situation when a person does not take in enough fluid for the body causing a decrease in amount of water in tissue

Dysphagia – difficulty swallowing

Fats – a nutrient that is a good source of energy and gives flavor to food

Fluid Balance – when fluids taken in equal the fluids eliminated

Force Fluids – medical order for person to drink more fluids

Intake – amount of fluids taken in each day

Iron – a mineral that helps blood carry oxygen to all parts of the body

Malnutrition – the lack of proper nutrition because of a lack of food intake, improper diet, or impaired use of food by the body

Minerals – a nutrient that helps the body function normally

NPO – nothing by mouth

Nutrients – substance found in food and fluids that are used by body for growth and maintenance of health

Nutrition – when the body takes in and uses foods and fluids to maintain health

Nutrition Facts Label – simple tool from Food and Drug Administration (FDA) found on all packaged foods and beverages and serves as a guide for making choices that can affect health

Output – amount of fluids eliminated each day

Proteins – a nutrient that is needed by every cell to help grow new tissue and help with tissue repair

Restrict Fluids – medical order for person to limit fluids taken in

Special Diet (therapeutic diet or modified diet) – a specific diet ordered for a person because of illness, condition, or preparation for a procedure

Serving Amount – shows the amount that is equal to one serving of a food or beverage

Serving Size – shows the number of servings in a package or container of food or beverage

Vitamins – a nutrient that helps the body function normally; body gets majority of vitamins from certain foods; examples are Vitamins A and C

Module J – Nutrition and Fluids	
(S-1) Title Slide **(S-2 & S-3) Objectives** 1. Describe nutrition and fluid requirements for the older adult. 2. Identify basic nutrients. 3. Explain the use of the U.S. Department of Agriculture's (USDA's) MyPlate. 4. Identify special diets ordered for the older adult based on particular illnesses or conditions. 5. Discuss nurse aide responsibilities related to dysphagia and prevention of aspiration, hydration and prevention of dehydration. 6. Explain the nurse aide's role in enteral and parenteral nutrition.	
Content	**Notes**
(S-4) Definitions • Nutrition – when the body takes in and uses foods and fluids to maintain health • Nutrients – substance found in food and fluids that are used by body for growth and maintenance of health • Malnutrition – the lack of proper nutrition because of a lack of food intake, improper diet, or impaired use of food by the body	
(S-5) Good Nutrition – Importance • Promotes physical and mental health • Increases resistance to illness • Produces energy and vitality • Aids in healing • Assists one to feel and sleep better • Helps avoid or manage common diseases o Certain cancers o Type 2 diabetes o Heart disease o High blood pressure o Obesity o Osteoporosis	
(S-6) Good Nutrition – Characteristics • Well-developed, healthy body, at the appropriate weight • Alert facial expression • Healthy, shiny hair • Clear skin and bright eyes • Healthy appetite • Regular elimination habits • Restful sleep patterns	
(S-7) Poor Nutrition – Characteristics • Changes in weight • Poor skin color and appearance	

Module J – Nutrition and Fluids	
• Dull looking hair, eyes and skin • Irregular elimination habits • Poor sleep patterns • Abnormal conditions, such as osteoporosis or anemia • Tired	
(S-8) Six Nutrients • Water • Fats • Carbohydrates • Proteins • Vitamins • Minerals	
(S-9) Water • Most essential nutrient • Needed for every cell in body • Main part of the blood • Importance to body o Helps move oxygen and nutrients into cells and removes waste products out of cells o Helps with digestion and absorption of food o Helps maintain temperature by perspiration • Only can survive a few days without water	
(S-10) Fats • Good source of energy and gives flavor to food • Certain fats may increase cholesterol levels and lead to heart disease • Sources of fat – butter, oil, fatty meat, etc	
(S-11) Carbohydrates • Supplies energy and helps body use fats • Certain carbohydrates add fiber to diet that help with elimination • Sources of carbohydrates – breads, fruits, candy, sugary soft drinks, etc	
(S-12) Protein • Needed by every cell to help grow new tissue and help with tissue repair • Sources of proteins – meats, cheese, beans, etc	
(S-13) Vitamins and Minerals • Vitamins o Help the body function normally o Body gets majority of vitamins from certain foods o Examples are Vitamins A and C • Minerals o Help the body function normally	

Module J – Nutrition and Fluids	
o One mineral, calcium, keeps bones and teeth strong o One mineral, iron, helps blood carry oxygen to all parts of the body	
(S-14) Serving Size • Two important pieces of information o Shows the number of servings in the package or container o Shows the amount for one serving of a food or beverage • Serving sizes given in familiar measurements, such as cups or pieces	
(S-15) Serving Size • Information on the label is based on one serving of the food or beverage • Be careful o If a label serving is one cup and you eat two cups, then you are doubling what is listed on the label • Examples – a bottle of soft drink or a bag of potato chips may have two or more servings	
(S-16) Methods to Determine Serving Size • Weighing the food • Using the hand as a frame of reference	
(S-17) Methods to Determine Serving Size • Using common objects as frames of reference o Postage Stamp o Deck of Cards	
(S-18) Serving Sizes Using the Hand • Palm – 3 ounces (meat, poultry, fish) • Handful – 1 ounce (nuts, raisins, small candies)	
(S-19) Serving Sizes Using the Hand • Woman's fist – 1 cup (rice, fruit, veggies, cereal, pasta, baked potato) • 2 handfuls – 1 ounce (chips, popcorn, pretzels	
(S-20) Serving Sizes Using the Hand • Thumb – 1 ounce or 1 tablespoon (peanut butter, hard cheese) • Thumb tip – 1 teaspoon (cooking oil, mayo, butter, sugar)	
(S-21) Serving Size Using Common Objects • Deck of cards – 3 ounces (meat, poultry, fish) • Baseball – 1 cup (rice, fruit, veggies, cereal, pasta)	
(S-22) Serving Size Using Common Objects • Tennis ball – 1 medium size fruit • Postage stamp – butter	
(S-23) Calories • Calorie is energy value of a food or beverage • Shows the number of calories in one serving	

Module J – Nutrition and Fluids	
• Most people who are trying to lose weight are concerned with calories	
(S-26) USDA's MyPlate • Developed by U.S. Department of Agriculture • It recommends balancing the intake of healthy food choices and physical activity • Designed to help people easily build a healthy plate during meal times • Shows the amounts of each food group that should be on a person's plate during meals • Emphasizes vegetables, fruits, grains, protein, and low-fat dairy	
(S-27) USDA's MyPlate • Think about halves – make half your plate fruits and vegetables; and make half your grains whole grains • Advocates drinking water instead of sugary drinks • Replaces the MyPyramid • Lots of helpful information at the following website: www.choosemyplate.gov	
(S-28) USDA's MyPlate • Make half your plate fruits and vegetables • Vegetables – choose a variety of colored vegetables • Fruits – choose whole fruits – fresh, frozen, dried, or canned in 100% juice • Grains – make half your grains whole grains • Dairy – choose low-fat or fat-free milk or yogurt • Protein – mix up your protein foods to include seafood, beans and peas, unsalted nuts and seeds, soy products, eggs, and lean meats and poultry	
(S-29) USDA's MyPlate Healthy Choices • Vegetables o Eat more red, orange, and dark-green, such as tomatoes, sweet potatoes, broccoli o Add beans or peas to salads, soups, or side dishes o For canned vegetables, choose reduced sodium or no salt added	
(S-30) USDA's MyPlate Healthy Choices • Fruits o Use fruits as snacks, salads, and desserts o At breakfast, add bananas or strawberries to oatmeal or cereal; or blueberries to pancakes o Choose fresh, frozen, canned in water or 100% juice, or dried o Select fruit juices that are 100% fruit juice	
(S-31) USDA's MyPlate Healthy Choices	

Module J – Nutrition and Fluids	
• Grains o Choose whole-grain instead of refined-grain foods when selecting breads, bagels, rolls, cereals, crackers, rice, and pasta o Whole grains include the “whole grain” and refined grains have valuable parts of the grain removed o Examples of whole grain include brown rice, wild rice, oatmeal, whole wheat/oats/corn products	
(S-32) USDA’s MyPlate Healthy Choices • Dairy o Choose skim (fat free) or 1% (low-fat) milk o Include low-fat yogurt on fruit salads and baked potatoes	
(S-33) USDA’s MyPlate Healthy Choices • Protein o Eat a variety of foods each week, including seafood, beans and peas, and nuts, plus lean meats, poultry, and eggs o Choose seafood twice a week o Choose lean meats and ground beef that is at least 90% lean o Cut fat from meat and remove skin from poultry	
(S-34) USDA’s MyPlate Activity Plan • Pick activities you like and do each for at least 10 minutes at a time – because every little bit adds up as activity increases • Adults – 2 ½ hours or more per week of activity of moderate effort, such as walking briskly	
(S-35) Age Related Changes Affecting Nutrition • Need for fewer calories • Vitamin and mineral requirements change • Drugs may affect how nutrients absorbed and used • Teeth/dentures affect ability to chew food • Saliva and gastric juices decrease • Appetite and thirst decrease	
(S-36) Age Related Changes Affecting Nutrition • Constipation may occur • Taste and smell diminish • May require assistance with dining	
(S-37) The Diet Card • Prepared by dietary department based on doctor’s order • Each resident’s meal has its own diet card • At a minimum, lists the resident’s room number, name, and type of diet • The nurse aide who delivers the meal tray must verify that the right resident is receiving the right meal tray, with the right diet on it	
(S-38) The Regular Diet • Ordered by the doctor	

Module J – Nutrition and Fluids	
• A basic, well-balanced diet • Without limits or restrictions	
(S-39) Special Diets • Also called therapeutic or modified diet • Ordered by the doctor and planned by dietician with input from resident • May restrict or totally eliminate certain foods or fluids, based on illness (i.e. Celiac Disease), in preparation for procedures, or to meet nutritional needs	
(S-40) Cultural Food Preferences and Dietary Restrictions • Culture influences dietary practices, food choices, and food preparation • Many Buddhists are vegetarians, but some may include fish in their diet • Some Christians, mostly Roman Catholics, do not eat meat on Fridays during Lent • Mormons may not drink alcohol, coffee, or tea.	
(S-41) Cultural Food Preferences and Dietary Restrictions • Many Jewish people eat kosher foods, but do not eat pork, lobster, shrimp, or clams (shellfish). Kosher food is prepared according to Jewish dietary laws. Kosher and non-kosher foods cannot come into contact with the same plates. Jewish people who observe dietary laws may not eat meat at the same meal with dairy products.	
(S-42) Cultural Food Preferences and Dietary Restrictions • Muslims do not eat pork. • They may not eat certain birds. • They may not drink alcohol. • Muslims have regular periods of fasting.	
(S-43) Advanced Diet • Food is gradually reintroduced to the resident • Reasons – surgery or medical condition • Resident may start out NPO (nothing by mouth) → ice chips → clear liquids → full liquids → mechanical soft → regular diet	
(S-44) Other Forms of Nourishment • Residents may be unable to eat due to illness, surgery, or injury • Enteral nutrition – feeds the resident through a feeding tube into the gastrointestinal tract, through the nose and directly into the stomach (naso-gastric tube), or into the stomach through the abdomen (gastrostomy)	
(S-45) Other Forms of Nourishment • Nurse is responsible for care of resident's gastrostomy • Nurse aide must keep the head of bed elevated per facility	

Module J – Nutrition and Fluids	
policy • Nurse aide must be careful to not pull on the gastrostomy tube and to keep tube secure	
(S-46) Other Forms of Nourishment • Intravenous (IV) Fluids – feeds the resident through a vein o Nurse is responsible for care o Nurse aide observes for and reports redness, swelling, or pain at the site o Nurse aide reports low supply of fluid in bag • Nurse aide must be careful with tubing and connections when providing care	
(S-47) Alternative and Supplemental Feedings • Sometimes given when resident needs extra protein, calories, and fluids o Ordered by physician and to serve as between-meal foods and fluids o Examples include: milk, juice, pudding, ice cream, milk shake, fruit, crackers • Nurse aide's responsibility o Assist the resident as needed Report amount resident ate or drank	
(S-48) OBRA Dietary Requirements for Resident's in Nursing Homes • Each person's o Dietary and nutritional needs are met o Diet is nourishing, well-balanced tastes good	
(S-49) OBRA Dietary Requirements for Resident's in Nursing Homes • The food is • Appetizing, smells and looks good • Varied in color and texture • Served at the correct temperature • Served promptly • Prepared to meet individual needs	
(S-50) OBRA Dietary Requirements for Resident's in Nursing Homes • Other foods are offered if food serve is refused • Each person receives at least 3 meals a day, with the offer of a bedtime snack • Assistive devices and utensils provided as needed	
(S-51) Dysphagia • Dysphagia is difficulty in swallowing • With dysphagia, there is a danger in aspiration	

Module J – Nutrition and Fluids	
• Causes of dysphagia o Illness, such as stroke o Some medicines o Problems with mouth and throat muscles o Weakness o Problems with teeth or dentures • Signs/symptoms of dysphagia o General – eats very slowly, frequent throat clearing – "ahem," and decrease in appetite o Avoids – eating and certain textured foods o When eating/drinking – vomits or chokes, has problems with breathing, eyes water, spits out food pieces, has difficulty with chewing, has difficulty swallowing small pieces of food (or pills), suddenly spits out food, and has to swallow several times when eating a single bite of food o During/after meals – drools or dribbles food or fluid from mouth, pockets or keeps food inside mouth or cheeks, coughs, gurgles when talking, and food/fluid comes up into or out of the nose o Complaints – heartburn, food getting stuck, and hoarseness after eating	
(S-52) Aspiration • Aspiration (recall the definition) – the accidental breathing in of food, fluid, vomit, or other object into lungs • Can cause pneumonia or death • Nurse aide's role in preventing aspiration o Place resident in upright position at 90 degree angle for eating and drinking, and at least 30 minutes afterward o Feed slowly o Avoid distractions o Offer small amounts of food o Offer bite of food, then sip of liquid, repeat o If one side is paralyzed, place food in non-paralyzed side of the mouth o Make sure food is swallowed after each bite before next bite/sip o Provide mouth care after meals o Report signs of aspiration immediately – gagging, vomiting, clutching throat (classic sign of choking), cyanosis, shortness of breath or difficulty breathing; unconsciousness, complaints of chest pain or chest tightness o Provide thickened liquids, per directive from nurse	
(S-53) Fluid Balance – Water • Needed to survive • Death can occur if you get too little or too much • Take in water by drinking fluids and eating foods	

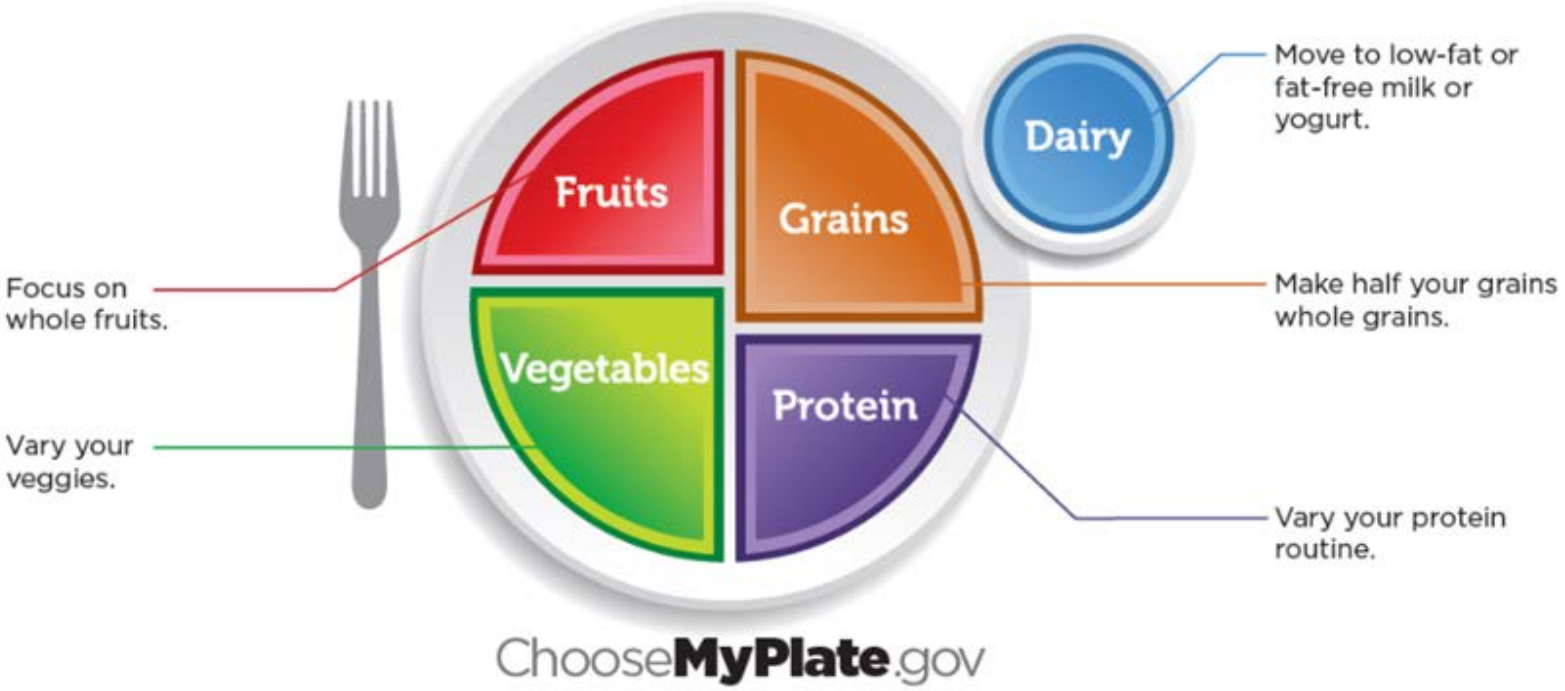
Module J – Nutrition and Fluids	
• Lose water via urine, feces, vomit, perspiration (sweat), and lungs (breathing out), plus drainage from wounds or liquids from stomach suctioning	
(S-54) Fluid Balance • Needed for good health • Amount of fluid taken in (intake) equals the amount of fluid lost (output)	
(S-55) Dehydration • If fluid intake is less than fluid output, dehydration occurs • Resident does not take in enough fluid for the body causing tissues to lack water • When does it occur? May occur with bleeding, dementia, fever, poor fluid intake, fluid restriction, excess sweating, vomiting, increase in urination, medicines. • Nurse aide's role in preventing dehydration o Determine preferences of fluids and offer o Assure water pitcher and cup are within reach o Offer assistance and use assistive devices if needed o Measure and record I & O accurately, if ordered o Force fluids (encourage to drink more fluids), if ordered by the doctor o Observe for and report signs and symptoms of potential dehydration and presence of dehydration • Warning signs of potential for dehydration o Drinks less that six 8-ounce glasses of fluids per day o Drinks little or no fluids during meals o Needs help drinking fluids o Has trouble swallowing fluids o Has fever, vomiting, diarrhea o Confused o Complaints of thirst, dry mouth o Decrease in urinary output • Signs/symptoms of dehydration o Severe thirst o Dry mouth and mucous membranes o Cracked lips o Warm, dry, wrinkled skin o Sunken eyes o Flushed face o Dark, strong-smelling urine, in small amounts o Constipation o Weight loss o Weakness, dizziness, confusion o Headache	

Module J – Nutrition and Fluids	
o Irritable o Rapid, weak pulse o Irregular heartbeat o Low blood pressure	
(S-56) Edema • If fluid intake is greater than fluid output o Tissues will swell with water – called edema o May occur with kidney or heart disease • Nurse aide's role o Obtain accurate weights, per order o Increase pillows per resident's request o Restrict fluids – fluids limited per doctor's order o Observe for and report signs/symptoms of fluid overload • Signs/symptoms of fluid overload o Weight gain (of 1 to 2 pounds in a day) o Fatigue o Difficulty breathing or shortness of breath o Swelling of ankles, feet, fingers, hands o Swollen abdomen o Coughing o Decrease in urine output o Tight, smooth, shiny skin o Increased heart rate	

Handout #1J What's on Your Plate?

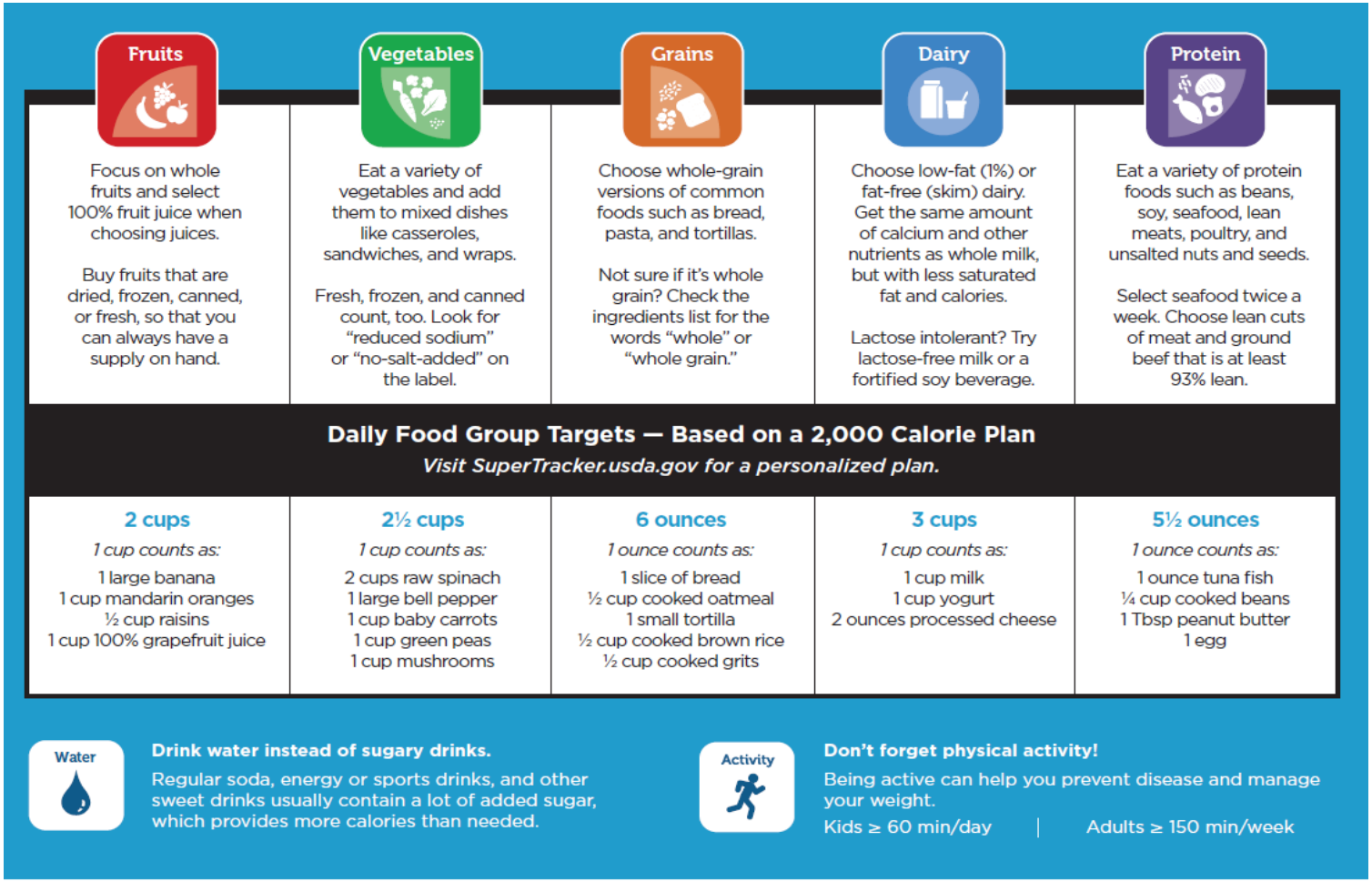
MyPlate, MyWins: Make it yours

Find your healthy eating style. Everything you eat and drink over time matters and can help you be healthier now and in the future.



Limit the extras.
Drink and eat beverages and food with less sodium, saturated fat, and added sugars.

Create 'MyWins' that fit your healthy eating style.
Start with small changes that you can enjoy, like having an extra piece of fruit today.



MyPlate, MyWins
Healthy Eating Solutions for Everyday Life
ChooseMyPlate.gov/MyWins

Center for Nutrition Policy and Promotion
May 2016
CNPP-29
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Handout #2J Special Diets

Type of Diet	Description	Purpose	Foods Allowed or Not Allowed
Clear Liquids	Can see through, non-irritating, non-gassy	Post-operative, acute illness, infection, nausea/vomiting, prepare for GI procedures	Water, tea, black coffee, carbonated drinks, gelatin, clear fruit juices (apple, grape, cranberry), clear broth
Full Liquids	All liquids	Next step after clear liquids, fever, nausea/ vomiting, resident unable to chew/swallow/digest solid foods	All clear liquids, plus custard, strained soups, strained fruit/ vegetable juices, milk, milk shakes, strained cooked cereal, plain ice-cream, sherbet, pudding, yogurt, popsicles
Mechanical Soft	Semi-solids, easily digested	Next step after full liquids, fever, nausea/ vomiting, resident unable to chew/swallow/digest solid foods	all liquids, plus non-fried eggs, non-fried meat/fish/poultry, mild cheeses, strained fruit juices, non-crusted breads, cooked cereal, cooked/pureed vegetables, cooked/canned non-seeded peeled fruits, plain cookies/cakes without nuts or fruit
Fiber Restricted	Leaves little residue and fiber in colon	Colon diseases, diarrhea	Coffee, tea, milk, carbonated drinks, strained fruit juices, refined bread/crackers/pasta (white), rice, cottage/cream cheese, non-fried eggs, plain puddings/cakes, gelatin, custard, sherbet/ice cream, strained vegetable juices, cooked/canned non-seeded peeled fruits, non-fried potatoes, strained cooked vegetables, NO RAW FRUITS OR VEGETABLES
High-Fiber	Increases residue and fiber in colon, stimulates movement of food	Constipation, GI disorders	All fruits and vegetables, whole-wheat bread, whole-grain cereals/rice, fried foods, milk, cream, butter, cheese, meats
Bland	Non-irritating, low in roughage, moderate temperature, not spicy	Ulcers, gallbladder/some intestinal disorders, after abdominal surgery	Lean meats, non-fried foods, white bread, creamed/refined cereals, cream/cottage cheese, gelatin, plain pudding/cakes/cookies, eggs, butter/cream, canned non-seeded peeled fruits/vegetables, potatoes, pasta, rice, strained/soft cooked carrots, creamed soups, NO FRIED FOODS

Type of Diet	Description	Purpose	Foods Allowed or Not Allowed
Calorie-Restricted	Promotes weight loss and lowers body fat	Weight loss	Choose low-fat, low-carbohydrate foods, and lean meats; avoid the following: butter, cream, rice, gravy, salad oils, noodles, cakes, pastries, carbonated/alcoholic drinks, candy, potato chips, and similar foods
High-Calorie	Calories increased to 3000 to 4000 daily	Weight gain, some thyroid problems	Increases in all foods, large amounts of regular diet, meals plus 3 in-between meal snacks
High-Iron	Foods high in iron	Anemia, blood loss, non-menopausal women	Liver and other meats from organs, lean meats, egg yolks, shellfish, dried fruits/beans, green leafy vegetables, lima beans, peanut better, enriched breads/cereals
Low Cholesterol	Fat controlled, foods low in fat and prepared without adding fat	Heart/gallbladder/liver/pancreatic disease, disorders of fat digestion	Fat-free (skim) milk, buttermilk, cottage cheese, gelatin, sherbet, fruit, baked/broiled/roasted meat/poultry/fish, fat free broth/soup, margarine, rice, pasta, breads, cereals, vegetables, potatoes
High-Protein	Promotes tissue healing	Burns, high fever, infection	Meat, milk, eggs, cheese, fish, poultry, breads/ cereals, green leafy vegetables
Sodium-Controlled	Sodium (salt) controlled	Heart/liver/some kidney diseases, fluid retention	Allowed: fruits/vegetables and unsalted butter; not allowed: highly salted foods and foods high in sodium, adding salt at the table; restricted: adding salt for seasoning while cooking
Diabetic Diet	Dependent upon individual needs, calories and carbohydrates carefully controlled, fats and proteins regulated	Diabetes	Right amounts and types of foods, at the right times, during mealtimes and snacks
Gluten Free	Free of gluten, which is a protein found in wheat,	Celiac Disease	Avoid foods containing wheat flour, such as tortilla, crackers, breads, cakes, pastas and cereals. Some sauces and dressings also

	rye, and barley.		contain wheat. Hot dogs, broth, candy, and medication may also contain gluten.
Vegetarian Diets: • **Lacto-ovo**	Excludes all meats, fish, and poultry, but allows eggs and dairy products	Diabetes Obesity Religious reasons Dislike of meat Compassion for animals Belief in nonviolence Financial issues	Avoid meats, fish, and poultry.
Vegetarian Diets: • **Lacto-vegetarian**	Excludes all meats, fish, poultry, and eggs, but allows dairy products.	Diabetes Obesity Religious reasons Dislike of meat Compassion for animals Belief in nonviolence Financial issues	Avoid meats, fish, poultry, and eggs.
Vegetarian Diets: • **Vegan**	Excludes all meats, fish, poultry, eggs, and dairy products, along with all foods that are derived from animals.	Diabetes Obesity Religious reasons Dislike of meat Compassion for animals Belief in nonviolence Financial issues	Avoid all meats, fish, poultry, eggs, dairy products, and all foods that are derived from animals.

Two-page Instructor Resource for Activity #2J (Do Not Hand Out to Students)

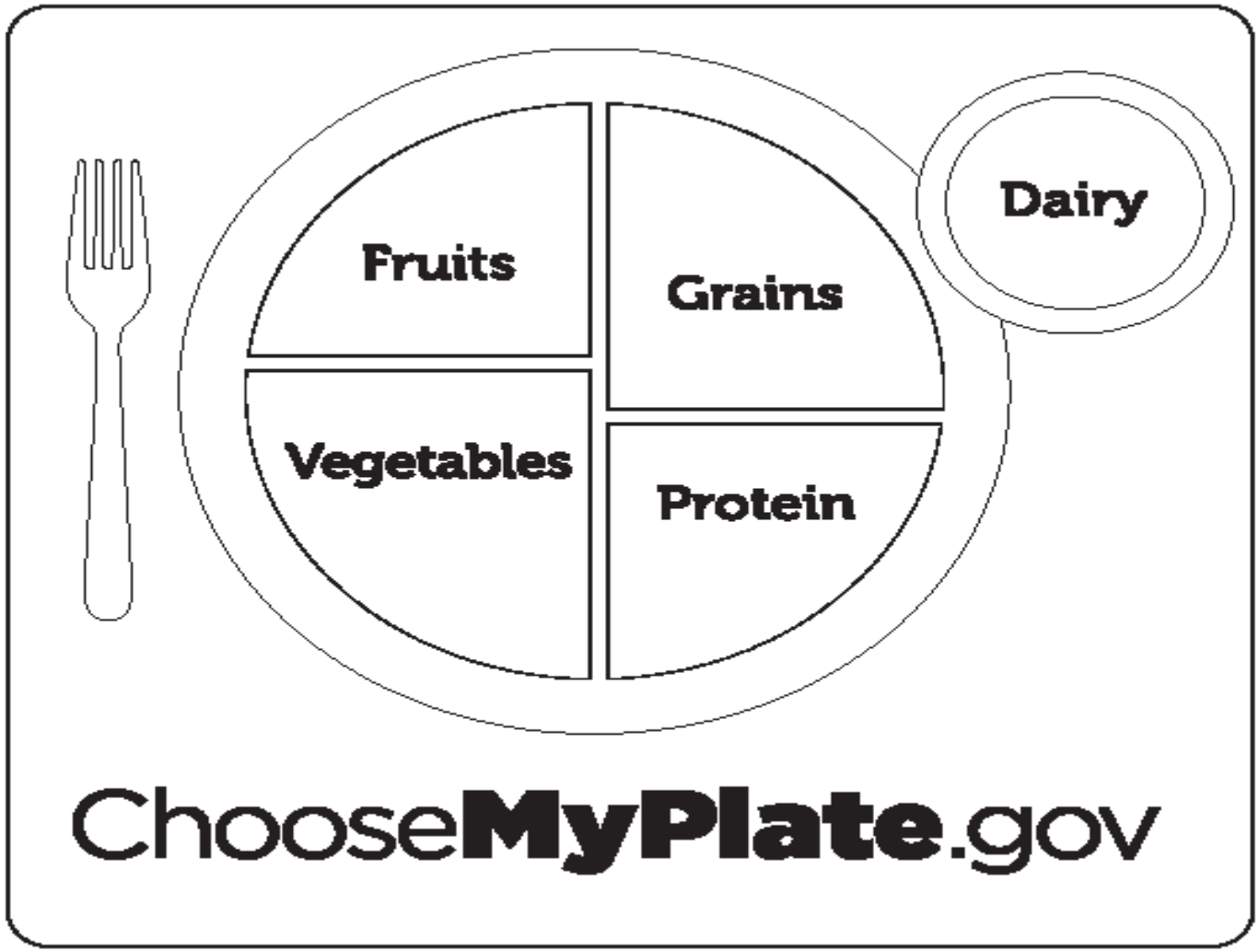
What Particular Nutrient Does or Why it is Important

Fats – diet high in fat can lead to hardening of the arteries, which can cause stroke or heart attack
Cholesterol – diet high in cholesterol can lead to hardening of the arteries, which can cause stroke or heart attack
Sodium – vital in fluid balance and function of nerves and muscles, important nutrient to observe with residents with high blood pressure
Carbohydrates – supplies energy and helps body use fats, important nutrient to observe with diabetics
Protein – needed for tissue growth and repair, important nutrient for residents who had surgery or have pressure ulcers
Calcium – keeps bones and teeth strong
Iron – helps blood carry oxygen to all parts of the body
Fiber – assists with elimination

Foods High in Fats • Meats • Butter, shortening, lard, oils • Milk • Cheese • Egg yolks • Nuts	**Foods Low in Fats** • Skim milk • Cottage cheese • Lean meat, poultry, fish (baked) • Vegetables • Fruits	**Foods High in Cholesterol (Hint: Comes from Animals)** • Eggs • Liver, whole milk, dairy products • Butter, cream • Shrimp • Duck and goose
Foods High in Salt (Sodium) • Processed foods – bacon, luncheon meats, hot dogs • Buttermilk and cheese • Condiments – mayonnaise, salad dressings, ketchup, mustard • Mexican foods • Sauces – soy, teriyaki, steak, barbecue • Soups – canned, packaged • Vegetable juices, canned vegetables, pickled vegetables • Salted snack foods – pretzels,	**Foods Low in Salt (Sodium)** • Fruits • Vegetables • Unsalted butter	**Foods High in Protein** • Meats • Fish • Poultry • Eggs • Milk and milk products • Beans and peas • Nuts • Green leafy vegetables

<table>
<tr><td>corn chips, potato chips, crackers
• Baked goods – biscuits, muffins, cake, cookies, pie</td><td></td><td></td></tr>
<tr><td colspan="2">Foods High in Carbohydrates
• Soft drinks, fruit juices
• Vegetables
• Fruits
• Cereals, breads
• Candy</td><td>Foods High in Calcium
• Egg yolks
• Milk and milk products
• Beans and dried peas
• Green leafy vegetables
• Whole grains
• Nuts</td></tr>
<tr><td colspan="2">Foods High in Iron
• Liver
• Meat
• Eggs
• Beans and dried peas
• Green leafy vegetables
• Breads and cereals
• Nuts</td><td>Foods High in Fiber
• Whole grain bread, muffins, bagels
• Bran cereals
• Cooked cereal, such as oatmeal
• Whole wheat pasta
• Whole grains, such as corn, brown rice, barley
• Fruits
• Vegetables
• Nuts, such as almonds</td></tr>
</table>

Activity #3J



USDA Center for Nutrition Policy and Promotion

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE K
Restraint Elimination, Reduction, Appropriate Use

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module K – Restraint Elimination, Reduction, Appropriate Use Definition List

Aspiration – breathing fluid, food, vomitus or an object into the lungs

Chemical Restraint – any drug that is used for discipline or convenience and not required to treat medical symptoms (F605)

Contracture – the lack of joint mobility caused by abnormal shortening of a muscle

Empathy – the ability to understand and share the feelings of another

Enabler – a device attached to the bed, similar to a short bedrail, that limits freedom of movement but is used to promote independence, comfort or safety

False imprisonment - unlawful restraint or restriction of resident's freedom of movement

Fracture – a broken bone

Pelvic Support – a physical restraint used between the thighs to keep a resident's hips from slipping forward

Physical Restraint – any manual method or physical or mechanical device, material, or equipment attached to or near the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body (F604)

Restraint – a physical or chemical way to restrict voluntary movement or behavior

Restraint Alternative – measures used instead of physical or chemical restraints

Restraint-free Care – an environment in which restraints are not kept or used for any reason

Seat Belt – a belt placed at a 45-degree angle over thighs when sitting to prevent falling from a chair or wheelchair

Soft Cloth Mitten – a physical restraint using a mitt that limits mobility of hands and use of fingers, frequently used for residents who could harm themselves by pulling at tubing, removing dressings, touching incisions or scratching a wound

Strangulation – the act of choking to death; serious or fatal obstruction of normal breathing

Vest or Jacket – a physical restraint put on the upper body to provide support in a wheelchair and limit mobility while in bed or in a chair

Wrist Restraint – a physical restraint that limits arm movement

Module K – Restraint Elimination, Reduction, Appropriate Use	
(S-1) Title Slide **(S-2) Objectives** 1. Discuss the use of different types of restraints used in health care 2. Explore risks encountered from use of restraints 3. Understand the need for restraints and laws that regulate their use 4. Discuss Resident's Rights and the NA's role 5. Discuss the importance of safe application and need for close observation	
Content	**Notes**
(S-3) Restraint-free Care and Restraint Alternatives • Restraint-free care – an environment in which restraints are not kept or used for any reason • Restraint alternative – measures used instead of physical or chemical restraints	
(S-4) Restraints – Definition and Types • Chemical, physical or mechanical methods used to restrict freedom of movement or normal access to one's body o Chemical: drugs or drug doses used to control behavior or restrict movement (F605) o Physical: any manual method, physical or mechanical device, material or equipment attached to or near an individual that cannot be removed easily and restricts freedom of movement or normal access to one's body (F604) • Cloth or leather o Soft cloth or mesh is used most often o Leather is used for extreme agitation and combativeness and is applied to wrists and ankles	
(S-5) Facility Restraint Practices • Facilities have practices that are considered forms of restraints • Side rails - used to keep resident from voluntarily getting out of bed • Tucking in or using Velcro to hold a sheet, fabric, or clothing tightly is used to restrict a resident's movement • Placing a resident in a chair (such as a Geri-chair/recliner) to prevent from rising • Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed • Placing a walker out of reach to discourage the resident independence • Be aware of ways residents may be restrained	
(S-6) Restraints – Risks • The use of restraints sometimes results in health risks/injuries to	

Module K – Restraint Elimination, Reduction, Appropriate Use	
the resident: o Cuts, bruises, skin tears, skin breakdown, pressure ulcers and fractures o Aspiration o Death from strangulation o Constipation, contractures, decreased ability to walk o Dehydration, incontinence o Infections such as pneumonia and urinary tract o Swelling (edema) in limbs, nerve damage o Mental health issues: agitation, anger, delirium, depression, reduced social contact, withdrawal o Self-esteem issues: embarrassment, humiliation, loss of dignity, confidence and self-worth	
(S-7) Restraints – Understanding the Need • Communicate, explore, observe and inquire about the resident's current and past medical history to gain understanding of the need for restraints • Consider how the following may influence the decision for use of restraints: o Pain, mental/physical illness/impairments, injury, discomfort o Uncomfortable clothing, wound dressings, body positioning o Anger/Loss of control o Fear of environment, family members, caregivers, self-image, death o Phobias, obsessions o Sleep disorders o Confusion, disorientation o Hunger, thirst, temperature changes	
(S-8) Restraints – Federal and State Laws • Federal and state laws are in place to protect residents • Accrediting agencies help oversee and enforce the laws o Code of Federal Regulations (CFR) o North Carolina Administrative Code o Centers for Medicare and Medicaid Services (CMS) o Food and Drug Administration (FDA) o The Joint Commission (TJA) o The Safe Medical Devices Act (SMDA) applies if a restraint causes illness, injury, or death • Remind students that while laws are meant to protect and can't be enforced unless concerns are accurately reported	
(S-9) Resident's Rights • The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms (CMS F604; F605) (42CFR483.10, 42CFR483.12)	

Module K – Restraint Elimination, Reduction, Appropriate Use	
• Unnecessary restraints are false imprisonment	
(S-10) Restraints – Criteria for Use • Restraints must protect the person • A doctor's order is required • Restraints are used only in the event other measures fail to protect the resident • The least restrictive method is used • Informed consent is required from the resident or designated legal representative • Residents must be monitored for vital signs, respiratory status and dehydration	
(S-11) Restraints – NA's Role (1) • Follow the Nursing Care Plan • Whenever possible, schedule care to align with the resident's past routines/likes/preferences • Consider the resident's needs based on Maslow's Hierarchy of Needs	
(S-12) Restraints – NA's Role (2) • Nutrition, elimination, breathing, sleep, exercise o Take time with meals, encourage fluids o Assist to the bathroom, encourage self-hygiene, place bedpan or urinal within reach o Allow time for bathing, back rubs and grooming o Make the bed comfortable, position pillows, provide warmth o Remove unwanted items from overbed/bedside table o Place items at arm's reach whenever possible o Reduce or eliminate noise, odors, other distractions	
(S-13) Restraints – NA's Role (3) • Safety and security o Observe, visit and <u>check on the resident every 15 minutes</u> or more often o Position bed at lowest height, lock wheels o Place floor cushions next to bed, when applicable o Remove or relocate furniture with sharp corners o Provide or eliminate lighting to promote sleep o Place call bell within reach and respond promptly o Be attentive to the resident's fears/reaction to people, places or things • Report accurately and promptly concerns seen, heard, and communicated by the resident or others	
(S-14) Restraints – NA's role (4) • Love and belonging o Spend time with the resident, encourage pleasant conversation, walk with the resident	

Module K – Restraint Elimination, Reduction, Appropriate Use	
o Provide diversion – TV, literature, books, videos, games o Encourage visits from family, friends and clergy • Self-esteem and Self-actualization o Encourage, compliment and reassure the resident	
(S-15) Restraints – Safety Guidelines • Resident safety is the highest priority • Restraints must be applied properly o Check size and condition of restraint (must be free from defect) o Ensure the restraint fastens correctly and securely o Secure straps out of the person's reach, under the seat or chair or wheelchair o Secure the restraint to movable parts of the bed frame so it does not tighten or loosen when the head or foot is raised or lowered	
(S-16) Restraints – Application (1) • Leave 1 to 2 inches of slack in the straps to allow some movement of the part, unless instructed otherwise • Pad bony areas as instructed by the nurse to prevent pressure and injury • **Observe the resident closely - every 15 minutes** or as directed by the Nursing Care Plan	
(S-17) Restraints – Application (2) • **Remove/release the restraint, reposition the resident and attend to their basic needs** (food, water, elimination, comfort, safety, hygiene and skin care) **at least every 2 hours for at least 10 minutes,** or as often as stated in the Nursing Care Plan • Monitor vital signs and perform range of motion (ROM) at intervals as instructed	
(S-18) Restraints – Observe, Report and Act • Report observations and communication accurately • Report to the nurse every time you check the resident and release the restraint • Keep scissors with you at all times, in case the resident's safety is compromised as in choking, aspiration, strangulation, seizures or other emergencies • Place the call light within the resident's reach at all times	
(S-19) Restraints – Safe Application (1) • Leg/ankle – limits mobility of leg/ankle o Should allow 1 finger between the leg and restraint • Arm – limits mobility of arm o Should allow 1 finger between the arm and restraint • Hand mitt – limits mobility of hand, prevents finger use	

Module K – Restraint Elimination, Reduction, Appropriate Use	
o Should allow 1 finger between the wrist and restraint	
(S-20) Restraints – Safe Application (2) • Wrist – limits arm movement, prevents pulling on tubes or medical devices and scratching the skin or a wound o The soft part is next to the skin o Should allow 1 finger between the wrist and restraint • Seat belt – reduces falls while sitting o Should be placed at a 45-degree angle over the thighs when sitting o Resident's hips should touch the back of the chair o Allows the resident to turn from side to side or sit up in bed	
(S-21) Restraints – Safe Application (3) • Jacket – limits mobility of upper body o Opening is in back o Should be snug but allow for movement o Should allow the resident to breathe easily o Should allow a flat hand to slide between the restraint and the resident's body	
(S-22) Restraints – Safe Application (4) • Vest – limits mobility of upper body o "V" is in front o Crisscrosses in front o Should be snug but allow for movement o Should allow the resident to breathe easily o Should allow a flat hand to slide between the restraint and the resident's body	
(S-23) Restraints – Safe Application (5) • Lap tray – helps prevent the resident from leaning forward and falling out of the chair o Should be secured properly o Resident's hips should touch the back of the chair o Observe often to prevent the resident from sliding down under the tray • Side rails – are prohibited unless they are necessary to treat a resident's medical symptoms (42CFR483.10(e), 42CFR483.12(a)(2)) • Enablers – are allowed to promote independence and in place for the resident to grasp to help turn or assist with standing	
(S-24) Facility Restraints • Facilities may unintentionally use methods to help ensure resident safety which may be viewed as restraints • It is important to recognize items that can restrict residents and	

Module K – Restraint Elimination, Reduction, Appropriate Use	
prevent them from being mobile • Communicate concerns to the nurse in a professional manner • Consider the use of: o Over-bed table – placed across a resident sitting in a chair or wheelchair o Sheets - placed around and under a resident o Geri-chair o Wheelchair locked – when the resident is unable to unlock it	
(S-25) Remember • Restraints are NEVER used as a convenience for the nursing staff or as an act of discipline/punishment • Unnecessary restraint (physical, mechanical, chemical) is considered false imprisonment (unlawful restraint or restriction of resident's freedom of movement) • Restraints are used as a last resort intended to protect the welfare and safety of the resident and others • Restraints take away a resident's right to freedom and violates his/her right to be treated with respect and dignity • Restraints require a doctor's order • Always ask for clarification before applying a restraint • Practice patience, show kindness and be empathetic to residents who are restrained	

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE L
Communicating with the Health Care Team

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
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Module L – Communicating with the Health Care Team
Definition List

Communicating with the Health Care Team – the exchange of information, either verbally or in written form, between and among members of the health care team

HIPAA (Health Insurance Portability and Accountability Act) – law that protects the privacy and security of a person's health information

Medical Record – a legal document that organizes all the information about care of a single resident in one document and allows each discipline involved in the care to know what all disciplines are doing

Objective Data – observations using the senses

Recording – the written/electronic documentation of care and observations by the health care team

Reporting – the oral account of care done and observations noted; informing other members of the health care team

Subjective Data – information collected through communication; what is said

Module L – Communicating with the Health Care Team	
(S-1) Title Slide **(S-2) Objectives** 1. Describe components of communication with the health care team. 2. Discuss the importance of reporting and recording accurately. 3. Define Health Insurance Portability and Accountability Act (HIPAA) and its impact on communication. 4. Explain conventional and military time and how to convert times. 5. Explore the NA's role in reporting and recording objective and subjective data.	
Content	**Notes**
(S-3) Communicating with the Health Care Team • The exchange of information, either verbal or written, between and among members of the health care team	
(S-4) Reporting • Is the verbal account of care provided and observations noted by the health care team • Is initiated immediately when there is a change in the resident's condition • Is communicated regardless of time, circumstances or schedules and prior to the end-of-shift	
(S-5) Recording • Is the written/electronic documentation of care and observations by the health care team • Medical Record o Legal document o Collection of documentation regarding a resident's condition and response to treatment and care o Is used to keep all team members updated about the resident's care	
(S-6) HIPAA • Health Insurance Portability and Accountability Act • Law that protects the privacy and security of a person's health information o Maintains that electronic transmission of documentation, photos, videos or other identifiable means is securely protected o Protects the person's identity; his/her past, present or future health conditions/concerns; phone number; social security number; and other identifiable information • Only people involved with direct resident care or processing records are allowed access to information	
(S-7) Importance of Communication • Observations and communication from the nurse aide are of vital importance to the health care team	

Module L – Communicating with the Health Care Team	
• Allows health members to make sound decisions about care and treatment plans • Accurate documentation from nurse aide becomes part of legal records • Must be reported and recorded accurately and in detail	
(S-8) Recording – NA's Role (1) • Information must be recorded in a responsible manner • Must be based on facts, not opinions, as per facility policy • Documents often used: o Check sheets o Flow sheet o Graphs o Incident reports o Facility specific forms	
(S-9) Recording – NA's Role (2) • Observe the resident, using senses o Sight (facial expressions, rashes, skin color, bruising, ambulation, body language) o Hearing (breathing, speaking, moaning) o Smell (odor of breath, urine, body) o Touch (lumps, skin temperature, change in pulse)	
(S-10) Recording – NA's Role (3) • Document observations regarding: o Personal care – oral, bathing, perineal, catheter, skin, turning/positioning o Treatments – hot/cold applications, soaks or wound care (as per facility policy) o Measurements – vital signs, intake/output, elimination o Activities – eating, sitting, ambulating, talking, sleeping, socializing, participation in activities or events o Mental/emotional status – subtle or drastic changes	
(S-11) Recording – NA's Role (4) • Document per facility procedures • Ask for assistance to understand various forms • Clarify what and where the NA is allowed to document information • Use a pen, with blue or black ink, or per facility policy • Do <u>not</u> use a pencil or ink that can be erased • Carry a small notebook/worksheet to make notations • Do not record protected information, in case the notebook or worksheet is misplaced/lost • Keep written information with you at all times	

Module L – Communicating with the Health Care Team	
• Write clearly – remember this is a legal document • Do not draw multiple lines through a writing error or use white out • Sign full name and title (NA), or per facility policy • Keep medical records in secure location ALWAYS, per facility policy • Always maintain confidentiality	
(S-12) Time • Include the date and exact time, each time information is recorded • Health care facilities choose to use conventional (also called civilian or standard) time or choose to use military time (also called the 24-hour clock)	
(S-13) Conventional Time • **Uses numbers 1 through 12** to show each of the 24-hours of the day • **Has either 3 or 4 digits -** the first one or two digits are hours and the remaining two are minutes • A colon (:) separates the hours from the minutes • a.m. is used to specify morning – beginning at 12:00 a.m. • p.m. is used to specify afternoon/evening – beginning at 12:00 p.m. (noon)	
(S-14) Military Time • **Has 4 digits** – the first two numbers are hours and the remaining two are minutes o a.m. and p.m. are not used • Examples: o 0100 hours is 1:00 a.m. (in the morning) o 0800 hours is 8:00 a.m. (in the morning) o 1200 hours is 12:00 p.m. (noon) o 1500 hours is 3:00 p.m. (in the afternoon) o 2100 hours is 9:00 p.m. (in the evening) o 2400 hours is (midnight) • **Midnight may be documented as 2400 hours or 0000 hours**	
(S-15) Convert Conventional to Military Time (1) • To convert conventional time **containing 3 digits** to military time**, add a 0 in front of the hour number** and remove the colon and a.m. o 5:30 a.m. is 0530 hours (0 was added in front) o 9:59 a.m. is 0959 hours (0 was added in front) • To convert conventional time **containing 4 digits** to military time, **do not add a 0** and remove the colon and a.m.	

Module L – Communicating with the Health Care Team	
o 10:00 a.m. is 1000 hours (0 was not added) o 11:30 a.m. is 1130 hours (0 was not added)	
(S-16) Convert Conventional to Military Time (2) • To convert conventional time to military time for the p.m., beginning at 1:00 p.m. (in the afternoon), **add 12 to the "hour" 1** and <u>remove the colon and p.m.</u> • Examples: o 1:00 p.m. is 1300 hours (1+12=13 hours, 00 minutes) o 4:00 p.m. is 1600 hours (4+12=16 hours, 00 minutes) o 8:00 p.m. is 2000 hours (8+12=20 hours, 00 minutes) o 12:00 a.m. (midnight) is 2400 hours or 0000 hours • **12 is only added to the "hour(s)" and not the minutes** o 1:45 p.m. is 1345 hours (1+12=13 hours, 45 minutes) o 6:30 p.m. is 1830 hours (6+12=18 hours, 30 minutes) o 9:45 p.m. is 2145 hours (9+12=21 hours, 45 minutes) o 11:20 p.m. is 2320 hours (11+12=23 hours, 20 minutes)	
(S-17) Convert Military to Conventional Time • To convert military to conventional time, **reverse the processes** • For a.m. simply **remove the 0** in front of the hours, add the colon and a.m. • For p.m. simply **subtract 12** from the hours, add the colon and p.m.	
(S-18) Electronic Recording – NA's Role • Document as per facility policy • Use the mouse and drop-down boxes or touch-screen • Sign electronically as per facility policy • Always maintain confidentiality	
(S-19) Reporting – NA's Role (1) • Report as per facility policy • Report accurately in a respectable manner • State facts, not opinions • Emphasize that facilities may choose to not allow students to document directly on a form or in a medical document • Explain that nurse aide students may be allowed to report observations and activities to facility employees • Remind students that they are guests in a facility and area required to adhere to facility policies	
(S-20) Reporting – NA's Role (2) • Use reminder notes from notebook or worksheet to report observations and activities • Report immediately and accurately to the designated	

Module L – Communicating with the Health Care Team	
employee • Reports facts, not opinions • Understand difference between objective and subjective data o Objective data – observations using the senses o Subjective data – information you are told that you cannot observe through your senses • Report changes as they occur • Report before end-of-shift so information can be passed to the next shift	
(S-21) What to Report – NA's Role • Care or treatment given, the time, and resident's response • Observations – what is normal and what appears to be abnormal; noticeable changes • Conversations with resident during treatment/activities that cause concern or appear to be out of the ordinary • Unusual actions/behaviors that deviate from the normal or from previous actions	
(S-22) What to Report - NA's Role • Observations must be reported to nurse IMMEDIATELY • Resident complains of sudden or severe pain • Change in resident's ability to respond – a responsive resident no longer responds, or a non-responsive resident who now responds • Change in resident's mobility – inability to move a body part, or improved ability to move a body part • Change in vision; pain or difficulty breathing; difficulty swallowing • Change in facial responses/appearance, drooping eyelid, crooked smile, drooling • Complaints of numbness in lips, arms, other areas • Vomiting • Bleeding • Bloody stools, change in bowels or urine • Unusual odors • Vital signs that are outside the resident's normal range or differ from normal ranges that were taught • Change in skin color, sore or reddened area	
(S-23) Remember (1) • HIPAA is a law that protects the resident's privacy; it is a legal document • Maintain confidentiality at all times • Report observations immediately and accurately	

Module L – Communicating with the Health Care Team	
• Report and record facts, not opinions • Relay information in specific terms not vague general terms	
(S-24) Remember (2) • Document according to established facility policy using the established conventional or military time • Ensure information remains confidential • Do not use electronic devices/computers/kiosks for anything other than the intended purpose • Do no share passwords or other information • Understand the difference between objective and subjective data and use it appropriately • When in doubt, always ask for clarification	

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NURSE AIDE I TRAINING PROGRAM

MODULE M
Nursing Process and Nursing Care Plan

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section

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Module M – The Nursing Process and Nursing Care Plan
Definition List

Activities of daily living (**ADLs**); refers to the basic self-care tasks an individual does on a day-to-day basis

Assessment – first step of nursing process; collecting information about a resident

Evaluation – fifth step of nursing process; deciding if nursing measures worked or were effective, and whether goal was met

Implementation – fourth step of nursing process; nursing measures carried out during resident care

Kardex – a type of card file that includes information important to the care of residents and includes drugs, treatments, diagnoses, routine care measures, and special needs

Kiosk – a machine that is generally interactive and provides a computer with a keyboard or touchscreen; used to collect, send, record and store information

Maslow's Hierarchy of Needs – a theory, developed by Abraham Maslow, researcher of human behavior, that explains the necessity of meeting an individual's physical needs before meeting psychosocial needs

Nursing Care Plan (or the care plan) – individualized, written plan of care for residents based on nursing process written by the nurse and used for coordination and continuity of care

Nursing Diagnosis – second step of nursing process; a health problem that nurses can treat using nursing measures

Nursing Process – method used by nurses to plan and deliver nursing care to the resident

Physiological - relating to the way in which a living organism or bodily part functions; physical

Planning – third step of nursing process; setting of resident goals that are prioritized

Self-Actualization - the realization or fulfillment of one's talents and potentialities, especially considered as a drive or need present in everyone

Self-esteem - confidence in one's own worth or abilities; self-respect

Therapeutic - having a beneficial effect on the body or mind

Module M – The Nursing Process and Nursing Care Plan	
(S-1) Title Slide **(S-2) Objectives** 1. Define and discuss the Nursing Process 2. Explain the importance of the nursing process and the role of the NA 3. Define and discuss Maslow's Hierarchy of Needs 4. Define the Nursing Care Plan and discuss its importance 5. Discuss the NA's role in the nursing care plan	
Content	**Notes**
(S-3) The Nursing Process • Method used by nurses to plan and deliver nursing care to the resident • Five steps are o Assessment – collecting information about a resident o Nursing diagnosis – describes a health problem that can be treated using nursing measures o Planning – setting priorities and goals for a resident o Implementation – performing or carrying out nursing measures that impact resident care o Evaluation – measuring to determine if priorities and goals were met that impacted resident care o Evaluation is time when nurses look at nursing care plans and see if plan worked in solving health issues and if interventions were effective • Based on the individual needs of the resident • Used to support directives given from the doctor and other members of the healthcare team	
(S-4) The Importance of the Nursing Process • Care is organized, individualized and has purpose • Care is consistent • Resident feels safe and secure • Assists healthcare team members to deliver care	
(S-5) The Nursing Process – NA's Role • Assist the nurse in collecting information through interactions with the resident. o Obtain heights and weights, vital signs, record intake and output • Encourage the resident to participate in meeting established goals • Provide care determined to positively impact the well-being of the resident o Turn, reposition, toilet, assist with activities of daily living (ADLs) • Report observations to help the healthcare team	

Module M – The Nursing Process and Nursing Care Plan	
determine if priorities and goals are met o Document accurately to assist the nurse with evaluating interventions o Nurse relies on observations by nurse aides to assist with evaluation o Most important part during intervention stage is to accurately report reactions to interventions o If intervention does not work, nurse modifies nursing care plan	
(S-6) Maslow's Hierarchy of Needs (1) • Maslow's Hierarchy of Needs is used to assist nurses prioritize and develop a plan of care on patient-centered outcomes • Physiological Needs: nutrition (water and food), elimination (toileting), breathing/circulation (vital signs), sleep, sex, shelter, and exercise • Safety and Security: injury prevention (call lights, hand hygiene, fall precautions, assistive devices, close observation); build trust (communication, reassurance, empathy); ensure clean, safe environment (free from harm, recognition and alleviation of fears) and resident and family education • Love and Belonging: supportive relationships free from social isolation, therapeutic communication skills, meaningful relationships • Self-Esteem: acceptance into a community or facility, personal achievement, sense of control or empowerment, accepting one's physical appearance and mental capabilities • Self-Actualization: empowering environment, spiritual growth, ability to recognize other's point of view, reaching one's maximum potential	
(S-7) Maslow's Hierarchy of Needs (2) • The order of importance begins at the lowest level on the hierarchy • Lower-level needs must be met before higher-level needs are met • The NA is a vital link in assisting the resident to achieve individual levels of need	
(S-8) Maslow's Hierarchy of Needs (3) • Physical needs include nutrition, elimination, breathing, sleep, sex, shelter and exercise; the absence of physical needs prevents an individual from moving to the next level	

Module M – The Nursing Process and Nursing Care Plan	
• Safety and security includes an environment free from harm, danger and fear • Injuries, neglect and abuse impact this level	
(S-9) Maslow's Hierarchy of Needs (4) • Love and belonging includes supportive relationships, therapeutic communication and meaningful relationships with others • Self-esteem is established when an individual thinks well of oneself, views their life as meaningful or useful and having value • Illness, injury and loss of home and family negatively impact self-esteem	
(S-10) Maslow's Hierarchy of Needs (5) • Self-actualization is achieved when an individual experiences his/her potential • Individuals may have difficulty achieving this level	
(S-11) The Nursing Care Plan • Responsibility of the nurse to provide a written plan of care o Is sometimes simply called the Care Plan o Outlines the individual priorities and goals established for the care of each resident • Based on the nursing process • Used for coordination and continuity of care • May be standardized, computerized or written in Kardex o A standardized form may be completed by the resident or a family member. The form may ask for contact information, medical conditions, preferred healthcare providers, hospitals or pharmacies, general or special medical needs, disabilities and advanced care planning directives. o A kiosk may be used to electronically submit a Care Plan. Medical updates, reports and resident activities of daily living (ADL) may also be entered by all members of the healthcare team, as per established facility policies. o Kardex is a type of card file that summarizes information found in the resident's medical record to include medications, treatments, diagnoses, equipment and special needs and routine care measures.	
(S-12) The Nursing Care Plan – NA's Role • Assist the nurse with collection of data o Through observation and working with the resident	

Module M – The Nursing Process and Nursing Care Plan	
• Report how the resident responds or reacts to interventions o If an intervention does not work, nurse modifies nursing care plan • Accurately report reactions to interventions • Nurse relies on nurse aides to assist with evaluation	
(S-13) The Nursing Process & Nursing Care Plan • Care of the resident is a process that constantly changes. It requires teamwork, effective communication, accurate observations and detailed reporting. • The resident's health and wellbeing are dependent upon the entire team	

Activity #1M Maslow's Hierarchy of Needs

Students are paired and given 15 small paper/plastic cups, markers/crayons/colored pencils and access to the following table that contains 25 words/expressions that represent Maslow's Hierarchy of Needs pyramid.

Based on the student's understanding of Maslow's Hierarchy of Needs, they should select and write a word/expression on each cup and asked to build a pyramid, beginning with 5 cups for the base (Basic Physiological Needs), 4 on the next level, 3 on the next, 2 on the next and 1 on top.

Food	Safe environment	Sleep	Breathing/Circulation	Education
Security	Water	Employment	Family	Health
Friendship	Intimacy	Self-esteem	Personal Achievement	Respect for others
Self-confidence	Creativity	Spontaneity	Morality	Elimination (toileting)
Exercise	Spirituality	Trust	Meaningful Relationships	Therapeutic Communication
Supportive relationships	Self-acceptance	Love	Reassurance	Empathy

Upon completion, allow students time to compare their pyramid with others.

As a group, discuss (1) why they chose particular words/expressions and (2) how they determined which level they belong on. It may become evident that students view levels of need, based on personal values and what they require to meet self-actualization.

Ask students to review Maslow's Hierarchy of Needs and compare with their own.

https://www.tutor2u.net/psychology/blog/maslows-hierarchy-of-needs-with-paper-cups

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MODULE N
Incident Report

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section

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Module N – Incident Report
Definition List

Gait - a manner of walking or moving on foot

Incident – any event that has harmed or could harm a resident, visitor, or staff member

Incident Report – documentation of facts surrounding any unexpected event in healthcare setting; also called an *occurrence, accident or event report.*

Punitive - inflicting, involving, or aiming at punishment

Module N - Incident Report	
(S-1) Title Slide **(S-2) Objectives** 1. Define and describe the significance of an incident report 2. Discuss the importance of accurate, detailed reporting and documentation 3. Determine which incidents require a report and who is involved in reporting 4. Provide guidelines for reporting and recording	
Content	**Notes**
(S-3) Incident Report (1) • Method of documenting facts surrounding an unexpected event in healthcare setting • Based on factual, objective account of what occurred o Explain how to documents facts through observation	
(S-4) Incident Report (2) • Are confidential and intended for use between the facility and facility legal team o Explain how documentation may be used if legal action is pursued by the resident, family or facility	
(S-5) Incident Report – Required when (1) • A resident falls, verbalizes or shows fear or signs of harm, develops unusual signs of pain, has a visible misalignment of an extremity or develops a noticeable change in gait o Resident may not put weight on a leg because a fracture has occurred during an unwitnessed event • A resident is reported missing from the facility	
(S-6) Incident Report – Required when (2) • A mistake is made while providing resident care • An item or personal belonging breaks, becomes damaged or is missing	
(S-7) Incident Report – Required when (3) • A request is made that is outside the NA's scope of practice • The NA is made to feel uncomfortable, threatened or unsafe	
(S-8) Incident Report – Required when (4) • Inappropriate actions, sexual advances or remarks are made • An angry outburst occurs by family members or staff	
(S-9) Incident Report – Importance • Required by the facility based upon State and Federal guidelines • Completed by individuals involved at the scene, those on duty at the time, and those who observed incident	

Module N - Incident Report	
• Detailed accurate account of who was involved, what, when and where the incident occurred, what immediate actions and additional steps were taken to prevent recurrence	
(S-10) Incident Report – Guidelines • Describe in detail what was seen or heard • Document the time the incident occurred • Describe the person's reaction to the incident • State the facts; do not include opinions • Describe the action taken to give care • Describe the outcomes noted from actions taken	
(S-11) Incident Report – Points to Remember • Complete the report as soon as possible • Reporting and recording events of the incident is a protective rather than punitive measure • Documentation is reviewed by management and members of the healthcare team o Becomes part of the resident's records o Is used to track how/if the resident becomes negatively impacted from the incident • New policies and procedures may be established to prevent future incidents	
(S-12) Incident Report – Can Help Save a Life	

Handout #1N for Activity #1N

RESIDENT INCIDENT REPORT

Resident: _____ MR# _____ Date_____ Time_____am__pm__

Witness/1st Responder/Other:_____Title: _____
Was resident performing independent activity as usual? Y__ N____Staff assist__
Was equipment involved? Y__ N__Specify_____
Was equipment in proper working condition? Y__ N____NA__Explain: _____
Resident stated, "_____"

Discovery/Assessment:
Alarm activation__Passing door__Routine care entry__Alerted by another person__Heard noise__
Alerted by resident: Called out__Call bell used__NA__
Location when alerted: Room__BR__Hall__DR__Lounge__Other_____
Location PRIOR to incident: Ambulating____In bed__in WC__ In chair____On toilet__ Other_____
Location AFTER incident: Sitting__ Lying____Back__ Abdomen__ Right side__Left side__

Extremities: Legs: Extended__ Abducted__ Adducted__ / Arms: Extended__ Abducted__ Adducted__
ROM change: Y__ N__/ Weight bearing as usual: Y__N__Right__Left__

Assessment:
Change in Consciousness: Y__ N__/ Change in speech: Y__ N__/ PERRLA: Y__ N___
Head trauma: Y__ N__Undetermined__Obvious__ Location_____
Pain verbalized: Y__ N__Undetermined__Obvious__ Location_____Scale 1-10_____

Resident states, "_____"

Pulse:_____/ BP:_____/ Respirations: _____

Skin trauma: Y__ N__Undetermined__Location_____
Skin tear: Y__ N__Abrasion: Y__ N__/ Size__ cms / Location_____
Color: Red__Bruising__ Discoloration__Bleeding__ Amount: Slight__Moderate__Large__
Breaks: Y__ N__None visible__
Did resident use call light for assistance: Y__ N__NA__
WC: wheels locked: Y__ N__NA__
Bed: Locked: Y__N__NA__/ Position: Low: Y__ No_ NA__/ Side rails up__down__NA__
Alarm in use: Y__N__Type_____ / Restraint in use: Y__ N__Type_____

Precipitating factors: Lighting: Y__ N__NA__/ Footwear: Y__N__NA__
Other factors: Explain: _____

Treatment:
Wound cleaned / bandaged: Y__ N__NA__ / Ice: Y__ N__NA__Other: _____

MD called: Y__ N__Time_____ am__pm__

Ambulance called: Y__ N__Time_____ am__pm__

Responsible party called: Y__ N__Time_____ am_pm____/ Name: _____

Transferred to hospital: Y__N__Time_____ am__pm__/ Private vehicle: Y__ N____

Witness/responder signature:_____Title:_____

Comments:_____

Review by DON: Date_____Time_____am__pm__

Review by Administrator: Date_____Time_____am__pm_____

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MODULE O
Critical Thinking

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Version 1. Full Text

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Module O – Critical Thinking
Definition List

Critical Thinking - exercising or involving careful judgment based on facts and observations

Module O – Critical Thinking	
(S-1) Title Slide **(S-2) Objectives** 1. Define and describe the importance of the nurse aide using critical thinking skills while performing resident care 2. Discuss the importance of critical thinking 3. List and discuss questions that nurse aides should ask in order to think critically	
Content	**Notes**
(S-3) Critical Thinking • Exercising or involving careful judgment based on facts and observations • Required to provide safe, competent care to residents in a variety of situations • Developed through real-life experiences, education, communication, observation and practical application • Incorporated into thought processes and daily activities	
(S-4) Critical Thinking – Importance • Allows the nurse aide to put theory into practice when caring for the resident • Allows the nurse aide to administer care in a safe confident manner • Requires the use of sound judgment in a variety of situations • Helps the nurse aide identify situations that deviate from the norm o Not all nurse aide activities can be specifically directed o Not all situations can be described in a textbook o Scenarios should focus on problem solving	
(S-5) Critical Thinking – Questions to Ask As critical thinkers, the nurse aide should ask questions: • What problem do I need to solve? o Who should be involved in the process? • What information do I need? o How do I determine it is accurate? • How do I solve the problem? o What are the advantages and disadvantages? • What am I missing?	
(S-6) Critical Thinking – Quote • "Critical thinking is important because it is what makes us adaptable, enables us to act independently, and allows us to move beyond what we already know or guess."	

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MODULE P
Family and Family Support

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Module P – Family and Family Support
Definition List

Family – a group of individuals related by blood, marriage, or a feeling of closeness

Family Support – offers of encouragement, assurance, and sense of connection for the resident offered by blood relatives or group of individuals close to the resident

Module P – Family and Family Support	
(S-1) Title Slide **(S-2) Objectives** 1. Describe the importance of family and family support to the resident 2. List measures that the nurse aide can do to support family members of residents	
Content	**Notes**
(S-3) Family • A group of people related by blood, marriage, or a feeling of closeness	
(S-4) Family Support • Encouragement, assurance, and a sense of connection for the resident offered by blood relatives or groups of individuals close to the resident	
(S-5) Family and Family Support – Importance • Gives resident sense of connection • Helps resident make difficult decisions • Gives assurance that specific wishes will be honored • Offers personal support and encouragement	
(S-6) Family and Family Support – Importance • Helps meet safety and security, love and belonging needs • Decreases loneliness • Provides comfort, support, relief from loneliness, contact with familiar people and things, mental stimulation, and reasons to live	
(S-7) Family and Family Support – Nurse Aide's Role • Orient family to the facility and how it works • Learn family names and address by name • Get to know family – their likes and dislikes • Get familiar with family routines • Keep in mind, each culture and family tradition is unique and may be different from nurse aide's	
(S-8) Family and Family Support – Nurse Aide's Role • Work to build positive and trusting relationship with family • Let family know role is supported • Keep lines of communication open • Always be respectful and kind to family • Encourage expressions of emotions	
(S-9) Family and Family Support – Nurse Aide's Role • Reassure family members as they cope with resident's actions, problems and concerns • Provide explanations when asked and refer to supervisor to assist the family when necessary • Refer family concerns to supervisor	

Module P – Family and Family Support	
• Incorporate and honor family wishes, if possible • Allow time for privacy during visits • Permit family members to assist with care if resident does not object	
(S-10) Family and Family Support – Nurse Aide's Role • Encourage family to assist with feeding/dining if safe and resident agrees • Encourage family to bring special foods or beverages for resident, if allowed	
(S-11) Family and Family Support – Nurse Aide's Role • Use tact in dealing with family complaints and requests that you cannot honor • Avoid involvement in family affairs • Be tactful when asking family member to leave resident's room	
(S-12) Family and Family Support – Nurse Aide's Role • After family visit ends, observe effects visit had on the resident • Report negative visit effects to supervisor	
(S-13) Family and Family Support – Points to Remember • Residents with no living relatives may have friends or neighbors who act as family members	
(S-14) Family and Family Support – Points to Remember • Resident's family may not look like nurse aide's definition of family	

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MODULE Q
Person-centered Care

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Module Q – Person-centered Care
Definition List

Person-centered Care – is the practice of basing resident care on individual resident needs, preferences, and expectations

Module Q – Person-centered Care	
(S-1) Title Slide **(S-2) Objectives** 1. Define person-centered care. 2. Describe the characteristics of a facility incorporating person-centered care.	
Content	**Notes**
(S-3) Person-centered Care • The practice of basing resident care on individual resident needs, preferences, and expectations	
(S-4) Goals of Person-centered Care (1) • To see the person as a unique individual (special, one of a kind, with an individual history and background) • To respect skills and abilities (things he or she is able to do, stories he or she tells you) • To support the person to be successful and maintain independence (need for some amount of control and decision making) • To help the person meet needs for attachment, inclusion, occupation, and comfort (to feel like he or she belongs, has a purpose, are in a relationship with others)	
(S-5) Goals of Person-centered Care (2) • To support the person as a member of a community (the community may be the nursing home or the larger community – church group, rotary club) • To honor the importance of keeping the person at the center of the care planning and decision-making process.	
(S-6) Person-centered Care and Relationships • There is no doubt that tasks are important in health care • Medications need to be passed, therapies conducted, meals prepared and served, activities of daily living assisted, etc. • What matters most are relationships • If a nursing home wants to be a welcoming home, it must begin by focusing on relationships • Relationships between the resident and the staff, among staff members, and between families and the staff are key to producing the best quality of life for residents • Always focus on the relationship even if you are completing a task	
(S-7) Importance of Person-centered Care • Person-centered is the practice of basing resident care on individual resident needs, preferences and expectations	

Module Q – Person-centered Care	
• Where a person lives, whether at home or in a nursing home, assisted living facility or a hotel, is the person's home • Each place should be made more like a home through person-centered care giving and personal choice including encouraging personal choice in daily activities such as waking, bathing, dining and sleeping. • Caregiver behaviors that encourage person-centered care include talking directly with a person to get the most accurate information about preferences and honoring individual preferences as much as possible in things the person does each day.	
(S-8) Resident Benefits from Person-centered Care Resident choice fosters engagement and improves quality of life • Residents o have autonomy and are able to direct care and services o live in an environment of trust and respect o are in a close relationship with staff that are attuned to their changes and can respond appropriately o continue to live in a way that is meaningful to them	
(S-9) Nurse Aide Role in Person-Centered Care (1) • Federal regulations for nursing homes address and support person-centered care and quality of life • There are many ways caregivers can put person-centered care into practice in a nursing home or other setting.	
(S-10) Nurse Aide Role in Person-Centered Care (2) • Examples of how to put person-centered care into practice o Support residents to be as independent as they are able and wish to be – example, being able to and wanting to take care of one's personal belongings o Support residents' wishes to be self-directed and have their preferences honored – example, being able to choose the type and timing of one's bath o Support the relationships that resident finds meaningful – example, being able to visit with friends and family when they wish to o Support resident's sense of continuity and identity – example, being able to practice one's faith o Pay attention to resident's physical well-being and sense of safety and order – example, alerting	

Module Q – Person-centered Care	
residents to changes in their regular routine with as much notice as possible	
(S-11) Person-centered Care – Care is About Relationships • It is through relationships that we come to understand ourselves, our co-workers, and our residents better • With strong relationships, we are better able to understand others' perspectives, preferences, and needs and are therefore better able to care for them	
(S-12) Revisiting Person-Centered Care Goals The goals of person-centered care • To see the person as a unique individual • To respect skills and abilities • To support the person to be successful and maintain independence • To help the person meet needs for attachment, inclusion, occupation, and comfort • To support the person as a member of a community • To honor the importance of keeping the person at the center of the care planning and decision-making process.	

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MODULE R
Cognitive Changes Due to Aging

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Module R – Cognitive Changes Due to Aging
Definition List

Cognition – the manner in which messages from the five senses are changed, stored in memory, recovered from memory, and later used to answer questions, respond to requests, and perform tasks

Learning – the gaining of information, skills, and knowledge measured by an improvement in some obvious response

Memory – involves the storing of information in the brain for later use and the ability to recall the information when needed

Pacing – the awareness and adjustment of nursing care based on how slow or how fast a person is functioning

Patience – the ability to deal with slowness, delay, or boredom without complaining or appearing rushed

Reaction Time – the time it takes for a person to begin an answer or a movement after someone asks him/her a question or makes a request

Module R – Cognitive Changes due to Aging	
(S-1) Title Slide **(S-2) Objectives** 1. Identify cognitive changes that occur due to aging 2. Describe the importance of pacing and patience while delivering care to the older adult	
Content	**Notes**
(S-3) Cognition • The manner in which messages from the five senses are changed, stored in memory, recovered from memory, and later used to answer questions, respond to requests, and perform tasks	
(S-4) The Healthy Aging Brain • Healthy older adults do not have notable decreases in cognitive ability and are able to learn new information o Cognitive function is related to use for healthy older adults o Important for an older person to use his/her brain or lose it o Ability to think or problem-solve remains sharp, especially for usual situations and familiar experiences o Generally remains as intelligent and creative as ever	
(S-5) Learning and Memory • Learning o The gaining of information, skills, and knowledge measured by an improvement in some obvious response o The ability to learn remains throughout life o Older adults learn things easier and better when they can set their own pace o Depends on the person's memory • Memory – involves the storing of information in the brain for later use and the ability to recall the information when needed	
(S-6) Cognitive Changes due to Aging (1) • Size of neurons (brain cells) progressively decrease • Total brain mass decreases	
(S-7) Cognitive Changes due to Aging (2) • Physiological/psychological responses slow down • Increased learning time needed for new activities • More difficulty in learning motor skills • Decrease processing, response time and reaction time, making fast-paced instruction more challenging	
(S-8) Cognitive Changes due to Aging (3)	

Module R – Cognitive Changes due to Aging	
• More deliberate, less frequent responses and less effective performance when pace is fast – particularly in stressful/unfamiliar surroundings • Slow with tasks when response speed is needed • Cannot adapt as well, especially in stressful/unfamiliar environments and with impaired senses • Easily confused when too many changes or losses happen at one time or when moved to a different environment	
(S-9) Cognitive Changes due to Aging (4) • Mild short-term memory loss often occurs (forgetting names, misplacing items, poor recall of recent conversations) • Motivation to learn decreases • Feels threatened more when declining cognitive abilities may be publicly demonstrated • Difficulties in doing more than one task or dealing with more than one request at a time occur • Unable to ignore irrelevant stimuli	
(S-10) Cognitive Changes due to Aging (5) • Reaction time – the time it takes for a person to begin an answer or a movement after someone asks him/her a question or makes a request o Changes in reaction time vary from person to person o Reaction time slows gradually after age 60 (it takes longer for resident to begin with an answer or to start a movement), especially when the older adult has to make a choice or change movement from one direction to another o Impaired by aging process, sensory deficits, or chronic disease	
(S-11) Understanding Reaction Time • Important that nurse aides who work with residents be aware of changes in reaction time and pace themselves accordingly • Important that nurse aides develop understanding of ways to help resident make up for slowed reaction time	
(S-12) Workload of the Nurse Aide • Let's switch gears and talk about the workload of the nurse aide o Tend to have a lot to do in a short period of time o When working with residents, nurse aides may accidentally quicken pace and expectations as they get pressed for time	

Module R – Cognitive Changes due to Aging	
(S-13) Effects of a Fast Pace on an Older Resident • Can negatively affect older resident's ability to learn something new, perform a task, or maintain motivation to complete an activity • Older residents tend to be more cautious and less willing to respond quickly in situations where they think they might fail • Some may choose not to even do task because of fear of failure	
(S-14) Social Breakdown Syndrome (1) • May occur if resident is rushed too much and not allowed enough time to begin to do tasks, respond to requests, or answer questions • Will likely keep quiet and not ask for slower pace and tends to blame self for not being able to keep up and then become frustrated • Gradually begins to feel incompetent and has decrease in self-esteem	
(S-15) Social Breakdown Syndrome (2) • May give up doing things leading to dependence and helplessness • Often labeled as slow and unable to keep up in society • Living in an advanced, high technological society, where everything and everyone is functioning at a high rate of speed, leads to lower self-esteem among older adult population • Society becomes impatient with those who cannot keep up	
(S-16) Pacing and Patience (1) • Pacing – the awareness and adjustment of nursing care based on how slow or how fast a person is functioning • Patience – the ability to put-up with slowness, delay, or boredom without complaining or appearing rushed • Pacing and patience can be used to offset effects of a resident's slowed reaction time	
(S-17) Pacing and Patience (2) • When allowed to take their time and set own pace, residents o Are better able to perform tasks or learn new things o Have time to use their physical and physiological assets to respond to the best of their abilities o Feel better about themselves, feel competent, and feel more in control	
(S-18) Pacing and Patience – Role of the nurse aide	

Module R – Cognitive Changes due to Aging	
• Slow down pace when working with residents • Let the resident set the pace • Ensure that the resident is wearing hearing aid and/or glasses before beginning a task, if applicable • Tell the resident ahead of time about the task	
(S-19) Pacing and Patience – Role of the nurse aide • Allow time for resident to focus attention on the task or question • Allow time for resident to think about what has been said • Give clear, short, easy instructions that are based on what the resident already knows • Relate new information or tasks with past experiences	
(S-20) Pacing and Patience – Role of the nurse aide • Use simple words that resident understands • Show the resident what is to be done • If something has just been learned, allow resident to look at equipment (if equipment is used) • Praise resident when a task is done	
(S-21) Praise Resident When Task Is Done • Good job! Give a hug; tell them exactly what you liked about the job they did; depending on how up-to-date with current gestures a person it, high-five; hand slap; fist bump, etc., could be used.	

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE S
Psychological Effects of Aging

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module S – Psychological Effects of Aging
Definition List

Basic Human Needs – elements necessary for survival and physical and mental well-being

Defense Mechanisms – unconscious behaviors that residents (and all of us) may display when stressed.

Omnibus Budget Reconciliation Act (OBRA) – major legislation passed nationally to protect residents in nursing homes and assure they have quality of care and quality of life

Psychological Effects of Aging – an exploration of feelings, emotional stress, physical, psychosocial and psychological adjustments that are part of the aging process

Module S – Psychological Effects of Aging	
(S-1) Title Slide **(S-2) Objectives** 1. Describe the psychological effects of aging. 2. Explain the nurse aide's role in meeting the basic needs of the resident. 3. Describe the nurse aide's role in caring for residents with a variety of responses – depressed resident, combative resident, and the agitated resident. 4. Describe the feelings and behaviors of older adults moving into a nursing home.	
Content	**Notes**
(S-3) Psychological Effects of Aging – Definition • An exploration of feelings, emotional stress, physical, psychosocial and psychological adjustments that are part of the aging process **Psychological Effects of Aging – Importance** • To function successfully, nurse aides should be aware of basic human behavior and needs and how these behaviors and needs change with aging	
(S-4) Basic Human Needs • Basic human needs – elements necessary for survival and physical and mental well-being • Nurse aides should be aware of ways to meet resident's basic human needs for life and mental well-being • Note that the term, "physical," is used in place of the term, "physiological," when discussing basic human needs	
(S-5) Physical Needs – Requirements for Sustaining Life (1) • Oxygen o Elevate head of bed o Up in chair o Assist with breathing exercises o Report cyanosis (or blue lip color)	
(S-6) Physical Needs – Requirements for Sustaining Life (2) • Food o Assist those unable to eat without help o Make sure dentures in place o Serve food at proper temperature, in a friendly manner, in a pleasant environment, in appropriate amounts • Water o Be sure it is within reach o Provide fresh water at periodic intervals during day	
(S-7) Physical Needs – Requirements for Sustaining Life (3)	

Module S – Psychological Effects of Aging	
• Shelter o Provide warmth o Dress resident properly for temperature o Be aware of drafts and drafty areas • Sleep o Minimize noise and lights during sleep hours o Provide back rubs to relax residents o Report complaints of pain to nurse o Listen to concerns or worries o Leave night light on-if requested	
(S-8) Physical Needs – Requirements for Sustaining Life (4) • Elimination o Assist with toileting as needed o Provide for privacy o Change soiled linen immediately o Follow routine for bowel and bladder training as required • Activity o Range of motion exercises as directed o Turn and reposition at least every two hours o Assist with activity as directed o Encourage movement o Encourage interesting recreational activities	
(S-9) Safety and Security Needs • Provide for warmth • Establish familiar surroundings o Explain procedures o Talk about their room o Keep promises o Provide safe environment o Promote use of personal belongings • Maintain order and follow routines • Assist to reduce fear and anxiety, check on resident frequently • Avoid rushing and assist resident in gentle manner	
(S-10) Love and Affection Needs (1) • Friendship • Social Acceptance • Closeness	
(S-11) Love and Affection Needs (2) • Meaningful relationships with others • Love • Sexuality	

Module S – Psychological Effects of Aging	

(S-12) Love and Affection Needs (3)
• Belonging
  o Need often met by family/support system
  o Friends may meet this need
• Nursing staff can become family
  o Sit and visit for a few minutes when time allows
  o Display human warmth with gentle touch
  o Show acceptance of resident for unique qualities
  o Promote care in kind, friendly, considerate manner	

(S-13) Basic Self-esteem • Value, worth or opinion of oneself • Seeing oneself as useful • Being well thought of by others	
(S-14) Self-esteem Needs of the Resident • Call resident by name he or she prefers • Praise accomplishments • Discuss current issues • Request resident's opinion • Show respect and approval • Assist to dress and help with grooming • Encourage independence and socialization • Share goals	
(S-15) Self-actualization Defined • Realizing personal potential including creative activities • Self-fulfillment • Seeking personal growth and peak experiences • A desire to become everything one is capable of becoming	
(S-16) Self-actualization in the Older Adult Self-actualization may be difficult for older adult due to unmet: • physical needs such as lack of mobility or pain • security needs such lack of privacy or fear • love and affection needs such as social isolation or lack of family support • Self-esteem needs such as negative feelings about self or lack of confidence	
(S-17) Encouraging Self-actualization in the Older Adult • Encourage resident to meet new people • Assist residents to attend presentations or activities such as guest speakers and musical performances in the facility or on a field trip • Discuss plans for trying something new • Offer praise when resident succeeds at something new	

Module S – Psychological Effects of Aging	
• Encourage creativity in music, art, poetry, writing • Offer audiobooks and/or music playlist with playback devices if available • Spend time with resident to discover what activities are meaningful to the resident; ask resident, "What matters to you?" and/or "What matters to you today?" to start a conversation; report information gained to the supervisor to share with other members of the team • Support resident in experiencing treasured activities after resident shares what matters such as enjoying outdoor life with a walk or socializing with others	
(S-18) Review of Hierarchy of Basic Human Needs	
(S-19) Basic Human Needs – Check Your Answers	
(S-20) Spiritual Needs • Residents have right to worship and express faith freely o Respect residents' beliefs and religious objects o Inform residents of the time and place for religious services important to them o Assist resident to attend religious services o Provide privacy for visits by members of the clergy	
(S-21) Sexuality • Expressed by individuals of all ages; sexual needs and desires continue throughout life • May be expressed in a variety of ways such as sexual intercourse, caressing, touching, holding hands, masturbation • Some ways to show feminine or masculine qualities is through choice of clothing styles and colors, hairstyles, hobbies and interests, sexual habits, and gestures • Illness, disability, or living environment may affect needs and desires	
(S-22) Resident Sexuality – Nurse Aide's Role (1) • Assist to maintain sexual identity by dressing resident in clothing of choice • Assist with personal hygiene • Assist to prepare for special activities by dressing up (selecting attractive clothing, styling hair in a special way, applying cosmetics, wearing a special perfume or aftershave) • Help to develop a positive self-image • Respect resident's sexual orientation and gender identity o Use transgender resident's chosen name and pronouns such as he, she, or other pronoun of choice	

Module S – Psychological Effects of Aging	
o Encourage resident to talk about their "family members of choice." o Avoid assuming all residents are heterosexual or straight – it deprives residents of dignity and respect	
(S-23) Resident Sexuality – Nurse Aide's Role (2) • Show acceptance and understanding for resident's expression of love or sexuality (provide privacy, always knock before entering a resident's room at any time, assure privacy when requested) • Accept the resident's sexual relationships • Respect *Do Not Disturb* signs • Refrain from gossiping and breaking confidentiality about resident's sexuality • Avoid viewing expression of sexuality as disgusting or cute – it deprives residents of dignity and respect • Provide protection for the non-consenting resident • Be firm but gentle in your objection of a resident's sexual advances	
(S-24) Developmental Tasks of Aging – Skills • Certain skills that must be mastered during a stage of development • Late adulthood tasks include o Adjustment to retirement, reduced income, death of friends, death of spouse, physical changes, loss of independence o Creating new friendships and relationships o Loss of vitality o Integrating life experiences o Preparation for death	
(S-25) Developmental Tasks of Aging – Issues • Issues involving care of elderly that may arise o Amount of care needed o Cost o Nutritional needs o Relationship with family/support system o Location of family/support system o Medical care needs o The elderly person may experience changes in lifestyle – living with a group of people, less independence, structured lifestyle, less privacy, difficulty adapting to change o Decision made by individual or family for long-term care may cause stress	
(S-26) The Place That I Call Home	

Module S – Psychological Effects of Aging	
(S-27) The Place That I Call Home	
(S-28) The Place That I Call Home	
(S-29) The Place That I Call Home	
(S-30) Home as a Castle • Most older adults view their home as their castle and have lived in their current home for 20 years	
(S-31) An Older Adult's Home • To an older adult, a home may represent o Independence o A link to the past o A part of his/her identity o The center for family gatherings o A connection to the neighborhood o Symbol of position in the community o A place to maintain autonomy and control	
(S-32) Relocation from the Home • Sometimes the older adult must relocate from the home due to: o Decrease in finances o Decline in physical or mental state resulting in the need for more assistance o Inability to manage the home o Lack of social support o Increasingly unsafe neighborhood	
(S-33) Reaction to Relocation • Individual people will have individual reactions to relocation from the home depending upon o Degree of choice that the older adult had o Degree of preparation that the older adult had o Degree of sameness of the new location with the previous location o Degree of predictability of the new location o Number of additional losses that occurred in older adult's life – loss of loved one, loss of health, loss of finances, loss of roles	
(S-34) Moving to a Nursing Home • Admission to a nursing home o About 1/3 of men and over 1/2 of women who turn 65 are expected to live in a nursing home before they die o The older adult may fear life in a nursing home more than his/her own death o Older adults often view admission to a nursing home as a series of losses and being forced into	

Module S – Psychological Effects of Aging	
unpredictable surroundings in which the only certainty is further loss o Admission is often involuntary and traumatic for the older adult and initiated by a family member	
(S-35) Sudden Admission to a Nursing Home • How does the older adult feel when he/she is suddenly admitted to a nursing home? o Typically experiences a great deal of stress and feels a sense of loss, fear, isolation, confusion, and being out of control o May feel relief over the move – no more caring for the home, no more cooking, no more cleaning, and no more shopping o Event is often viewed as the ending of one phase of the older adult's life and the beginning of the final phase	
(S-36) Nursing Home as an Accidental Community • May be perceived as an accidental community where people with different interests, tastes, cultural backgrounds, social classes, educational backgrounds, former occupations, and income live together in a blended living arrangement in an institutional setting with dozens or even hundreds of people	
(S-37) Life in a Nursing Home – Residents • Residents of a nursing home represent a wide range of ages, may stay for a short time or a long time, have a variety of diagnoses, vary in their degree of functional impairment or disability, vary in their level of cognition, and are 75% female	
(S-38) Life in a Nursing Home – Routines and Schedules • Fixed routines and schedules for personal care (baths and showers); meals, medications, wake times, and bedtimes used in most nursing homes to accommodate needs of all residents • Older adult's life is built on previously established social roles and personal routines • Personal routines and schedules may collide with institutional schedules, causing conflict • Examples – John has always been the king of his household and now has discovered that he must do what he's told; George is expected to eat breakfast at age 76 years of age for the first time in his life; Mary can no longer read her morning paper before breakfast	

Module S – Psychological Effects of Aging	
(S-39) Life in a Nursing Home – Limited Space • Personal space is limited and reduced to a few square feet around the bed • Storage space is limited	
(S-40) Life in a Nursing Home – Lack of Privacy • Resident may live in a shared bedroom with no choice of roommates and no control over who stays in other bed – could be someone dying, a resident who is confused, or even a series of roommates • May feel violated if confused residents invade their personal space or take personal items	
(S-41) Life in a Nursing Home – Lack of Privacy • At home o Older adult could lock the door and choose whether to answer a knock at that door o May also choose whether to let the individual come through the door • At nursing home o Resident cannot lock door o A knock on the door signifies that entry is being announced, instead of person requesting to come into room	
(S-42) Life in a Nursing Home • Cognitively impaired residents are housed with cognitively intact residents o Cognitively intact and cognitively impaired residents share the same dining hall in most nursing homes and may be a shock to the cognitively intact (such as residents drooling or spitting) o Programs and activities are often the same for cognitively intact and cognitively impaired residents, and often very simple and very basic – and not very challenging o Residents may be frightened by erratic screams, moans, or repetitive sounds from other residents	
(S-43) Adapting to Life in a Nursing Home (1) • The cognitively intact older adult adapts to life in a nursing home in one of three ways o Becomes depressed or may regress, withdraws from others and only shows interest in events that affect own personal, physical self, OR o Becomes narrow-minded, uncooperative with staff, and fights all attempts to be included into normal, standard routine of nursing home activities, does not view nursing home as home, OR	

Module S – Psychological Effects of Aging	
o Determined to make the best of his or her stay in nursing home and claims to prefer it to life before admission	
(S-44) Adapting to Life in a Nursing Home (2) • Important to realize that a normal response to sudden placement into a nursing home, such as depression, withdrawal, or moodiness, is often viewed as poor adjustment to nursing home life • Nursing home staff may unfairly and prematurely label the resident as difficult or a troublemaker	
(S-45) Life in a Nursing Home – Nurse Aide's Role (1) (by Individualizing the Admission Process) • Staff can decrease resident's doubts and fears of unknown, and increase feelings of control by providing newly admitted residents with orientation to facility o Find out how each resident wishes to be addressed (Mr., Mrs., Ms., Dr.) and preferred name (first name, middle name, last name, nickname); use with all subsequent introductions and verbal communications with resident o Provide each resident with map of facility, a personalized tour, and visual points of reference to help get used to facility o Introduce resident to staff and other residents o Provide initial explanations of routines and procedures o Always explain what is being done, reason it is being done, and where resident is being taken o Learn about resident's previous lifestyle, environment, and routines so that nurse can add to nursing care plan	
(S-46) Life in a Nursing Home – Nurse Aide's Role (2) (by Personalization and Links to Past) • Older adults must part with many important objects when relocating to a nursing home; familiar objects and keep-sakes are links to resident's background and relationships o Encourage as much personalization of space as possible to provide sense of continuation of life; items may include a piece of furniture, figurines, pictures of family members, books, children's art work, etc.; be tolerant of clutter o Let resident have plenty of time to decide on placement of keepsakes; may keep resident's	

Module S – Psychological Effects of Aging	
thoughts and attention for one or two weeks; only after resident has organized living space can he/she direct their energies to new people and new places in facility o Provide praise for personalization of resident's space	
(S-47) Life in a Nursing Home – Nurse Aide's Role (3) (by Privacy and Respect for Personal Space) • Lack of privacy and personal space, can increase stress and anxiety for resident; can be displayed in form of illness, aggression, anger, submissiveness, and withdrawal; when resident's privacy, personal space, and personal belongings are respected, can relate better to others, feels more secure, and maintains identity • Remember that each resident needs down time or time to relax and get away from people o Always knock on resident's door and wait to be invited in before entering o Approach resident slowly and maintain a degree of physical distance when possible o Ask resident for permission before touching belongings or going into closet and drawers o Never read resident's mail unless requested to do so o Keep the resident's personal belongings safe, yet available for use	
(S-48) Life in a Nursing Home – Nurse Aide's Role (4) (in Providing Emotional Support) • Be aware of resident's reasons for admission (death of spouse, declining health) and understand these stressors directly affect behavior and reactions to nursing home life; also, remember it is difficult to change lifelong habits, schedules, and rituals o Realize major changes that resident is expected to handle in short period of time and empathize o Recognize losses – home and familiar surroundings, belongings, former neighbors, former routines and lifestyles, declining health, and possible loss of loved ones o Recognize adjustments – to a confined living space, living near others, possibly having to share a bedroom with a stranger, new routines, services, and facility staff watching his/her every move o Encourage resident to have as much control as possible; encourage to participate in planning of daily schedule	

Module S – Psychological Effects of Aging	
o Encourage resident to set own pace and prioritize daily activities o Encourage resident to participate in facility activities when ready to do so	
(S-49) OBRA • Do you remember when Ms. Smith, the state surveyor, knocked on your door when you were a resident of Happy Care Nursing Home? • There actually are Ms. Smiths in our State who inspect nursing homes • Recall learning about OBRA and how OBRA was major legislation that was passed to protect residents in nursing homes and to assure that they would receive quality care and have a quality life • The law requires States to have a survey and certification process in place, whereby each nursing home is surveyed annually to determine compliance with federal regulations • The survey is unannounced and performed annually to review quality of care as indicated by an evaluation of criteria including medical, nursing, and rehabilitative care; dietary services; infection control; pharmacy services; physical environment; incidents of abuse, neglect, and exploitation; and resident-centered care planning • Variety of methods are used during survey – observations of staff providing care, resident/family interviews, evaluation of environment for safety and cleanliness, and records review • Based on findings of the state surveyors, the nursing home can get a clean bill of health and found to be in compliance; or may be subject to fines, denial of federal funds, or at the extreme – closed	
(S-50) OBRA Empowers Nursing Home Residents • The regulation of nursing homes focuses on quality of life for residents and emphasizes their individual rights. Because of OBRA, nursing home residents are more empowered and have a greater say in their own quality of life.	
(S-51) Caring for Residents Who Are Depressed • Recognize reasons for depression o Loss of independence o Death of spouse or friend o Loss of job or home o Decreased memory o Terminal illness	

Module S – Psychological Effects of Aging	

• Recognize common signs and symptoms of depression
  o Change in sleep pattern
  o Loss of appetite and weight loss
  o Crying
  o Withdrawal from activities
  o Appearing sad
• When the resident is depressed
  o Listen to feelings
  o Encourage to reminisce
  o Involve in activities
  o Encourage friends and family to visit
  o Report changes in eating, elimination or sleeping patterns
  o Avoid pitying the resident
  o Help to focus on reality
  o Monitor eating and drinking
  o Promote self-esteem
  o Report observations to supervisor
• Recognize defense mechanisms – unconscious behaviors that resident may display when stressed	

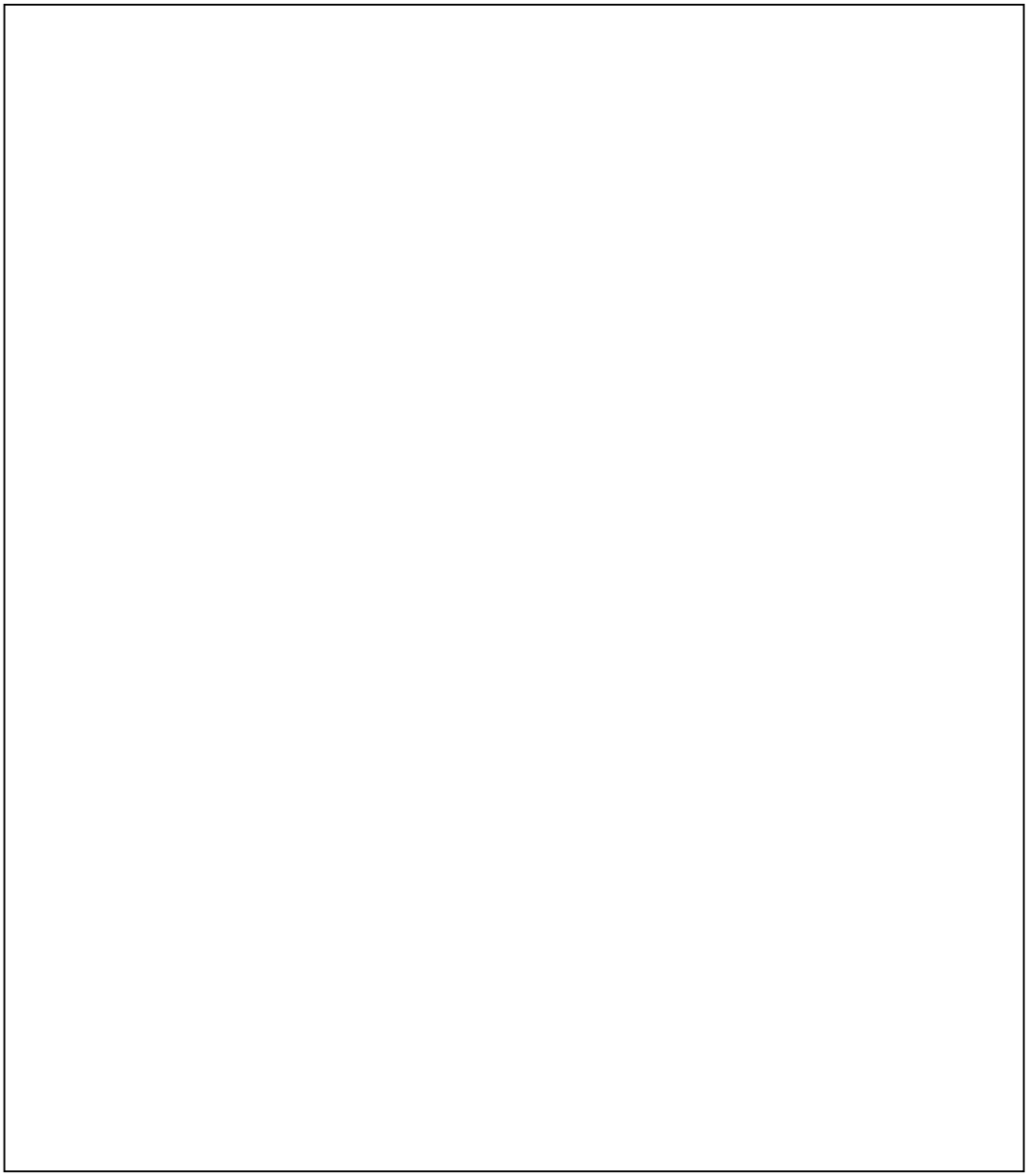
(S-52) Defense Mechanisms (1) • Projection – blaming others • Rationalization – false reason for situation • Denial – pretending a problem does not exist • Compensation – making up for a situation in some other way	
(S-53) Defense Mechanisms (2) • Displacement – transferring feelings about the one person to another person • Daydreaming – escape from reality • Identification – idolizing another and trying to copy him/her • Sublimation – redirecting feelings to constructive activity	
(S-54) Caring for Residents with Developmental Disabilities – Nurse Aide Role • Diagnoses may include mental retardation or cerebral palsy • Treat the individual with respect and dignity • Encourage residents to make personal choices, do as much as possible for themselves, use age appropriate personal skills, achieve their potential, interact with others • Do not act as resident's parent, create dependency, label or categorize residents	

Module S – Psychological Effects of Aging	
• Provide privacy • Build resident's self-esteem	
(S-55) Caring for Residents who are Stressed – Nurse Aide Role • Listen to concerns • Observe and report nonverbal messages • Treat with dignity and respect • Attempt to understand behavior • Be honest and trustworthy • Never argue with residents • Attempt to locate source of stress • Support efforts to deal with stress	
(S-56) Caring for Residents Who Are Demanding – Nurse Aide Role • Attempt to discover factors responsible for behavior • Display a caring attitude • Listen to verbal and nonverbal messages • Give consistent care • Spend some time with the resident • Agree to return to see the resident at a specific time and keep your promise	
(S-57) Caring for Residents Who Are Agitated – Nurse Aide Role • Encourage to talk about fears • Remind resident of past ability to cope with change • Encourage to ask questions about concerns • Involve in activities that promote self-esteem • Observe for safety and to prevent wandering • Assign small tasks • Use reality orientation	
(S-58) Caring for Residents who are Paranoid – Nurse Aide Role • Reassure the resident that you will provide safety • Realize behavior is based on fear situations • Avoid agreeing or disagreeing with comments • Provide calm environment • Involve in reality activities	
(S-59) Caring for Residents who are Combative – Nurse Aide Role • Display a calm manner • Avoid touching the resident • Provide privacy for out-of-control residents • Secure help if necessary	

Module S – Psychological Effects of Aging	
• Do not ignore threats • Protect yourself from harm • Listen to verbal aggression without argument	

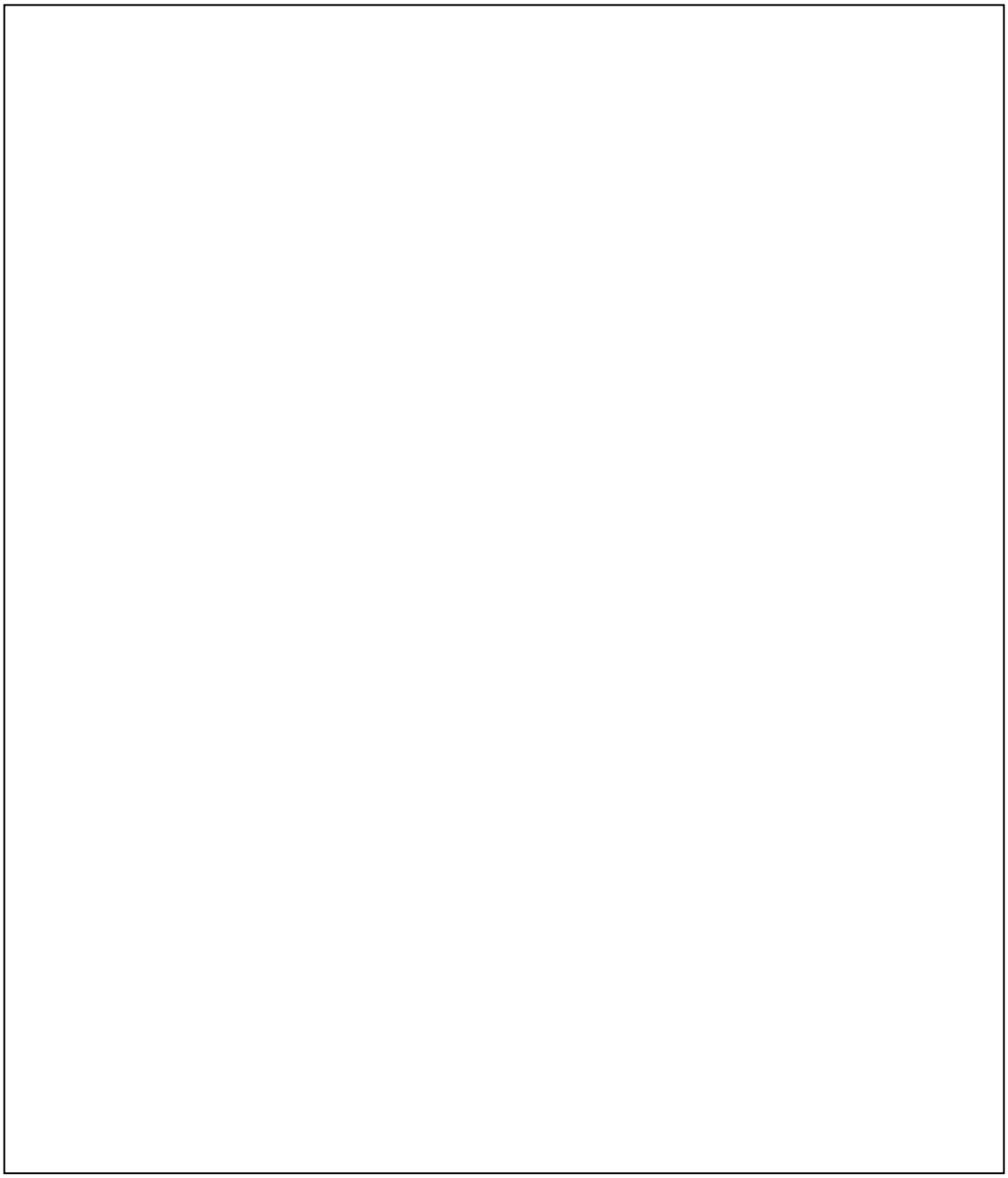
The Place That I Call Home Homework (Page 1 of 3)

Think about where you are currently living. Draw a picture of the outside of your home and your yard. Be sure to include plants, trees, pets, a sidewalk, your car, garden, fence, mailbox, porch swing, birdhouses or other things a person would notice if he/she would ride by your home.



The Place That I Call Home Homework (Page 2 of 3)

Think about where you are currently living. Draw a floor plan of the inside of your home. Be sure to include all rooms, doors, windows, indoor pets, televisions, telephones, closets (page 2 of 3)



The Place That I Call Home Homework (Page 3 of 3)

Think about where you are currently living. Answer the following questions regarding the place that you call home.

1. Do you enjoy living in your home?

2. What do you love most about your home?

3. When you are home, where do you go when you want to be alone?

4. When friends or relatives come to see you at your home, do they knock on your door or just go into your home without knocking?

5. When a stranger wishes to see you at your home, does he/she knock on your door or just go into your home without knocking?

6. Do you sometimes not want to see anyone or be bothered and therefore not answer your door or answer your phone?

7. How often do you go out to eat?

8. Do you usually eat alone or with someone?

9. Do you prepare your own food and go to the refrigerator for a snack whenever you are hungry?

10. Do strange noises scare you at night?

11. When you bathe – do you shower or take a bath?

12. If you were forced to move from your home and could bring only five things with you, what would those five things be?

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NURSE AIDE I TRAINING PROGRAM

MODULE T
Dementia and Alzheimer's Disease

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module T – Dementia and Alzheimer's Disease
Definition List

Activity-based Care – care focused on assisting resident to find meaning in his or her day, rather than doing activities just to keep the person busy

Alzheimer's disease (AD) – is a progressive disease characterized by a gradual decline in memory, thinking and physical ability, over several years

Behavior – how a person acts

Catastrophic Reactions – out-of-proportion, extreme responses to activities or situations

Cognition – ability to think quickly and logically

Confusion – inability to think clearly, causing disorientation and trouble focusing

Delirium – a state of severe confusion that occurs suddenly and is usually reversible

Delusion – a false belief

Dementia – usually progressive condition marked by development of multiple cognitive deficits, such as memory impairment, aphasia, and inability to plan and initiate complex behavior

Depression – a loss of interest in usual activities

Dignity – respect and honor

Doing Activities – activities that keep the person busy

Independence – ability to make decisions that are consistent, reasonable and organized; having the ability to perform activities of daily living without assistance

Irreversible – disease or condition that cannot be cured

Meaningful Activities – have value to the resident with dementia

Onset – the time when signs and symptoms of a disease begins

Paranoia – an extreme or unusual fear

Progressive – the way a disease advances

Quality of Life – overall enjoyment of life

Respect – treated with honor, show of appreciation and consideration

Sundowning – increased agitation, confusion and hyperactivity that begins in the late afternoon and builds throughout the evening

Trigger – an event that causes other events

Wandering – moving about the facility with no purpose and is usually unaware of safety

Module T – Dementia and Alzheimer's Disease	
(S-1) Title Slide **(S-2) Objectives** 1. Define the terms dementia, Alzheimer's disease, and delirium. 2. Describe the nurse aide's role in the care of the resident with Alzheimer's disease.	
Content	**Notes**
(S-3) Dementia • Usually progressive condition marked by development of multiple cognitive deficits such as memory impairment, aphasia, and inability to plan and initiate complex behavior	
(S-4) Types of Dementia • Alzheimer's disease – most common cause of dementia. Thought to be caused by clumps of proteins (referred to as tangles) in the brain • Vascular dementia – can occur when blood circulation to the brain decreases as a result of a stroke or another problem, damaging blood vessels in the brain • Dementia with Lewy bodies – deposits of protein that develop throughout the brain. These protein deposits damage and kill nerves in the brain over time. • Mixed dementia -	
(S-5) Alzheimer's Disease • Progressive disease • Gradual decline in memory, thinking and physical ability over several years • Average life span in 8 years, but survival may be from 3 to 20 years • Progressive into 7 stages	
(S-6) Alzheimer's Disease – Stage 1 – No Impairment • Alzheimer's disease is not evident • No memory problems	
(S-7) Alzheimer's Disease – Stage 2 – Very Mild Decline • Minor memory problems • Lose things around the house • Unlikely to be noticed by family members	
(S-8) Alzheimer's Disease – Stage 3 – Mild Decline • Family members and friends may begin to notice cognitive problems • Difficulty finding the right word during conversations • Difficulty organizing and planning • Difficulty remembering names of new individuals	

Module T – Dementia and Alzheimer's Disease	
(S-9) Alzheimer's Disease – Stage 4 – Moderate Decline • Difficulty with simple math • Poor short-term memory (may not recall what they ate for lunch) • Inability to manage finances	
(S-10) Alzheimer's Disease – Stage 5 – Moderately Severe Decline • Maintain functionality • Usually able to bathe and toilet independently • Still know their family members • Difficulty dressing appropriately • Inability to recall simple details, such as their own address or telephone number • Significant confusion	
(S-11) Alzheimer's Disease – Stage 6 – Severe Decline (1) • Need constant supervision, usually require professional care • Confusion or unawareness of environment and surroundings • Inability to remember most details of personal history • Loss of bladder and bowel control	
(S-12) Alzheimer's Disease – Stage 6 – Severe Decline (2) • Major personality changes • Possible behavior problems • Need assistance with bathing and toileting • Wandering	
(S-13) Alzheimer's Disease – Stage 7 – Very Severe Decline • Final stage and nearing death • Lose ability to communicate or respond to their environment • May be able to utter words or phrases • No awareness regarding their condition • Need assistance with all activities of daily living • May lose their ability to swallow	
(S-14) Delirium • State of severe sudden confusion that is usually reversible • Triggered by acute illness or change in physical condition • Can be life threatening if not recognized and treated • Symptoms of delirium o Rapid decline in cognitive function (ability to think)	

Module T – Dementia and Alzheimer's Disease	
o Increased confusion o Disorientation to place and time o Decreased attention span o Poor short-term memory and immediate recall o Poor judgment o Restlessness o Altered level of consciousness o Suspiciousness o Hallucinations, delusions • Notify nurse and stay with resident • Communicating with a resident who is showing signs of delirium o Stay calm o Keep voice at a normal volume; do not shout o Use resident's name o Speak clearly in simple sentences o Use facial expressions and body language to aid in understanding o Reduce distractions in the environment, such as turning down TV or closing curtains to block bright sunlight	
(S-15) Dementia or Delirium? • Delirium and dementia are often confused • Remember, delirium is sudden, severe, and usually reversible; dementia is progressive and irreversible • A resident who has dementia may experience delirium; immediately report any sudden change in behavior or a sudden increase in behaviors associated with dementia to the nurse – a resident with dementia may be experiencing delirium	
(S-16) Dementia and Alzheimer's Disease – Key Terms • Cognition – ability to think quickly and logically • Confusion – inability to think clearly, causing disorientation and trouble focusing • Irreversible – disease or condition that cannot be cured • Onset – the time when signs and symptoms of a disease begins • Progressive – the way a disease advances	
(S-17) Maintenance of Respect, Dignity and Quality of Life • Dignity – respect and honor • Independence – ability to make decisions that are consistent, reasonable and organized; having the ability to perform activities of daily living without assistance • Quality of life – overall enjoyment of life	

Module T – Dementia and Alzheimer's Disease	
• Respect – treated with honor, show of appreciation and consideration	
(S-19) Maintenance of Respect, Dignity and Quality of Life • Every human being is unique and valuable, therefore, each person deserves understanding and respect • Dementia does not eliminate this basic human need • Person-centered care maintains and supports the person regardless of level of dementia	
(S-20) Maintenance of Respect, Dignity and Quality of Life • Residents' abilities, interests, and preferences should be considered when planning activities and care • As the disease progresses, adjustments will be required in order to maintain dignity • Important for staff to know who the resident was before the dementia started	
(S-21) Maintenance of Respect, Dignity and Quality of Life • An individual's personality is created by his/her background, including o Ethnic group membership (race, nationality, religion) o Cultural or social practices o Environmental influences, such as where and how they were raised as children o Career choices o Family life o Hobbies	
(S-22) Maintenance of Respect, Dignity and Quality of Life • Encourage residents to participate in activities and daily care, but avoid situations where resident is bound to fail • Humiliation is disrespectful, degrading, and can increase likelihood of disruptive behaviors • To promote independence, do things with resident rather than for them	
(S-23) Maintenance of Respect, Dignity and Quality of Life • Allow time for residents to express feelings and take time to understand what they are feeling • Provide emotional support • Long-term care facilities must provide care for residents in a manner and an environment that promotes maintenance or enhancement of each resident's dignity,	

Module T – Dementia and Alzheimer's Disease	
respect, and quality of life	
(S-24) Dementia and Alzheimer's Disease – Communication • Residents with Alzheimer's disease often experience problems in making wishes known and in understanding spoken words • Communication becomes more difficult as time goes by • Changes commonly seen in the resident with Alzheimer's o Inability to recognize a word, phrase o Inability to name objects o Using a general term instead of specific word o Getting stuck on ideas or words and repeating them over and over o Easily losing a train of thought o Using inappropriate, silly, rude, insulting or disrespectful language during conversation o Increasingly poor written word comprehension o Gradual loss of writing ability o Combining languages or return to native language o Decreasing level of speech and use of select words, which may also cause the use of nonsense syllables o Reliance on gestures rather than speech	
(S-25) Communicating with Resident with Dementia and Alzheimer's Disease – Nurse Aide's Role • There are several components when assisting resident with communication o Patience with resident o Show interest in the subject o Offer comfort and reassurance o Listen for a response o Avoid criticizing or correcting o Avoid arguments with resident o Offer a guess as to what resident wants o Focus on the feelings, not on the truth o Limit distractions o Encourage non-verbal communication	
(S-26-27) Dementia and Alzheimer's Disease – Communication Techniques Used by Nurse Aide • Nurse aide's method of communicating with the resident with Alzheimer's disease is as critical as the actual communication • Utilizing the following techniques will decrease frustration for both the resident and nurse aide o Obtain resident's attention before speaking and maintain attention while speaking	

Module T – Dementia and Alzheimer's Disease	
o Address resident by name, approach slowly from front or side and get on same level or height as resident o Set a good tone by using calm, gentle, low-pitched tone of voice o If conversation is interrupted or nurse aide or resident leaves room, start over from beginning o Slow down, do not act rushed or impatient o If information needs to be repeated, do so using same words and phrases as before o Speak clearly and distinctly using short, familiar words and short sentences, and avoiding long explanations o Emphasize key words, break tasks and instructions into clear and simple steps, offer one step at a time; and provide resident time and encouragement to process and respond to requests o Use nonverbal cues, such as touching, pointing or starting the task for resident o If the resident's speech is not understandable, encourage to point out what is wanted or needed	
(S-28) Dementia and Alzheimer's Disease – Communication Strategies Used by Nurse Aide • Communication strategies to use when communicating with residents that have dementia o Listen carefully and encourage them; do not talk down to them, nor talk to others about them as if they were not present o Minimize distractions and noise o Allow enough time for resident to process and respond; if they have difficulty explaining something, ask them to explain in a different way o Monitor body language to ensure a non-threatening posture and maintain eye contact o Nonverbal communication is very important to dementia residents o Choose simple words and short sentences, and use a calm tone of voice o Call the person by name and make sure you have their attention before speaking o Keep choices to a minimum in order to reduce resident's frustration and confusion o Include residents in conversations with others o Do not make flat contradictions to statements that are not true o Change the way responses are made to avoid	

Module T – Dementia and Alzheimer's Disease	
confusion, frustration, embarrassment, and behavioral outbursts o Use of communication devices (such as a picture board, books, or pictures) encourages resident's independence and decreases frustration	
(S-29-30) Dementia and Alzheimer's Disease – Communication Tips by Nurse Aide • Communication tips to use when caring for resident with Alzheimer's disease o Be calm and supportive o Focus on feelings, not facts o Pay attention to tone of voice o Identify yourself and address the resident by name o Speak slowly and clearly o Use short, simple and familiar words, and short sentences o Ask one question at a time o Allow enough time for a response o Avoid the use of pronouns (e.g., he, she, they), negative statements and quizzing o Use nonverbal communication, such as pointing and touching o Offer assistance as needed o Have patience, flexibility and understanding	
(S-31) Dementia and Alzheimer's Disease – Key Words About Behavior Issues • Behavior – how a person acts • Catastrophic reaction – an extreme response • Delusion – a false belief • Depression – a loss of interest in usual activities • Paranoia – an extreme or unusual fear • Sundowning – increased agitation, confusion and hyperactivity that begins in the late afternoon and builds throughout the evening • Trigger – an event that causes other events • Wandering – moving about the facility with no purpose and is usually unaware of safety • Alzheimer's disease progresses in stages and so does behavior	
(S-32) Dementia and Alzheimer's Disease – Behavior Issues • Behavior – an observable, recordable, and measurable physical activity o People with normal brain function have the ability to control responses	

Module T – Dementia and Alzheimer's Disease	
o People with Alzheimer's disease and dementia have lost much of this ability	
(S-33) Dementia and Alzheimer's Disease – Behavior Issues • Behavior is a response to a need o The resident is frequently unable to express his or her needs because of cognitive losses o Nurse aides must be attentive to gestures and clues demonstrated by the resident o Every behavior is a response to a need or situation o Gestures, sounds, and conversation may reveal trigger to the behavior o As verbal skills diminish, behavior becomes the communication method • Before choosing a specific behavioral intervention, trigger of behavior must be identified • Triggers may be environmental, physical, or emotional o Environmental triggers – rearrangement of furniture, increased number of people in facility, change in daily schedule o Physical triggers – new medications, infections, pain o Emotional triggers – may include reactions to loss, depression, frustration, self-perception, past life events, personality	
(S-34) Dementia and Alzheimer's Disease – Behavior Issues • Effective behavior management o Identifying trigger o Understanding trigger o Adapting environment to resolve behavior • Changing the environment (such as reducing excessive noise and activity) or providing comfort measures (such as rest or pain medication) may reduce behavior • Intervention must meet needs of resident while maintaining respect, dignity and independence • Successful behavioral interventions o Preserve resident's dignity o Helps staff gain confidence, improve morale, and increase job satisfaction • Behavior control also assists in reducing use of restraints, decreases abuse and neglect, and increases family satisfaction	
(S-35) Dementia and Alzheimer's Disease – Behavior Issues • Common behaviors	

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o Wandering o Sundowning o Depression o Disorientation to person, place, and/or time o Inappropriate sexual behavior o Emotional outbursts o Combativeness (hostility or tendency to fight) o Inappropriate toileting (use of inappropriate areas for toileting, such as a plant) o Easy frustration o Repetitive speech or actions o Swearing, insulting, or tactless speech o Shadowing (following others) o Withdrawal o Hoarding (hiding objects or food) o Sleep disturbances o Paranoia and suspiciousness o Delusions and/or hallucinations o Decreased awareness of personal safety o Catastrophic reactions (extreme emotional responses such as yelling, crying, or striking out that seem out of proportion to the actual event)	
(S-36) Wandering • Wandering is a known and persistent problem behavior that has a high risk factor for resident safety • Safety risk factors may include o Falls o Elopement o Risk of physical attack by other residents who may feel threatened or irritated by the activity • Residents wander for several reasons and may include o Trying to fulfill a past duty, such as going to work o Feeling restless o Experiencing difficulty locating their room, bathroom or dining room o Reacting to a new or changed environment • Preservation of resident safety is the main objective when caring for the wandering resident and interventions include o Establish a regular route o Provide rest areas o Accompany the resident o Provide food and fluid o Redirect attention to other activities or objects o Determine if behavior is due to environmental stress	

Module T – Dementia and Alzheimer's Disease	
(S-37) Sundowning • Sundowning is behavioral symptom of dementia that refers to increased agitation, confusion, and hyperactivity that begins in late afternoon and builds throughout the evening • Interventions o Encourage rest times o Plan bulk of activities for the morning hours o Perform quieter, less energetic activities during the afternoon	
(S-38) Sexual Activity • Inappropriate sexual activity is another behavior issue. Offensive or inappropriate language, public exposure, offensive and/or misunderstood gestures are the characteristics of this behavior • Interventions o Treat the resident with dignity and respect o Remove resident from public situation o Redirect attention to an appropriate activity o Assist the resident to bathroom	
(S-39) Dementia and Alzheimer's Disease – Agitation • Agitation occurs for a variety of reasons • Nurse aides must ensure safety and dignity of agitated resident while protecting safety and dignity of other residents • Interventions o Do not crowd the resident; allow them room to move around while still providing for safety o Ask permission to approach or touch them o Maintain a normal, calm voice • Interventions o Slow down and do not rush the resident o Limit stimulation in the resident's area o Avoid confrontations and force o Avoid sudden movements outside of the resident's field of vision	
(S-40) Dementia and Alzheimer's Disease – Disruptive Verbal Outbursts • Disruptive verbal outbursts are one of the most persistent behaviors in a long-term care facility. These outbursts may include: o Screaming o Swearing o Crying o Shouting	

Module T – Dementia and Alzheimer's Disease	
o Loud requests for attention o Negative remarks to other residents or staff (including racial slurs) o Talking to self • Anger and aggression are often the visible symptoms of anxiety and fear. • Interventions o Reassure residents that they are safe o Redirect their attention to an activity o Assist residents with toileting, feeding or fluids o Move residents to a quiet area • Notify nurse immediately of aggressive behaviors that may threaten other residents and/or staff and stay with the resident	
(S-41) Dementia and Alzheimer's Disease – Catastrophic Reaction • Emotional, environmental, or physical triggers may result in a catastrophic reaction • Catastrophic reactions are out-of-proportion responses to activities or situations • Warning signs of a possible reaction o Sudden mood changes o Sudden, uncontrolled crying o Increased agitation o Increased restlessness o Outburst of anger (physical or verbal)	
(S-42) Dementia and Alzheimer's Disease – Catastrophic Reaction • Interventions include o Speak softly and gently in calm voice o Protect resident, self, and others as necessary o Remove the person from a stressful situation o Avoid arguing with the resident o Avoid the use of restraints o Redirect the resident's attention o Change activities if the activity is causing the reaction	
(S-43) Dementia and Alzheimer's Disease – Catastrophic Reaction • Interventions that should not be used include o Arguing with resident or other staff members o Speaking loudly to resident or other staff members o Treating resident like a child o Asking complicated questions o Using force or commanding resident to do something	
(S-44) Dementia and Alzheimer's Disease – Catastrophic	

Module T – Dementia and Alzheimer's Disease	
Reaction • Caregiver behaviors that should be encouraged and used to decrease or prevent use of restraints o Maintaining calm and non-controlling attitude o Speaking softly and calmly o Asking one question at a time and waiting patiently for the answer o Using simple, one step commands, and positive phrases o Avoiding crowding resident with more people than needed for the task o Providing a distraction, such as an activity or music	
(S-45) Dementia and Alzheimer's Disease – Activities • Goal in the care of residents with Alzheimer's disease is to give support needed so that they can participate in the world around them to the best of their ability • Nurse aide must focus on the fact that the resident is involved and satisfied, not on the task or activity	
(S-46) Dementia and Alzheimer's Disease – Activities • Activities fall into two categories o Doing activities – keep the person busy o Meaningful activities – have value to the resident with dementia • Activity-based care is focused on assisting resident to find meaning in his or her day, rather than doing activities just to keep the person busy	
(S-47) Dementia and Alzheimer's Disease – Activities • Principles of activity-based care o Focuses on giving caregivers the tools to create chances for residents with dementia to be successful in activities and their relations with other people o Uses any daily activity that can be broken down into individual, sequential steps o Works within remaining abilities or strengths of the resident with Alzheimer's disease, helping to shift emphasis away from resident's disabilities and impairments o Adjusts an activity based on resident's ability level o Depends on caregiver's interest and desire to create opportunities for successful interactions that are planned and guided to encourage resident's full involvement o Rewards the resident's attempts at participating in activities and provides them with a sense of being capable and alive	

Module T – Dementia and Alzheimer's Disease	

(S-48) Dementia and Alzheimer's Disease – Activities
• Timing of activities is important and individualized
  o Attention and focus activities, physical activities and sensory activities provided during each resident's prime time and on a set, routine basis may increase participation and satisfaction with that activity
• Cultural environment refers to values and beliefs of people in an area
  o Staff, residents, families, visitors and volunteers determine culture of the facility
  o Promotion of positive environment begins with inclusion of the residents and making them feel important to relationships and activities	

(S-49) Dementia and Alzheimer's Disease – Nurse Aide Stress and Burnout
• Providing care on daily basis for resident with Alzheimer's or dementia extremely stressful
• This population of residents may be more prone than others to becoming victims of abuse or neglect
• Because of this, nurse aides that deal with Alzheimer's or dementia residents must take additional precautions to ensure they do not over-react or react negatively to resident behaviors
• Regardless of the cause, nurse aides must take necessary steps to ensure that they do not react inappropriately to resident behavior
• Frustration can lead to
  o Negative, harsh or mean-spirited statements made to staff or residents
  o Physical abuse of residents
  o Emotional abuse of residents
  o Verbal abuse of residents
  o Neglect of residents
• Nurse aides must always remember that statements and behaviors of residents suffering from Alzheimer's or dementia are beyond control of the resident and not personally directed toward nurse aide
• Usual profile of employee who is subject to burnout
  o Takes work personally and seriously
  o Works over at end of a shift
  o Works extra shifts
  o Takes on extra projects
  o Very high or unrealistic expectations
  o Perfectionist attitude
• Signs of staff burnout include	

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o No longer enjoying work o Irritable with residents and co-workers o Fear of failure, inadequacy, job loss and obligation to supervisor, co-workers, family o Feelings of being overwhelmed o Viewing work as a chore o Frequent complaints of illness • Strategies to use to assist in preventing burnout include o Maintain good physical and mental health o Get adequate amounts of sleep on off days and before each shift o Remain active within family and community o Maintain a separation between work and personal relationships o Maintain a sense of humor	

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE U
Mental Health and Mental Illness

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module U – Mental Health and Mental Illness
Definition List

Anxiety – a feeling or worry, nervousness, or unease.

De-escalate – to (cause to) become less dangerous or difficult

Depression – feelings of sadness and/or a loss of interest in activities once enjoyed

Mental Health – a resident's ability to cope with and adjust to everyday stresses in ways that society accepts

Mental Illness – a disturbance in the ability to cope or adjust to stress; behavior and function are impaired; mental disorder, emotional illness, psychiatric disorder

Module U – Mental Health and Mental Illness	
(S-1) Title Slide **(S-2) Objectives** 1. Explain the role of the nurse aide in the de-escalation of the resident who is agitated.	
Content	**Notes**
(S-3) Mental Health and Mental Illness • Mental health – a resident's ability to cope with and adjust to everyday stresses in ways that society accepts • Mental illness – a disturbance in the ability to cope or adjust to stress; behavior and function are impaired; mental disorder, emotional illness, psychiatric disorder • De-escalate – to (cause to) become less dangerous or difficult	
(S-4) Mental Health and Mental Illness – Importance • Great day-to-day relationships are at the heart of de-escalation • The nurse aide can come to know what is normal for particular resident and what signs resident may have that he or she is becoming agitated	
(S-5) Causes of Mental Illness • Physical factors such as illness, disability, aging, substance abuse, and chemical imbalances • Environmental factors such as weak interpersonal or family relationships • Traumatic past experiences, such as abuse • Inherited traits • Ability to cope with stress	
(S-6) Anxiety Disorders • Generalized anxiety disorder is characterized by anxiety and worry, in the absence of an imminent event • Obsessive-compulsive disorder is categorized by obsessive behavior or thoughts, which may cause an individual to repeatedly perform a behavior or routine such as washing their hands over and over • Posttraumatic stress disorder is brought on by experiencing or witnessing a traumatic event, such as a violent crime or combat in the military • Phobia is an intense, irrational fear of an object, place or situation, such as flying.	
(S-7) Mood Disorders • Depression may cause a loss of interest in activities once enjoyed, such as eating, sleeping, and work. The individual may suffer intense emotional and physical	

Module U – Mental Health and Mental Illness	
pain. If left untreated, depression may lead to suicide, especially in older adults. • Bipolar disorder is a condition in which an individual has mood swings and changes in energy levels including the ability to function. The mood swings can alternate from extreme activity (a manic episode) to periods of deep depression (a depressive episode). • Schizophrenia interferes with an individual's ability to interact with others, make decisions, think normally, and communicate clearly. Individuals who experience hallucinations may see someone or something that is not really present or hear a conversation that is not real. Individuals who experience delusions may believe that other people are controlling their thoughts.	
(S-8) Mental Health and Mental Illness – Treatment • Medication • Psychotherapy • Cognitive behavioral therapy	
(S-9) Mental Health and Mental Illness – Nurse Aide's Role • Important to recognize appropriate and inappropriate behavior and function so nurse aide can o Report inappropriate or different behavior and/or function to the nurse immediately o De-escalate behaviors • Has many chances to observe and get to know resident	
(S-10) De-escalation of a Resident Who is Agitated While Keeping Self and Others Safe • First and only objective in de-escalation is to reduce level and intensity of resident behavior so that discussion becomes possible	
(S-11 and S-12) De-escalation of a Resident Who is Agitated While Keeping Self and Others Safe • Behavior o Appear calm, centered, and self-assured even if that is not the case o Anxiety can make resident feel anxious and unsafe which can escalate aggression • Posture o Always be at the same eye level – encourage client to be seated, but if he/she needs to stand, stand up also o Keep relaxed and alert posture o Stand up straight with feet about shoulder width apart and weight evenly balanced o Avoid aggressive stances	

Module U – Mental Health and Mental Illness	
• Position self for safety o Never turn back for any reason o Maintain distance of at least two arms' lengths between self and agitated party o Place hands in front of body in open and relaxed position because this gesture appears non-threatening and positions hands for blocking if need arises • Body movement and language o Body movements indicate anxiety and will tend to increase agitation o Minimize body movements, such as excessive gesturing, pacing, fidgeting, or weight shifting o Avoid crossed arms, hands in pockets, or arms behind back since it can be interpreted as negative body language, as well as putting self at tactical disadvantage if attack occurs o Refrain from pointing or shaking finger o Refrain from touching even if some touching is generally culturally appropriate and usual in setting; cognitive disorders in people who are agitated allow for easy misinterpretation of physical contact as hostile and threatening • Facial expression o Maintain neutral facial expression o A calm, attentive expression reduces hostility • Eye contact o Maintain limited eye contact o Loss of eye contact may be interpreted as expression of fear, lack of interest or regard, or rejection o Excessive eye contact may be interpreted as threat or challenge, do not stare down resident	
(S-13) De-escalation of a Resident Who is Agitated While Keeping Self and Others Safe • Attitude o Refrain from becoming defensive even if comments or insults are directed at nurse aide; comments are not about nurse aide; the nurse aide should not defend self or anyone else from insults, curses, or misconceptions about roles or behaviors o Be respectful even when firmly setting limits or calling for help; individual who is agitated is sensitive to feeling shamed and disrespected; resident needs to know that it is not necessary to show that they should be respected; automatically treat them and all	

Module U – Mental Health and Mental Illness	
residents with dignity and respect • Tone o Use low monotonous tone of voice (normal tendency is to have a high-pitched, tight voice when scared) o Refrain from getting loud or trying to yell over screaming person; wait until resident takes a breath, then talk o Speak calmly at an average volume • Responses o Respond selectively o Answer only informational questions no matter how rudely asked, (e.g. “Why am I in this g-d place”?) – this is real information-seeking question o Do not answer abusive questions (e.g. “Why are all nurses’ a**holes”?); this sort of question should get no response whatsoever o Be honest; lying to resident to calm them down may lead to future escalation if they become aware of the dishonesty o Do not volunteer information which may further upset resident • Reasoning o If directed by nursing care plan, explain limits and rules in authoritative, firm, but respectful tone o Give choices, where possible, in which both alternatives are safe ones (for example, “Would you like to continue our walk calmly or would you prefer to stop now and come walk later today when things can be more relaxed?”) – approach is most useful with residents who do not have trouble thinking and not residents with dementia o Empathize with feelings, but not with behavior (for example, “I understand that you have every right to feel angry, but it is not okay for you to threaten me or my staff.”) – approach is most useful with residents who do not have trouble thinking and not residents with dementia o Suggest alternative behaviors where appropriate (for example, “Would you like to take a break and have a cup of coffee or some water?”) o Do not analyze or interpret how a person is feeling o Refrain from arguing or convincing o List consequences of inappropriate behavior without threats or anger – approach is most useful with residents who do not have trouble thinking and not	

Module U – Mental Health and Mental Illness	
residents with dementia o Express limitations are because of facility rather than personal – approach is most useful with residents who do not have trouble thinking and not residents with dementia	
(S-14) De-escalation of a Resident Who is Agitated While Keeping Self and Others Safe • Trust instincts; if nurse aide decides or feels that de-escalation is not working, the nurse aide should STOP and calmly call for help	
(S-15) De-escalation of a Resident Who is Cognitively Impaired While Keeping Self and Others Safe • Control the environment o Stand with feet 18 inches apart and to the side of the resident; keep a distance of 6 feet o Move others out of harm's way o Remove objects that could harm o Watch client without touching o Keep client safe • Look for meaning of the behavior and be a detective o Address feelings, not just words o Look at body language and facial expression o Given what is known about the resident, what might the behavior mean? • Check for underlying causes because all behavior has meaning o Physical or medical conditions (for example, pain, infection, hunger, medications) o Social or emotional triggers (for example, resident was startled, nurse aide with bad mood sensed by resident, losses, feeling threatened) o Environmental conditions (for example, loud and hectic area, too hot/cold, change in preferred schedule, around people resident doesn't like) • Respond in person's reality o Redirection – draw attention to another subject o Explore triggers of behavior o Engage in resident's story (for example, if resident is upset about husband who passed away years ago not coming to pick her up today, comment that the resident must really care about her husband and ask her to talk about husband)	
(S-16) Mental Health and Mental Illness – Points to Remember • Residents are more than a diagnosis	

Module U – Mental Health and Mental Illness	
o Recognize that a person with a mental illness is an individual o Every resident diagnosed with depression, anxiety, paranoia, mania or bi-polar disorder is different from all the other residents with the same diagnoses	
(S-17) Mental Health and Mental Illness – Points to Remember • All behavior has meaning – looking for the meaning behind the behavior is key • In some instances, such as a resident with dementia, the resident is not responsible for his or her behavior – resident may not be doing things on purpose • Nurse aide can lay the groundwork for successfully handling situations when resident is stressed and agitated by knowing how to communicate effectively day-to-day with resident	
(S-18) Mental Health and Mental Illness – Points to Remember • When a resident's unusual or inappropriate behavior escalates, or increases quickly and becomes more serious, resident may be a danger to self and others o Nursing care plan will include specific details about resident's condition and any special approaches to use when working with resident o An important tool to calm residents who are agitated is de-escalation • This is worth repeating: great day-to-day relationships are at the heart of de-escalation	

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MODULE V
Pain

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module V – Pain
Definition List

Pain – anything the patient says it is, occurring whenever the patient says it does

Module V – Pain	
(S-1) Title Slide **(S-2) Objectives** 1. Define pain. 2. Explain the role of the nurse aide in pain management.	
Content	**Notes**
(S-3) Pain • Margo McCaffery, a nurse and expert in the field of pain management defines pain as “anything the patient says it is, occurring whenever the patient says it does.” • Health care team does not define resident’s pain. • Most widely accepted symptom of pain is self-reported pain	
(S-4) Pain – Importance • Believing what the patient says will lead to more effective evaluation and treatment of pain	
(S-5) Pain – How Residents Might Describe Pain • Aching • Burning • Creaky • Dull • Exhausting • Gnawing • Hurting • Miserable • Nagging • Numb • Penetrating • Radiating • Sharp • Shooting • Sore • Squeezing • Stabbing • Stiff • Tender • Throbbing • Tiring • Unbearable	
(S-6) Pain – Facts • Pain may come with aging, but people do not have to live with unrelieved or unmanaged pain • Pain is significantly under-reported in nursing facilities especially among the oldest old, females, minorities and	

Module V – Pain	
the cognitively impaired; although pain can be relieved in up to 90% of cases, a significant number of nursing home residents receive inadequate or no treatment • In nursing homes, 71-83% of residents experience pain; up to 80% experience pain that interferes with activities of daily living and quality of life • Caregivers, including nurses and nurse aides, commonly underestimate pain • Under rating and under treating pain can be neglect, negligence, or even elder abuse • Nursing homes that do not manage pain properly will be cited with a deficiency by long-term care surveyors; surveyors will interview nurse aides, the caregivers who work most closely with residents, about residents' pain and how it is treated	
(S-7) Pain – Factors Effecting Reactions to Pain • Religious beliefs and cultural traditions affect pain; men and women may report pain differently; staff should consider these differences; some residents, families and staff worry about drug side effects, addiction and dependency; others fear bothering the nursing staff • Staff's religious beliefs and cultural traditions affect how they view and manage residents' pain. Resident may be in pain and staff member does not recognize it or believe it should be treated • Commonly held beliefs about opioids **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html** **https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/Opioid-Resources-Page.html** **https://www.ahrq.gov/data/infographics/opioids-impact-seniors.html**	
(S-8) Pain – Acute Pain • Temporary, lasts for a few hours, or, at most, up to six months • Usually comes on suddenly, as a result of disease, inflammation or injury • Goes away when the healing process is complete	
(S-9) Pain – Acute Pain • Serves a purpose because it warns the body of a problem that needs attention • Identifying and treating the cause of acute pain is usually possible	

Module V – Pain	
• When people are in acute pain, their discomfort tends to be obvious • In fact, acute pain can rev up the body and may cause pale sweaty skin and an increase in heart rate, respiratory rate and blood pressure	
(S-10) Chronic Pain • Considered chronic when it is long-term, lasting for six months or more • Often comes on gradually, people may have a hard time pinpointing when it started and/or describing it to others • Chronic pain serves no purpose since it continues after the healing process is complete • Diagnosing the cause of chronic pain can be difficult and may persist despite treatment • When people are experiencing chronic pain, the source of their discomfort may not be obvious to others; they may just seem depressed. This is because chronic pain can slow down the body, causing a decrease in both heart rate and blood pressure	
(S-11) Pain – Common Causes • Arthritis • Cancers • Headache pain • Ischemic pain • Neuropathic pain • Osteoporosis and associated fractures • Pain associated with contractures • Pain from other medical causes including ulcer disease, urinary tract infection, angina, constipation • Phantom limb pain • Physical therapy • Pressure sores • Recent surgeries • Wound dressing changes	
(S-12) Pain – Effects • Giving up hope • Depression • Anxiety • Withdrawal • Decrease in or loss of appetite • Decrease in activities • Inability to sleep	
(S-13) Pain – Effects • Restlessness/agitation	

Module V – Pain	
• Refusal to participate in activities of daily living • Refusal to participate in treatment programs • Thoughts of suicide/suicide • Negative effect on immune system • May be higher risk for injuries, accidents or falls	
(S-14) Pain – Use of Medications • Nurse aide reports complaints of pain to nurse so nurse can assess pain and medicate if appropriate	
(S-15) Pain – Nurse Aide Role in Pain Management • Nurse aides play an important role in pain management • Nurse aides are at the bedside and often the people most likely to notice when a resident is acting differently or showing signs of pain • Nurse aides' personal relationships with residents can be helpful in pain management • Nurse aides should take an active role in pain management • Pain should be controlled or alleviated whenever possible	
(S-16) Screening of Pain: When to Ask Residents About Pain • During personal care • During transfers and ambulation • Following activities • At appropriate times after pain management therapies	
(S-17) Screening of Pain: What to Ask Residents About Pain • Are you in pain, uncomfortable, hurting? • Where is the pain? Ask the resident to point to area • When did the pain start? • How long does the pain last; how often does it occur? • How bad is the pain? Pain scales: use the one available at facility (examples – 0-10 Numeric Rating Scale, Wong-Baker Faces Pain Rating Scale) • Does pain come and go? • Have you had this pain before? What helped relieve it? • Do you remember what you were doing when the pain started?	
(S-18) Comfort Measures – Nurse Aide's Role • Supportive talk • Gentle touch • Music • Soft lighting • Decreased noise	

Module V – Pain	
(S-19) Comfort Measures – Nurse Aide's Role • Warm or cold packs (if approved by nurse) • Massage • Re-positioning • Soothing activities • Prayer and spiritual support	
(S-20) Comfort Measures – Nurse Aide's Role • Listening and conversation • Favorite foods or drinks • Help with personal cleanliness • Reminiscing • A walk	
(S-21) Care of the Resident Who is Cognitively Impaired and Who is in Pain • Observe for signs (listed as most frequent occurring to least frequent occurring) o Change in facial expression, especially grimacing o Restless body movement o Change in behavior based on individual o Moaning o Tense muscles o Agitation o Combative/angry (pulls away when touched) • Report what is observed to the nurse immediately • When you find something that works, let the nurse and other nurse aides know • Work as a team with other staff members	

Handout #1V Myths/Misconceptions Regarding Pain

- Acknowledging chronic pain is a sign of personal weakness
- Chronic pain is a punishment for past actions
- Chronic pain means death is near
- If you take a narcotic for pain, death must be near
- If there is not a reason for pain, then the pain is all in one's head
- Chronic pain always indicates the presence of a serious disease
- Acknowledging pain will lead to a loss of independence
- Discuss the opioid epidemic
- Older adults, especially the cognitively impaired, have a higher tolerance for pain
- Older adults, especially the cognitively impaired, feel less pain.
- Older adults and the cognitively impaired cannot accurately self-report pain
- Residents in long-term care say they are in pain in order to get attention
- Older adults are likely to become addicted to pain medication
- Pain management is a form of chemical restraint
- Once you start pain medications, you always have to increase the dose
- Healthcare providers do an adequate job of providing adequate pain control
- A resident who is sleeping is not in pain
- A resident who is watching television or laughing with visitors is not in pain
- Alterations in vital signs are reliable indicators of pain in a patient
- Unrelieved pain is a part of getting older. The older adult just needs to learn to live with pain
- Chronic pain may inconvenience older adults, but will do them no real harm

State-approved Curriculum
NURSE AIDE I TRAINING PROGRAM

MODULE W
End of Life Care

Student Manual
Version 1. Full Text

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
NCDHHS is an equal opportunity provider and employer.

Module W – End of Life Care
Definition List

Acceptance - the final stage of grief (in response to near death) when person has worked through feelings and understands that death is imminent

Advance Directive – a living will written while resident is mentally competent or by resident's legal representative which outlines choices about withdrawing or withholding life-sustaining procedures, if terminally ill

Anger – the second stage of grief (in response to near death) when person expresses rage and resentment; often upset by smallest things; lashes out at anyone

Apnea – respiration stops

Bargaining – the third stage of grief (in response to near death) when person tries to arrange for more time to live to take care of unfinished business; bargains with the doctors or God

Cheyne-Stokes Breathing – when resident takes several shallow breaths followed by periods of no breathing for 5, 30, or even 60 seconds; does not cause the resident discomfort

Death – the end of life and cessation of bodily functions

Denial – the first stage of grief (in response to near death) when a person is told of impending death; person may refuse to accept diagnosis or discuss situation

Do Not Resuscitate (DNR) – an order written by a doctor at the request of a resident, which tells the health care team that the resident does not wish any extraordinary measures to be used when resident suffers cardiac or respiratory arrest

Depression – the fourth stage of grief (in response to near death) when person begins the process of mourning; cries, withdraws from others

Dying – the near end of life and near cessation of bodily functions

End of Life Care – support and care provided during the time surrounding death

Extraordinary Measures – interventions used to restore heart beat or respiratory effort (cardiopulmonary resuscitation or CPR)

Five Stages of Grief – stages of grief in response to near death, based on personal, cultural and religious beliefs and experiences, according to Elizabeth Kubler-Ross

Hospice Care – health care agency or program for people who are dying (usually less than six months to live) that provides comfort measures and pain management, preserves dignity, respect and choice, and offers empathy and support for the resident and the family

Mottling – changes in skin color (pale and bluish) of the hands, arms, feet, and legs when death is near

Obituary – a description (typically placed in a local newspaper) of a resident's life, including listing of relatives, birth information, accomplishments/activities, and death, written upon the death of the resident

Post Mortem Care – care of the body after death

Module W – End of Life Care	
(S-1) Title Slide **(S-2) Objectives** 1. Describe the nurse aide's role in end of life care. 2. Describe cultural differences in dealing with end of life. 3. Examine own feelings about the end of life.	
Content	**Notes**
(S-3) End of Life Care and Key Terms • Defined – support and care provided during the time surrounding death; may last days, weeks, or months • Terminal illness – an illness or injury from which the person will not likely recover; a terminal illness ends in death • Dying – the near end of life and near cessation of bodily functions • Death – the end of life and cessation of bodily functions • Post mortem care – care of the body after death	
(S-4) Obituary • A description (typically placed in a local newspaper) of a resident's life, including listing of relatives, birth information, accomplishments/activities, and death, written upon the death of the resident	
(S-5) Death • Death is natural conclusion to life • Death may be sudden and unexpected or expected • Resident's response to death is based on personal, cultural and religious beliefs and experiences; affects both emotions and behavior • A nurse aide's feelings about death affect the care given • Because nurse aides are often the caregiver closest to the resident, the nurse aide must understand the dying process and know how to react and approach the resident with care, kindness, and respect	
(S-6) Grief • Grief – deep distress or sorrow over a loss; a dynamic and personal process • The dying resident and family may pass through five stages of grief, according to Dr. Elizabeth Kubler-Ross • Five stages of grief are denial, anger, bargaining, depression, and acceptance • Each person may experience stages at different rate or time; some may stay in one stage until death; others may bounce back and forth between stages • May not even be possible for person to pass through	

Module W – End of Life Care	
stages if death is fast or unexpected • Nurse aide's role – understand the stages; do not take anger personal; listen and be ready to assist	
(S-7) 1st Stage – Denial • Begins when people are told of impending death; may refuse to accept diagnosis or discuss situation; may believe that a mistake was made and demands that lab work be repeated; may act like it is not really happening; the "no, not me" stage	
(S-8) 2nd Stage – Anger • Expressions of rage and resentment; normal and healthy reaction; often upset by smallest things; lashes out at anyone; begins to face possibility of upcoming death; may be angry because of the healthy lifestyle maintained throughout life; the nurse aide may be the target of anger, but must not take it personal; the "why me" stage	
(S-9) 3rd Stage – Bargaining • Person tries to arrange for more time to live to take care of unfinished business; bargains with the doctors or God; this stage is usually private and spiritual; the "yes me, but…." stage	
(S-10) 4th Stage – Depression • Person begins the process of mourning; cries, withdraws from others; may be becoming weaker and symptoms are worsening; may lack the strength to do simple things; will need additional assistance with physical care and emotional support; the "yes me" stage; nurse aide needs to demonstrate understanding and a willingness to listen	
(S-11) 5th Stage – Acceptance • Person has worked through feelings and understands that death is imminent; is calm, at peace, and accepts death; may or may not make it to this stage before death; this is the stage that the person begins to get affairs in order – financial and personal; may make plans for the care of others and pets; may plan for the funeral; reaching this stage does not mean death is imminent	
(S-12) Advance Care Planning • Choices an individual makes about the medical care the individual would want to receive if he/she suddenly became incapacitated and could not speak for his/herself; choices are based on personal values, preferences and discussions with loved ones	
(S-13) Advance Directive • Patient Self-Determination Act (PSDA) and the Omnibus Budget Reconciliation Act of 1987 (OBRA) give persons	

Module W – End of Life Care	
the right to accept or refuse treatment; also give persons the right to make advance directives; also requires that health care facilities that receive Medicare/Medicaid funds give residents who are newly admitted information about their rights related to advance directives • Advance directive – legal documents that allow people to decide what kind of medical health care they wish to have in the event they cannot make those decisions themselves • Includes living wills and durable powers of attorney • Can be changed or cancelled at any time by the person • Legally, the nurse aide must honor advance directives	
(S-14) Advance Directives Documents • Living will – a document that outlines the medical care a person wants or does not wants in case the person cannot make those decisions; living will must be written while resident is mentally competent or by resident's legal representative • Durable Health Care Power of Attorney – a signed, dated, and witnessed legal document that appoints someone to make healthcare decisions for the person in the event he/she cannot do so	
(S-15) Do Not Resuscitate (DNR) • A choice of the resident • A medical order that instructs medical professionals not to perform cardiopulmonary resuscitation (CPR) if the person no longer has a pulse and/or is breathing • Tells health care team that the resident does not wish any extraordinary measures to be used if resident suffers cardiac or respiratory arrest; extraordinary measures – interventions used to restore heart beat or respiratory effort (cardiopulmonary resuscitation or CPR) • Typically written for o A person with a terminal illness o A person who almost certainly could not be saved if CPR was initiated • Legally, the nurse aide must honor the resident's DNR order and not initiate CPR	
(S-16) Physician Orders for Life-sustaining Treatment (POLST) • Doctor's order stating what treatments are to be used when person is very sick • Includes medical measures the resident wants to receive and not those to be withheld	

Module W – End of Life Care	
• Based on conversations between the resident and the doctor – beliefs, goals, diagnosis, prognosis, and options (that include benefits and detriments for each option); decisions become medical orders	
(S-17) Hospice Care • Health care agency or program for people who are dying (usually less than six months to live) • Purpose is to improve the quality of life for a person who is dying • Provides comfort measures and pain management • Preserves dignity, respect and choice • Offers empathy and support for the resident and the family • Works with staff as well as resident and family	
(S-18) Palliative Care • In hospice care, goals are the resident's comfort and dignity • Type of care given to residents who are dying that focuses on relieving pain, controlling symptoms, and minimizing side effects and complications • Nurse aide's role – be a good listener, respect privacy and independence, individualize care, be aware of own feelings and stress nurse aide may feel • Nurse aide must take care of self to provide palliative care to others	
(S-19) End of Life Care – Importance • Most people die in hospitals or long-term care facilities • A nurse aide's feelings about death affect care given • A caring, kind, and respectful approach helps the resident who is dying and family	
(S-20) End of Life Care – Nurse Aide's Feelings About Death • Nurse aide must recognize and deal with own feelings and attitudes toward death in order to provide essential support to residents who are dying • Many factors influence attitudes, such as age, personal experiences, culture, and religion • First encounters with death and dying can be frightening • Nurse aide can use co-workers as support system for dealing with the experience	
(S-21) Environmental Needs of The Resident Who is Dying • Keeping resident's environment as normal as possible o Room – well lighted and well ventilated	

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o Open drapes and door o Play resident's favorite music	
(S-22) Physical Needs of The Resident Who is Dying • Positioning o Place resident in most comfortable position for breathing and avoiding pain o Maintain body alignment o Change resident's position frequently to avoid pressure ulcers • Cleanliness o Providing skin care, including back rubs o Bathe and groom resident frequently to promote self-esteem • Mouth and Nose o Clean sores or bleeding in mouth following Standard Precautions o Provide oral care as needed. Cover lips with thin layer of petroleum jelly o Check for difficulty swallowing or choking o Gently clean nose o Offer drinking water as often as possible • Nutrition o Offer resident's favorite foods; include liquids or semi-liquids o Offer foods frequently and in small amounts o A balanced diet is not a primary concern • Elimination o Keep the resident's skin and linen clean o Provide perineal care as often as necessary	
(S-23) Emotional And Psychological Needs Of A Resident Who is Dying and the Family • Identify incidents that affect resident's moods; note behavior changes and report to nurse immediately • Approach resident and dying process with dignity • Respect each resident's idea of death and spiritual beliefs • Offer support/understanding • Respect resident preference regarding solitude or interaction • Use touch where appropriate • Listen to resident and family • Communicate with resident, even if non-responsive; identify self and explain everything being done • Be aware of resident's sensitivity to what is being said/ability to hear when other senses diminish	

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• Be guided by resident's attitude • Present a positive attitude and provide positive physical and emotional care • Give resident and family privacy, but not isolation • Spend time with the resident even when not providing care. • Do not take anger directed at you personally • Be supportive • Respect the resident's and family's spiritual beliefs • Encourage family members to participate as much as they can	
(S-24) End of Life Care – Culture and Religion • Culture and religion provide framework within which personal experiences with death take on meaning • Personal experiences, culture, religion, and age influence resident's individual set of beliefs in ways that may differ from nurse aide's personal beliefs about death • Nurse aide must not impose beliefs upon the resident who is dying, the family, or those people close to the resident who is dying	
(S-25) End of Life Care – Culture and Religion • It is important for team to discover specific, cultural issues in order to provide respectful care to resident who is dying • Individuals from different cultures appreciate being asked about practices. Health care team may ask: o Who is allowed to provide personal care? (In some cultures, a member of the opposite sex cannot provide care) o Does the resident or family have any special customs? o Are there specific post mortem customs that the staff should know? • Some cultures believe dying at home is preferable while others fear death at home • Chinese culture o Traditional healing practices include using herbal preparations given only once o Autopsy and disposal of body are not permitted by religion; therefore, organ donation encouraged o Japanese culture – number four means death, so getting medication four times a day could be problematic • Vietnamese culture o Believe in reincarnation, so quality of life is more	

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important than length of life • Hindu culture o Persons are often accepting of God's will o Desires to be clear-headed at time of death o Prayer helps deal with anxiety and conflict o Blood transfusions, organ transplants, and autopsies are allowed o Cremation is preferred o Believes in reincarnation	
(S-26) Feelings and Responses By The Resident's Family, Friends And Other Residents During The Dying Process • Realize that even if the dying process is prolonged, staff and the family may not be prepared for the actual moment of death • Staff may be shocked or surprised when death actually happens; these feelings are normal • Recognize variety of feelings/responses may be displayed – guilt, anger, sadness/depression, avoidance, denial, acceptance, relief • Listen empathetically • Demonstrate caring, interested attitude • Observe for changes in other residents (such as signs of depression, etc) and report/record appropriate information.	
(S-27) Impending Death: Signs That the Resident is Within Hours or Days of Death and Should be Reported to Nurse • Psychological and physical withdrawal • Decreased level of alertness, with increased periods of sleeping • Body temperature rises o Feels cool, looks pale, and perspires • Circulatory system fails o Pulse is fast or slow, weak and irregular o Blood pressure drops o Extremities become cold and pale, mottling occurs (bruise-like discoloration • Respiratory system fails with erratic breathing patterns occurring o irregular, rapid and shallow or slow and heavy o Cheyne-Stokes breathing – when resident takes several shallow breaths followed by periods of no breathing for 5, 30, or even 60 seconds; does not cause the resident discomfort	

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o Noisy respirations o Mucus collects in airway, a rattling or gurgling sound as the resident breathes (what some people refer to as “death rattle”) o Apnea – respiration stops • Digestive system – slows down o Distention of abdomen o Fecal incontinence due to relaxed muscles o Nausea and vomiting • Urinary system o Dark-colored urine in very small amounts due to decreased blood supply to the kidneys o Incontinence due to relaxed muscles • Muscle tone o Starting in the feet and legs movement and muscle tone are lost o Eventually mouth muscles relaxes and jaw sags; o Body becomes limp • Sensory – sensory perception decline o Blurred and failing vision; may stare yet not respond, lack of blinking; o Touch is diminished o Hearing is believed to be the last sense to be lost o Pain decreases with loss of consciousness	
(S-28) Death: Signs That the Resident has Died; Notify Nurse Immediately • Notify the nurse immediately • No pulse/heartbeat • No respirations • No blood pressure • Pupils are fixed (do not respond to light) and dilated (big) • No response when resident is talked to or touched • Eyelids may remain opened; enlarged pupils that do not respond to changes in light • Mouth may remain open • May have bowel and bladder incontinence	
(S-29) Nurse Aide’s Role in Performing Postmortem Care • Defined – care of the body after death and is done to maintain a good appearance of the body • Begins when resident is pronounced death • Consult with nurse to find out if o Dentures are inserted or left out and placed in denture cup	

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o If rings are removed and secured per policy or left on o The family wants to view the body • Within 2 to 4 hours after death, rigor mortis develops; important to position in normal alignment before rigor mortis occurs • Understand that because post mortem care involves movement of the body, air may escape from the lungs and expelled from the intestines causing sounds to be heard; do not let these sounds scare you as they are normal and to be expected • Wash body and comb hair; put on gown and cover perineal area with a pad • Position body in supine position, legs straight and arms folded across abdomen with one pillow under head • Each facility has its own policy regarding post mortem care; nurse aides must follow this policy and perform only tasks delegated to them	
(S-30) Nurse Aide's Role – Care of the Family After Death • Show family members to a private place to sit where they can talk privately • Inquire if there is anyone that they would like called • Provide water or a beverage • If family members would like to visit with the deceased, provided privacy and close door quietly; do not rush family • Nurse aides respond differently to the death of a resident; may not know what to say; may cope with stress by talking too much; the nurse aide should offer support without talking too much; listen patiently when family members want to talk and do not interrupt • What to say? Key is to be sincere and understand that a simple, "I'm sorry" is enough; avoid the non-therapeutic response of "she is in a better place" or "it is for the best"; the nurse aide could possibly say something like "your mom will be missed here" if it is true, this response is both kind and supportive	

Activity #1W How Do I Feel?
Self-Inventory of Attitudes About Caring for Residents who are Dying

Directions for Students

Purpose: In this activity, you will answer questions that will help you understand more about your feelings about caring for residents who are dying. The better you understand your own responses to death and loss, the better you will be able to deal with patients and families experiencing death and loss. Regardless of the type of nursing you plan to do, you will have patients who die. This activity will help prepare you to care for residents who are dying.

Instructions: Work individually on this activity. Read the self-inventory and mark the number that most describes your feelings about the statement. Total your score and compare it to the scoring scale

Application: After scoring your self-inventory, write a paragraph about your strengths and weaknesses in caring for dying patients based on the following:

- What experiences in your life have given you insight into loss?
- What experiences have given you a desire to avoid being near others who are grieving?
- How will you draw on and overcome these experiences to care for residents who are dying?
- Hand in your paragraph to your instructor

LEARNING ACTIVITY #1W – How Do I Feel?
Self-Inventory of Attitudes Toward Caring for Resident who is Dying

Place a checkmark in the space that corresponds to your feelings about each statement.

Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
I am afraid to care for a resident who is dying.					
I am very uncomfortable around people who are sad or crying.					
I do not want to touch a resident who is dying.					
A resident who is dying should be left in peace, not given usual nursing care such as bathing and turning.					
Residents who are terminally ill should not be told that they are dying.					
If I cry around residents who are dying or their families, I am not being professional.					
I am afraid to go into the room after a resident has died.					
If one of my residents were to die unexpectedly, I would feel that I must have made an error in care.					
I don't want residents who are dying to talk to me about their feelings; it makes me feel frightened.					
I am afraid that I might have to care for children or young adults who are dying.					
TOTAL					

Scoring the self-inventory:

- Give yourself 5 points for every answer marked Strongly Agree.
- Give yourself 4 points for every answer marked Agree.
- Give yourself 3 points for every answer marked Undecided.
- Give yourself 2 points for every answer marked Disagree.
- Give yourself 1 point for every answer marked Strongly Disagree.

Interpreting the score:

- Scores of 41-50 indicate that you have a great deal of anxiety about caring for residents who are dying.
- Scores of 31-40 indicate that you are unsure and slightly anxious about caring for residents who are dying.

- Scores of 21-30 indicate that you are fairly confident in your ability to care for residents who are dying.
- Scores of 10-20 indicate that you are quite confident in your ability to care for residents who are dying.

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MODULE Z
THREADS OF CARE

Student Manual
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North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section

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Module Z – Threads of Care – Complete Bed Bath	
Objectives • Promote increased comfort, good health, and hygiene. • Demonstrate how to bathe a resident who is confined to bed.	
Content	**Notes**
Cognition • Explain to resident in terms resident understands what care nurse aide is going to provide • Be aware that residents with cognitive impairments may resist bathing • Be aware that residents with cognitive impairments may require special measures • Reinforce nurse aide measures for the cognitively impaired so removal of clothes does not cause resident fear	
Infection Prevention • Always follow Standard Precautions • Always wash from clean to dirty • Wash eyes and face first; wash perineal area and buttocks last • Dry all areas well including between fingers and toes • Use clean area of washcloth for each stroke during perineal care • Change bath water and wash cloth if they become dirty • Make sure bed linens are dry and wrinkle free when bath is completed • Good hygiene prevents body odors and infections • Exercise caution with all tubing connected to resident	
Legal • Nurse aides who leave residents dirty may be liable for abuse and neglect • While bathing resident, be observant and report any discolorations, bruising, or abrasions immediately to the nurse • Follow facility policies and procedures	
Safety • When rolling a resident to wash resident's back, side rails should be up on opposite side of bed • When rolling a resident, be aware of position and placement of resident • Use comfortable water temperature for resident - usually between 110°F and 115°F (Fahrenheit (43.3°C and 46.1°C [centigrade]) for adults. • Check water temperature by using the nurse aide's wrist	

Module Z – Threads of Care – Complete Bed Bath	
and ask resident to check water by placing hand in water, if able • Return bed to lowest position when bathing is complete or when leaving room • Place call bell within reach of resident • Clean spills immediately and thoroughly	
Ethics • It is easy to avoid a full bed bath and leave it for someone else because it is time consuming • Do not avoid nail care and foot care as part of bath • Treat care given during the bed bath in the same manner as you would like to be treated • Only the nurse aide may know if the bed was left damp or wrinkled	
Dignity • Expose only 1 body area at a time • Keep resident appropriately covered at all times • Always provide care in a manner to protect resident's privacy • Be respectful even if resident is soiled to decrease embarrassment for the resident • Ask resident to participate in bathing process • Encourage resident to do as much of their care as possible • If resident is able to wash his or her perineal area, offer to leave room, if applicable • Be respectful, courteous, and explain what you are doing at all times	
Rights • The resident has the right to privacy • The resident has the right to be treated with respect • The resident has the right to compassionate care • The resident has the right to good hygiene • The resident has the right to refuse a bath • Respect resident preferences and cultural differences	
Communication • Use positive approach • Address resident concerns and explain the need for good hygiene • Offer reassurance • Offer choices of skin/hair products and use what the resident prefers • Communicate with the resident and repeat explanations as needed	

Module Z – Threads of Care – Complete Bed Bath	
Family and Family Support • Encourage family participation as appropriate according to resident preference	
Appropriate Anatomy and Physiology • Appropriate hand and foot care is encouraged to soften thickened, hardened nails • Elderly residents have less muscle and fatty tissue • Skin becomes thin, fragile and dry with aging • Incontinence increases risk for pressure sores • Residents on bed rest are prone to pressure sores • Bathing helps stimulate circulation • Use gentle downward strokes on the legs to promote circulation • Some residents, due to thin, fragile, dry skin, may not bathe every day • Resident's joints are fragile and may be painful with movement	
Body Mechanics • Raise bed to safe, comfortable working level • Keep resident's body in proper alignment when turning • Avoid stretching across resident • Ask for assistance when moving a large resident	
Pain • Exercise caution when turning residents • Stop bathing the resident if there are complaints of pain • Report complaints of pain to the nurse immediately and document per facility policy • Support joints when bathing resident's limbs to prevent pressure or pain	
Person-centered Care • Encourage resident to be involved in bed bath as appropriate • Perform bed bath based on resident needs and cultural considerations • Keep resident covered to provide warmth and privacy • Honor resident's wish and give bed bath at requested time of day • Meet resident's elimination needs prior to bath	
Documentation • Report to nurse and document any abnormal changes noted in resident's skin such as color, texture, bruises, cuts, tears, drainage, swelling, foul odors • Report corns, calluses, skin tears or breakdown between toes on feet	

Module Z – Threads of Care – Complete Bed Bath	
Critical Thinking • Stop the bed bath and immediately report any signs of pain	
Employee Behavior • Follow facility policies and procedures • Show empathy to the resident that may be experiencing emotions during the bed bath	

Module Z – Threads of Care – Dressing and Undressing	
Objective • Demonstrate assistance in dressing and undressing a resident while maintaining the resident's dignity and independence.	
Content	**Notes**
Cognition • Some residents dress and undress themselves; others need extensive help due to illness or a cognitive impairment, such as dementia • Check with residents who dress independently to see if they need assistance • Residents with dementia may not want or remember how to change clothes; for residents with dementia, encourage resident to choose from two to three outfits; change clothes at the same time every day; encourage resident do as much as resident is able to do; stack clothes in the order that the resident will put them on so resident sees only one item at a time	
Infection Prevention • Clothing must be changed on a regular basis and when wet or soiled • Clothing laundered on routine basis • Follow Standard Precautions when clothing is soiled with body fluids • If resident is receiving intravenous fluids (an IV), do not disconnect or remove any part of IV set-up	
Legal • Do not use one resident's clothing for another resident – considered misappropriation of resident's property (theft) • Poor hygiene, which includes condition of clothing, can be considered neglect	
Safety • Clothing should be in good repair and fit appropriately. • Report garments that need repair, such as missing buttons, tears, worn areas or garments too long, to appropriate person	
Ethics • Never dress resident in wet or soiled clothing; use clothing that is dry and clean	
Dignity • Provide for privacy • Do not expose resident • Encourage resident to dress in street clothes during the day and night clothes at night	

Module Z – Threads of Care – Dressing and Undressing	
Rights • Personal choice is a resident right; encourage resident to choose what to wear • Treat residents' clothing carefully – may have clothing that means a lot to them or cultural importance, such as a special sweater knitted by a granddaughter • Encourage resident to do as much as possible when dressing and undressing • Do not rush resident through process; may take longer but helps maintain independence and gain or regain skills	
Communication • This is a good time to talk with the resident about whatever is on their mind; you can begin conversation by talking about clothes • Often conversation about family is a good place to start • Might inquire about plans for the day	
Family and Family Support • Encourage family members to participate in changing clothes with resident's permission	
Appropriate Anatomy and Physiology • Dressing and undressing can increase muscle strength and stimulate circulation	
Body Mechanics • Support arms or legs of resident when removing or putting on clothing • There are assistive devices that help residents to dress	
Pain • Stop dressing or undressing resident if resident complains of pain • Be gentler and/or check with nurse to see if resident takes pain medication, if it is chronic pain • Report to nurse immediately if pain is new	
Person-centered Care • Resident's wishes about clothes should be sought and followed • Focus on relationship rather than task	
Documentation • Make sure that an inventory of the resident's personal clothing is documented	
Critical Thinking • People with dementia may not want to or cannot remember how to dress and undress • For a resident with dementia, clothes can be stacked so	

Module Z – Threads of Care – Dressing and Undressing	
that only one item is seen at a time by the resident	
Employee Behavior • Show pacing and patience when assisting resident to dress or undress • Be cautious of nonverbal signs of nurse aide's own impatience	

Module Z – Threads of Care – Pericare	
Objective • Demonstrate perineal care while observing sound infection prevention principles.	
Content	**Notes**
Cognition • Explain what nurse aide is planning to do and why in terms resident understands	
Infection Prevention • Follow Standard Precautions • For the female, wiping front to back reduces infection risk • For the male, wiping in a circular motion from tip to base reduces infection risk • This is a good opportunity to observe for any redness, swelling or rashes • Be acutely aware of odor; some infections of perineal area present with a distinctive odor; and if noted, report to nurse and document	
Legal • Because perineal care involves touching genital and anal area, obtain person's consent for procedure	
Safety • Locking bed wheels is important as female resident, in particular, will roll from side to side; males roll somewhat to remove protective pad • Be sure side rails are up during procedure • Be sure to leave side rails to their beginning position, once procedure is completed • Hot water can burn delicate tissue; water is usually 105 to 109 degrees; test water with bath thermometer or inside of wrist	
Ethics (program-specific content)	
Dignity • Always provide privacy, especially during perineal care • Remember nurse aide is working with a person's most private areas	
Rights • The resident has right to have a clean perineal area • The resident has a right to have adequate privacy during procedure • The resident has the right to refuse perineal care	
Communication • Conversation about other topics during cleaning process may help resident to get through the procedure	

Module Z – Threads of Care – Pericare	
• Be attuned to nonverbal cues	
Family and Family Support • Family should be asked to leave room until procedure is completed unless resident requests their presence	
Appropriate Anatomy and Physiology • The urethra is longer in the male and shorter in the female. As a result, urinary tract infections are more likely in female. • Urinary tract infections, while less likely in males, are possible • The front of the perineal area is cleaner than the back of the perineal area • The male foreskin may be present or not present, usually due to circumcision	
Body Mechanics • Raise bed to a comfortable working height • Lower side rail on the side where nurse aide is working • Raise the head of the bed slightly for comfort of resident during procedure	
Pain • Often these areas have skin folds that may have not been lifted or moved in a long time. If so, there may be pain. Proceed with caution • Should pain be evident, report to nurse and await further instructions as to whether or not to proceed	
Person-centered Care • Remember this is one of the most embarrassing procedures to endure; be mindful of need for privacy; have empathy for this moment in time • Respect resident's desire to have someone else present during procedure • Respect and honor preferences, if possible • Some people are comfortable with conversation during procedure and others may want to be quiet; read non-verbal and honor preference	
Documentation • Document if any redness, rash, unusual odor, discharge or pain is present • Also, document if none were found	
Critical Thinking • It is important to learn what a normal pericare procedure consists of, so that should anything abnormal occur, the nurse aide stops the procedure – a decision nurse aide would make	

Module Z – Threads of Care – Pericare	
Employee Behavior • Not all humans are formed alike; just as noses and eyes differ, so do perineal areas differ • Healthcare employees are bound by ethics as well as law to not talk about findings from a pericare experience • Because this is such an uncomfortable procedure for most residents, act in a professional manner at all times	

Module Z – Threads of Care – Making an Occupied Bed	
Objectives • Discuss the variety of beds that may be encountered in differing work settings. • Demonstrate proper bed making technique that promotes physical and emotional well-being. • Demonstrate how to operate a bed.	
Content	**Notes**
Cognition • Explain what nurse aide is planning to do and why in terms resident understands	
Infection Prevention • Always adhere to infection prevention principles • Clean or dirty linen/pillow should never touch nurse aide or nurse aide's uniform • Do not shake linen because it could shake germs into the air • Never transfer linen from one room to another • Never place linen on floor • Change bed linens as soon as they become soiled or wet o Wear gloves when you change, carry, and discard in correct container o Roll linen up during linen change so that dirty side is inside o Carry soiled linen away from clothes	
Legal • Facility policies always describe care procedures, including changing sheets to minimize risk of pressure injuries. • Nurse aides who leave residents in soiled beds may be liable for abuse and neglect • Before removing linen, check linen closely for resident belongings, such as dentures, glasses or jewelry	
Safety • Use side rails per facility policy or doctor's orders • Place call bell within reach of resident after linen is changed • Make sure bed is locked and in low position after linen is changed	
Ethics (program-specific content)	
Dignity • Always keep resident appropriately covered • Be respectful when changing soiled linens to decrease embarrassment for resident	

Module Z – Threads of Care – Making an Occupied Bed	
Rights • Give prompt and compassionate care • Provide care in such a way as to protect resident's privacy	
Communication • Address resident's concerns and reassure as needed	
Family and Family Support • Respond positively to family requests for additional linen needs • Encourage family participation as appropriate	
Appropriate Anatomy and Physiology • Resident's skin may be fragile so clean, dry, tight fitting, wrinkle-free linens are needed	
Body Mechanics • Use proper body mechanics • Good body mechanics are required and a violation of facility safety policy if not used • Get help if resident needs assistance in moving or is very large	
Pain • Exercise caution when moving frail residents • Notify nurse if resident complains or shows signs of pain	
Person-centered Care • Consider resident's bed making preferences when possible. As an example, some people do not like their sheets tucked in at the bottom	
Documentation (program-specific content)	
Critical Thinking • Report to the nurse any changes or unusual findings, such as blood on linens	
Employee Behavior • Follow agency policies and procedures • Making a bed in a health care facility is different from how one makes a bed at home	

Module Z – Threads of Care – Foot Care	
Objectives • Foster good resident care by providing quality foot care. • Demonstrate foot care consistent with current nursing standards.	
Content	**Notes**
Cognition • People with dementia may require special measures to meet foot care needs	
Infection Prevention • Areas between toes can harbor microorganisms if not kept clean and dry • Never apply lotion between the toes of a resident with diabetes • Never share equipment between residents • Dirty feet, socks or stockings harbor microbes, cause odors, and lead to infection • An injury to the foot would be a point of entry for infection	
Legal • For a resident who has diabetes, an infection can lead to a severe wound or amputation if the skin is broken	
Safety • NEVER cut or trim toenails; notify nurse if they need trimming • Check nursing care plan for possible diabetic diagnosis • Smooth, short nails help prevent injury • If an injury occurs during foot care, report it immediately • Feet can burn easily because an older resident cannot feel hot temperatures • Never apply lotion between the toes of a resident with diabetes	
Ethics • It is easy to avoid foot care and leave it for next shift	
Dignity • Clean feet can contribute to a resident's sense of well-being	
Rights • Residents have a right to refuse foot care • Residents have a right to clean feet	
Communication • Use positive approach to encourage resident to agree to foot care	
Family and Family Support • Encourage family participation as appropriate according to resident preference	

Module Z – Threads of Care – Foot Care	
• Use lotions or nail polish provided by the family during foot care	
Appropriate Anatomy and Physiology • Poor circulation prolongs healing if there are cuts or nicks around nails • Thickened, hardened nails sometimes come with aging; nails can be softened by soaking in warm water • There is decrease in feeling or sensation in toes as part of aging process; diseases may contribute to this loss such as diabetes	
Body Mechanics • Perform skill in a comfortable position for both the resident and the nurse aide	
Pain • Stop foot care immediately if resident complains of pain; complaints of pain should be reported to nurse and documented immediately	
Person-centered Care • Do foot care based on resident's schedule and needs • Check agency policy for use of nail polish during foot care • Provide information to resident and family regarding opportunities for professional pedicures in the facility • Some people are ticklish when it comes to their feet	
Documentation • Document anything unusual that happens during foot care and per facility policy • Report and record reddened, irritated or calloused areas, breaks in skin, corns, very thick nails and loose nails as well as any changes to the feet	
Critical Thinking • Observe and report any changes in foot condition to nurse	
Employee Behavior • Follow facility policies and procedures.	

Module Z – Threads of Care – Fingernail Care	
Objective • Foster good resident care with attention to fingernails. • Demonstrate nail care consistent with current nursing standards.	
Content	**Notes**
Cognition • People with dementia may require special measures to meet nail care needs	
Infection Prevention • Fingernails collect and harbor microorganisms; microorganisms may cause infection, injuries and odors • Never share fingernail equipment between residents	
Legal • An injury to the hand during fingernail care can be considered neglect	
Safety • Be sure skin surrounding nails is not cut or nicked; nail files can tear fragile skin around nails • Check nursing care plan for possible diabetic diagnosis; never cut nails of a resident with diabetes • Smooth, short nails help prevent injury • If an injury occurs during nail care, report it immediately to nurse	
Ethics • It is easy to avoid nail care and leave it for the next shift	
Dignity • Cleaning and filing nails may improve resident's self-esteem and sense of well-being	
Rights • Residents have a right to refuse nail care. • Residents have a right to clean nails	
Communication • Use positive approach to encourage resident to agree to nail care	
Family and Family Support • Encourage family to participate in nail care with the permission of the resident	
Appropriate Anatomy and Physiology • Nail growth is slower, and skin becomes thinner and more fragile as part of aging process • Poor circulation prolongs healing if there are cuts or nicks around nails • Thickened, hardened nails sometimes come with aging; nails can be softened by soaking in warm water; softened	

Module Z – Threads of Care – Fingernail Care	
cuticles can be pushed back with an orangewood stick • There is a decrease in feeling or sensation in fingertips as part of aging process as well as diseases processes such as diabetes	
Body Mechanics • Perform skill in a comfortable position for both the resident and nurse aide	
Pain • Stop nail care immediately if resident complains of pain; complaints of pain should be reported to the nurse and documented immediately	
Person-centered Care • Do nail care based on resident's schedule and needs • Check agency policy for use of nail polish during nail care • Provide information to resident and family regarding opportunities for professional manicures in facility	
Documentation • Document anything unusual that happens during nail care and per facility policy	
Critical Thinking • Observe and report any changes in nail condition to nurse, such as splitting or discoloration	
Employee Behavior • Follow facility policies and procedures	

Module Z – Threads of Care – Mouth Care	
Objective • Describe the importance of good mouth care. • Identify items needed for mouth care based on resident ability and need. • Demonstrate mouth care of the unconscious resident in a competent and safe manner. • Identify the level of assistance needed for denture care. • Demonstrate alternative methods to use with cognitively impaired residents.	
Content	**Notes**
Cognition • Some residents may provide their own mouth care with minimal assistance; others need extensive help due to illness or cognitive impairment • Residents with dementia may not want or remember how to do their mouth care • Promoting as much independence as possible improves resident's overall condition • Explain to resident in terms resident understands what the nurse aide is planning to do and why • Residents who have dementia may have specialized mouth needs and require special measures based on their cognitive status • Cognitively impaired residents may not understand commands but may understand if given a toothbrush • When providing mouth care for the resident who does not understand – provide simple, step-by-step instructions ("Your teeth need cleaning." "Please open your mouth.") • Redirect a resident with dementia during mouth care by talking with resident; singing or playing music; providing a favorite food or drink; and gentle touching or light massage (rub shoulders or arm while talking slowly and calmly) • When providing mouth care to a resident with dementia: know the resident; approach from the front; get permission first; focus on the person, not the task; listen for clues about the person's needs; encourage participation; give simple step-by-step directions; explain each step beforehand; be patient and repeat if necessary; give positive feedback and encouragement; use gentle touch and reassurance; and establish a routine with the same caregiver	
Infection Prevention • Mouth care is not about grooming, but a vital part of infection prevention and health promotion	

Module Z – Threads of Care – Mouth Care	
• Bacteria from plaque buildup can infect other parts of the body, especially the lungs • Aspiration of plaque bacteria is one of the most common causes of pneumonia in residents living in nursing homes • Use a toothbrush with soft bristles because hard bristles can scratch the teeth and injure gums creating more places for bacteria to grow • Wash the nurse aide's and the resident's hands, before and after mouth care • Observe Standard Precautions • Change clothing if it becomes wet or soiled during mouth care • Be aware that body fluids carry microorganisms which may cause an infection • It is important to clean dentures every day because bacteria and yeast can grow on them and infect gums • It is important to clean all other surfaces of dentures (and not just the teeth part) that come in contact with gums and roof of mouth because of bacteria and yeast • When mouth care and/or denture care is/are completed, disinfect work surface, discard gloves, and wash hands • Isolation – always wear gloves; wear gown and mask as directed; set up supplies outside; take in only supplies to be used with the resident; and disinfect self when care is completed	
Legal • Follow facility policies and procedures • Poor mouth care by facility staff may lead to a charge of neglect	
Safety • The nurse aide should exercise caution against putting fingers into a resident's mouth; use interdental brush or go-between when flossing between a resident's teeth • Always keep fingers on outside of teeth when providing mouth care for a resident with dementia; consider using a rubber handled toothbrush to provide a prop to keep mouth open • Be aware of choking possibility on unconscious resident; never put any quantity of liquids into unconscious resident's mouth; be prepared to perform relief of choking • Unconscious residents should be placed in a lateral position prior to mouth care • Exercise caution when handling dentures as they may easily break	

Module Z – Threads of Care – Mouth Care	
• Exercise caution when providing mouth care to a cognitively impaired resident as they may bite down very hard on toothbrush or swallow toothpaste • Dipping the toothbrush in water works just as well as applying toothpaste; there is less chance of the person coughing or choking with water • Resident who needs assistance with mouth care may have a hard time cooperating and not want the nurse aide to touch mouth; may resist the care and hit, bite, and/or spit at nurse aide • Foam action of toothpaste can cause resident to cough or choke so avoid use with resident with swallowing problems • To prevent aspiration for a resident who has trouble with spitting or swallowing, sit resident up and use a very small amount of liquid (because there will be very little to spit), and dry mouth with gauze pad • Because toothpaste uses the swish and spit technique, toothpaste should not be used with people who cannot follow directions well or have advanced dementia or stroke • It is important to identify loose teeth and report to supervisor immediately because loose teeth can fall out and be swallowed or inhaled into lungs • Always store dentures submerged in cool water in a denture cup and away from direct sunlight and heat; dentures allowed to dry out or are placed in direct sunlight or next to a heat source can cause the dentures to change shape and then fit poorly in resident's mouth	
Ethics • Assist with mouth care in the same manner you would like to be treated • Only you as a nurse aide know how well you performed the mouth care	
Dignity • It is important to support a resident's ability to do as much of mouth care as possible by watching the resident and helping as needed – especially with early stage dementia (set up supplies, assist to sink or set up over-bed table, and prompt with step-by-step instructions) – the nurse aide can go back and brush areas missed ("Let me help you out.") • Good mouth care can make people feel better every day by not just improving health but also the resident's quality of life; when the mouth is clean, food tastes better	

Module Z – Threads of Care – Mouth Care	
• Be aware that some residents are self-conscious without their dentures • Time mouth care so it doesn't interfere with activities and visitors • Dentures need to be clean and in place before resident dines • Use a clothing protector to prevent drops of water or toothpaste on clothing • Talk to the resident even if the resident is unconscious	
Rights • Resident has a right to receive good mouth care • Respond appropriately to a resident's request to assist in their own care	
Communication • To begin mouth care, greet the resident and explain what is to be done • Make conversation with residents even if resident does not talk • Do not ask resident questions while doing mouth care, if resident's mouth is open and teeth are actively being brushed • Give short and clear verbal cues to prompt resident • Speak clearly, slowly and directly with face-to-face contact when possible; sit down as appropriate • Refrain from using childish gestures when assisting with mouth care • Watch for non-verbal cues indicating the resident's need to spit during mouth care • Behavior happens for a reason; the behavior of a resident with dementia during mouth care is a form of communication – it is the resident's way of telling the nurse aide that he/she needs something because of the inability for the resident to communicate with words	
Family and Family Support • Ask family if resident has a routine or any special preferences to time of mouth care	
Appropriate Anatomy and Physiology • Good mouth care can prevent serious illnesses, such as pneumonia and heart disease and improve diabetic control and nutrition, leading to a reduced incidence of hospitalization and death • Incidences of pneumonia are greater among residents who receive poor mouth care • Assistance with mouth care is often hard to provide for	

Module Z – Threads of Care – Mouth Care	
the resident because many older adults do not have perfect teeth; they may have broken teeth and/or may have appliances, such as dentures • For many older residents, swallowing is difficult, so the nurse aide must be particularly conscious of encouraging residents to spit when necessary • Ability to taste may diminish with age, but a healthy mouth promotes a healthy appetite • Mouth care consists of brushing the teeth or dentures, gums, tongue, and caring for the lips • An unconscious resident may be able to hear the aide's communication during mouth care • An unconscious resident's mouth may become dry	
Body Mechanics • Sit at resident's eye level if possible when providing mouth care to the conscious resident • Adjust bed to a safe comfortable level of the nurse aide when providing care to the unconscious resident	
Pain • When the nurse aide first starts brushing a resident's teeth, may see such things as food debris, thick deposits on teeth/tongue and gums that bleed when teeth are brushed; if it has been a while since resident has had appropriate mouth care, the resident may experience pain and have gums that bleed • A broken tooth may be quite painful when touched; use a cotton tip swab instead of a toothbrush to clean broken teeth • Report pain or signs of discomfort associated with mouth care to the nurse • Report any evidence of improper fitting dentures	
Person-centered Care • Be courteous and mindful of resident's wishes at all times • Some residents may prefer to sleep in their dentures while others may wish for them to soak overnight • Determine individual preferences for mouth care – when (morning/bedtime; before a meal/after a meal) and how often (once a day/several times a day) • Goal for quality mouth care is to be easy/rewarding for nurse aide and comfortable/pleasant for the resident receiving care; must be individualized and person-centered • Adjust type of care based on needs – toothless, full dentures, partial dentures, loose tooth, swallowing	

Module Z – Threads of Care – Mouth Care	
problems, or tube feeding • Mouth care can be an opportunity to build a positive relationship; focus on the person as an individual and not a task • Mouth care is all about the relationship between the nurse aide and the resident; when getting started with mouth care – focus on the relationship and connecting with the resident • Individualize care – every resident is different; mouth care techniques that work for one resident with dementia may not work for another resident with dementia; plus what worked yesterday with a resident, may not work today for that same resident • Some residents feel strange when others brush their teeth; feel nervous when a toothbrush comes towards their mouths that is being held by others; and may feel discomfort as their teeth are being brushed	
Documentation • Document per facility policy • Accurate documentation may impact medical plan of care and nutritional status of resident	
Critical Thinking • Observe and report any abnormalities in the mouth during mouth care such as swollen reddened gums, loose teeth, yellow or white spots, pus, coated tongue • Recognize that cognitively impaired residents may perceive mouth care as a threat • When deciding which mouth care product to use, refer to facility policy and also consider the person's ability and needs • Adjust type of care based on needs – toothless, full dentures, partial dentures, loose tooth, swallowing problems, or tube feeding • In order to assist a resident to be successful with their ability to perform self-care, the nurse aide needs to figure out what the resident can do through observation, then support that ability, and then assist as needed • Sometimes the nurse aide must think like a detective to determine the meaning behind behavior for the resident with dementia and what is being communicated by the resident **–** must be flexible and patient to figure out the resident's needs and how best to meet them	
Employee Behavior • Follow facility policies and procedures	

Module Z – Threads of Care – Mouth Care
• It is important for the nurse aide to schedule mouth care based on individual needs and preferences of each resident and not on the nurse aide's schedule • Use gentle touch if received well by resident • Report any changes in mouth or dentures to nurse

Module Z – Threads of Care – Handwashing	
Objective • Demonstrate proper handwashing technique according to CDC guidelines. • Explain hand hygiene. • Identify when to wash hands.	
Content	**Notes**
Cognition • Explain to resident in terms resident understands what care nurse aide is going to provide • Be aware that residents with cognitive impairments may resist bathing • Be aware that residents with cognitive impairments may require special measures • Reinforce nurse aide measures for the cognitively impaired so removal of clothes does not cause resident fear	
Infection Prevention • Handwashing is the single most important thing you can do to prevent the spread of disease • Washing hands with soap and water is the best way to reduce and remove germs • **<u>Use soap and water when hands are visibly dirty or soiled</u>** with blood, body fluids, secretions, or excretions • How to wash hands: o Wet hands using warm water o Point fingers down and keep lower than wrists Ask students, why they think this is important. Want germs gliding down hands into sink instead of running up wrists and arms? o Use friction (rubbing hands together, interlacing finger, scratching palms, washing wrists to produce a good lather,) to help rub off germs o Scrub hands a minimum of 20 seconds, using soap and water, per CDC recommendations Ask students, how long is 20 seconds? Require them to watch the second hand on the clock for 20 seconds OR, hum the Happy Birthday Song, two times OR, sing Old McDonald Had a Farm (including 1 animal with sounds) • **<u>Use hand rub if hands are not visibly soiled</u>** • If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol. Alcohol-based hand sanitizers can quickly reduce the number of germs on hands in some situations, but sanitizers do not eliminate all types of germs, such as	

Module Z – Threads of Care – Handwashing	
norovirus • How to use hand sanitizer: o Apply the product to the palm of one hand o Rub hands together o Rub the product over all surfaces of hands and fingers, and around nails, until hands are dry • When performing handwashing or using hand sanitizer: • Keep fingernails short and clean • Do not wear artificial/acrylic/fashion/gel nails, nail extensions/enhancements/tips or wraps, because they can hide harmful germs • Consider removing jewelry because harmful germs hide in crevices and around stones • Lotion may be applied after washing, to keep hands soft and skin intact (not chapped or cracked); use unscented type o When at work, only use facility provided lotion; some lotions make medicated soaps less effective and some lotions break down latex • According to an article published in July 2018 by the American Department of Agriculture (USDA), 97% of Americans wash their hands incorrectly. The CDC has identified areas most missed during handwashing were the finger-tips, finger-webs, the palms, and the thumbs	
Legal • There may be legal consequences if certain cases of facility acquired infections can be traced back to poor hand hygiene	
Safety • If you splash water when you wash your hands, clean it up	
Ethics • Sometimes only you will know if you washed your hands	
Dignity (program-specific content)	
Rights • Residents have a right to cleanliness	
Communication • Let residents know when you wash your hands • Encourage and assist residents to wash hands frequently	
Family and Family Support • Remind family the importance of handwashing	
Appropriate Anatomy and Physiology • Certain diseases may alter one's risk of infection, for	

Module Z – Threads of Care – Handwashing	
example open wounds, surgical incisions, cancer • The elderly are at a higher risk of infection and often have weakened immune system as a result of aging and/or chronic illnesses.	
Body Mechanics • Use good body mechanics when washing hands	
Pain (program-specific content)	
Person-centered Care (program-specific content)	
Documentation • Is supporting evidence that handwashing was performed to help prevent infection and reduce cross contamination while providing care to residents at increased risk for infection or who are critically ill or immunocompromised	
Critical Thinking • Use good judgment when choosing between soap and water and alcohol-based hand rubs • Anticipate resident's need to have hands washed	
Employee Behavior • Adhere to facility polices and procedures related to handwashing and hand hygiene products	

Module Z – Threads of Care – Personal Protective Equipment (PPE)	
Objectives • Demonstrate proper use of PPE, including putting on and taking off gloves, gowns, and masks to prevent transmission of disease. • Explain how to implement Standard Precautions in the work setting.	
Content	**Notes**
Cognition • Explain the purpose of PPE to the resident in terms the resident can understand • Reassure the confused resident why the nurse aide is using PPE	
Infection Prevention • PPE helps protect both the resident and the nurse aide from potentially infectious materials by breaking the chain of infection at the mode of transmission link • Four key points to remember about use of PPE – first, always put it on before contact with resident, preferably before entering room; second, even though nurse aide is wearing PPE, care must be taken not to contaminate skin or clothes; third, after completing care, be very careful when removing PPE; fourth, always wash hands after taking off PPE • To take off PPE safely, nurse aide must know what is considered clean and what is contaminated o Areas that are considered contaminated or dirty are outside front and sleeve of the gown, outside front of the mask, and outside of the gloves o Areas that are considered clean are the parts that will be touched when removing PPE; clean areas include inside the gloves, inside and back of the gown plus the ties, and the ties or elastic ties. • Gloves are most common type of PPE that nurse aide will wear while working at a long-term care facility • Gloves – description o Two types of gloves that nurse aides wear – sterile and non-sterile (clean); nurse aide wears non-sterile (clean) gloves o Gloves come in different sizes o Gloves are made using different materials, such as vinyl or latex; if allergic to latex, wear non-latex gloves • Gloves – rules o Gloves should be worn once and then thrown away o When wearing gloves, always work from (or touch) a clean area, before touching contaminated (or dirty) area	

Module Z – Threads of Care – Personal Protective Equipment (PPE)	
o Change gloves if hands are going to move from body part that is contaminated (dirty), to a body part that is not contaminated (clean) o Change gloves right away if they get dirty or tear o Take gloves off very carefully and do not touch skin or clothes with dirty sides of gloves o Do not touch anything with dirty gloves that anyone may touch without gloves, like a doorknob o The fit should be comfortable – not too loose or not too tight • Gown – description o The gown is made of liquid-resistant material • Gown – rules o Gowns should be worn once and discarded immediately after use o Gown should be changed right away if it gets wet, dirty, or tears o Take gown off very carefully and do not touch skin or clothes with dirty sides of gown o Do not leave the resident's room until gown is removed • Mask - rules o Masks should be worn only once and discarded immediately after use o Masks should fit snugly over mouth and nose o Change mask right away if it gets wet, dirty, or tears o Take mask off very carefully and do not touch skin or clothes with dirty side (outside) of the mask o Do not leave resident's room until mask is removed	
Legal • There may be legal consequences if certain cases of facility acquired infections can be traced back to Standard Precautions not being followed	
Safety • Appropriate use of PPE's protects the resident as well as the nurse aide	
Ethics • Use Standard Precautions for all people regardless of diagnosis • Sometimes no one will know but you if you washed your hands after removing gloves	
Dignity • Realize that PPE may be dehumanizing, humiliating and intimidating to residents, therefore important for nurse aide to recognize this and consider resident's feelings	

Module Z – Threads of Care – Personal Protective Equipment (PPE)	
when PPE is in use	
Rights – not applicable • Residents have a right to cleanliness	
Communication • Explain and reassure why nurse aide is using PPE	
Family and Family Support • Reinforce nurse's instruction about PPE with the family • Notify the nurse if family does not follow PPE order	
Appropriate Anatomy and Physiology • Certain diseases may alter one's risk of infection, for example open wounds, surgical incisions, cancer • The elderly are at a higher risk of infection and often have weakened immune system as a result of aging and/or chronic illnesses	
Body Mechanics (program-specific content)	
Pain (program-specific content)	
Person-centered Care (program-specific content)	
Documentation • Check nursing care plan for transmission-based precautions that require use of PPE	
Critical Thinking • Relate use of PPE to breaking the chain of infection	
Employee Behavior • Follow facility policies and procedures • The nurse aide is responsible for knowing where to locate and how to apply and remove PPE	

Module Z – Threads of Care – Measuring and Recording Vital Signs	
Objectives • Discuss the importance of accurate measurement of vital signs of residents. • Demonstrate correct measurement and recording of vital signs.	
Content	**Notes**
Cognition • Explain to resident in terms the resident understands what nurse aide is planning to do and why • Be aware that residents with cognitive impairments may require special approaches	
Infection Prevention • Sanitize blood pressure cuff, stethoscope, and electronic thermometer between residents, per facility policy	
Legal • It is illegal if the nurse aide records a guess or writes down a value near or equal to a previous vital sign obtained by someone else, when the nurse aide is unsure of the value obtained	
Safety • Place call bell within reach of resident after procedure is done • Nurses and doctors make decisions based on the assumption that vital sign readings are accurate • Vital signs are important methods used to monitor condition of or functioning of resident's organs	
Ethics • Vital signs may be difficult to obtain on some residents, so never guess	
Dignity • Avoid opinionated comments about vital sign values	
Rights • Provide care in such a way as to protect resident's privacy • The resident has a right to refuse having vital signs taken	
Communication • Address resident's concerns and reassure as needed	
Family and Family Support • Refer questions from family members to nurse	
Appropriate Anatomy and Physiology • Checking vital signs is an important task for nurse aide and is a vital indication of resident's condition and any changes in condition • When one or more of resident's vital signs are too high or too low, a potential health problem may be occurring	

Module Z – Threads of Care – Measuring and Recording Vital Signs	
• Being aware of normal and abnormal vital sign variations is important	
Body Mechanics (program-specific content)	
Pain • Pain is sometimes referred to as the fifth vital sign, so it is important to observe and report routinely • Any complaints of pain associated with taking of vital signs should be reported to nurse	
Person-centered Care – program-specific content	
Documentation • Ensure that nurse aide follows facility policy on documentation of vital signs	
Critical Thinking • Report any changes or unusual findings in any of the vital sign values obtained • The nurse aide must understand difference among different ways to check a resident's vital signs • Use a blood pressure cuff appropriate to size of resident's arm	
Employee Behavior • The nurse aide must always be truthful and accurate when reporting and recording vital sign values	

Module Z – Threads of Care – Measuring and Recording Height and Weight	
Objective • Discuss the importance of accurate height and weight measurements of residents. • Demonstrate correct measurement and recording of height and weight.	
Content	**Notes**
Cognition • Explain to resident in terms resident understands what nurse aide is planning to do and why	
Infection Prevention (program-specific content)	
Legal (program-specific content)	
Safety • Place call bell within reach of resident after procedure is done • Assist resident when stepping on and off scales	
Ethics (program-specific content)	
Dignity • Maintain a professional attitude while weighing a resident • Refrain from commenting on weight of resident or teasing about the weight amount, no matter how much or how little the resident weighs • Be respectful, courteous, and explain what you are always doing	
Rights • Provide care in such a way as to protect resident's privacy	
Communication • Address resident's concerns and reassure as needed	
Family and Family Support (program-specific content)	
Appropriate Anatomy and Physiology • Report weight loss or gain, no matter the amount, immediately to the nurse • Loss of weight may indicate dehydration or malnutrition • Gains in weight may indicate retention of fluid • For height, some residents cannot straighten due to contractures and nurse aide is required to follow curvature of resident's body with a tape measure and add the inches	
Body Mechanics • Use proper body mechanics • Get help if resident needs assistance in moving or is	

Module Z – Threads of Care – Measuring and Recording Height and Weight	
large	
Pain (program-specific content)	
Person-centered Care • Provide privacy during weighing because a person's reaction to weighing may vary from person to person and it is often a personal matter	
Documentation • Follow facility policy on documentation of weight and height	
Critical Thinking • Report any changes or unusual findings, such as weight loss or gain to nurse • Convert units of measurements within household system • Convert common units of measurements between household and metric system	
Employee Behavior • Follow agency policies and procedures	

Module Z – Threads of Care – Collecting Routine Urine Specimen	
Objective • Demonstrate collecting a routine urine specimen following the rules of medical asepsis.	
Content	**Notes**
Cognition • Explain what nurse aide is planning to do in terms resident understands • Make sure the resident understands by getting him/her to verbalize understanding	
Infection Prevention • Follow Standard Precautions • Do not touch inside of specimen cup or the lid • Do not place specimen container on over-bed table • Assist resident to wash hands after urine is collected • Never place urine specimen in a refrigerator that is used for food	
Legal • Nurse aide should label and take specimen to designated place promptly	
Safety • Clean spills immediately and thoroughly per facility policy	
Ethics • No one else may know if the nurse aide forgot and left the specimen sitting in the resident's bathroom for 4 hours	
Dignity • Always provide privacy during collection and transportation of specimen • Never comment on the odor of concentrated urine	
Rights • The resident has a right to privacy during the procedure • The resident has a right to refuse collection of a routine urine specimen • The resident has a right to be informed as to why the specimen is needed	
Communication • Reinforce nurse's instructions regarding urine collection • Reinforce the chosen method of collection and why medical asepsis is important	
Family and Family Support (program-specific content)	
Appropriate Anatomy and Physiology • Keep catheter bag below bladder to prevent flow of urine	

Module Z – Threads of Care – Collecting Routine Urine Specimen	
back into bladder • Some medications may change color of urine • Some urine may have a strong odor • Some urine may have particles of sediment floating in it • Remember the anatomy of males and females may require nurse aide to vary the technique needed to accurately collect urine specimen	
Body Mechanics (program-specific content)	
Pain • Complaints of pain while voiding should be reported to nurse	
Person-centered Care • Be mindful of need for privacy • If assistance is needed, be considerate of resident wishes • Be courteous and respectful of resident wishes at all times	
Documentation • Label specimen according to facility instructions • Document any abnormal findings, such as cloudy or dark urine, blood or mucus in urine, strong offensive or fruity smelling urine	
Critical Thinking • Residents with cognitive impairment may require repeated instructions • Residents with cognitive impairment may require additional assistance • Be alert for signs resident does not understand collection procedure and reinforce instructions as needed • A change in appearance of urine should be reported to nurse since this may signal other health problems	
Employee Behavior • Treat resident with empathy, even when extra patience is needed • Prevent resident embarrassment by acting in a professional manner • Accuracy in collecting a urine specimen is critical since treatment plans may be based on findings	

Module Z – Threads of Care – Assisting with Use of Bathroom and Measuring and Recording Urinary Output	
Objective • Demonstrate the proper technique when assisting with the use of the bathroom, bedside commode, bedpan and urinal. • Accurately measure and record urinary output.	
Content	**Notes**
Cognition (program-specific content)	
Infection Prevention • After elimination, all equipment should be rinsed, dried and returned to storage using Standard Precautions • Be aware that body wastes, both urine and feces, carry microorganisms, which may cause infection • Raised toilet seats, urinals, and bedpans should be labeled with the name of the user • NEVER place ANY elimination equipment on the over-bed table	
Legal • To ignore a resident who has expressed a need to eliminate is neglect and abuse • If someone is injured attempting to go to bathroom on their own, this may be neglect	
Safety • The fracture pan is safely used for those who cannot raise their hips to use a regular bedpan • The regular bedpan is higher on the sides and requires extra caution for safety • Raised toilet seats on the bathroom commode can assist the resident in getting up and down; handrails make the use of a raised seat safer • Those who can walk to the bathroom may still need assistance; being in bed for long periods may cause weakness on rising and sometimes dizziness • Always return bed and side rails to original position once elimination is complete • Use disinfectant and odor neutralizers with caution • Residents must be kept clean and dry	
Ethics • Long periods of time spent on bedpans, holding a urinal, or sitting on a commode can be harmful in many ways and is to be avoided • Only the nurse aide knows if a resident is left in a wet bed	

Module Z – Threads of Care – Assisting with Use of Bathroom and Measuring and Recording Urinary Output	
Dignity • Privacy is paramount in all methods of assisting with elimination • Most times, the resident attempting elimination would like to be alone • Treat the resident as an adult; don't use childish words; use proper words for bodily functions and outcomes • Remember, residents may be embarrassed at needing assistance with elimination • Always be professional and neutral when assisting with any of the types of elimination • Pads and briefs are available for adults who are incontinent • It is important to realize how residents feel about having to be assisted with elimination, when all their life, they have been able to do that for themselves • Those who are incontinent may be embarrassed; be careful what is said when assisting with incontinence cleanup	
Rights • The resident has a right to assistance with elimination in a manner appropriate to their condition • The resident has a right to privacy during elimination • Per the Minimum Data Set (MDS), any time a resident's skin or anything touching a resident's skin is wet from urine, this is counted as an episode of incontinence (cite the law)	
Communication (program-specific content)	
Family and Family Support • Often resident does not want the family present during elimination • Often family does not want to be present during elimination • Abide by resident preference related to family involvement • Remind the family if the resident is on output	
Appropriate Anatomy and Physiology • Factors that may cause normal changes in urine qualities include foods and food dyes, medications, vitamins and food supplements • Factors that may affect urination are aging, psychological factors, fluid intake, medications, and diseases	

Module Z – Threads of Care – Assisting with Use of Bathroom and Measuring and Recording Urinary Output	
• Incontinence is not a normal part of aging • Urine is irritating to skin and should be washed off immediately	
Body Mechanics • When residents can move with assistance, but cannot walk to bathroom, consider a portable, bedside commode • Use good body mechanics to assist resident to commode and back to bed • When offering bedpan or urinal, raise bed to a comfortable working height; be sure side rails are up	
Pain • Any complaints of pain upon elimination should be reported to nurse	
Person-centered Care • It is important to ask about preferences of elimination assistance; do not just choose a bedpan when resident might be able to use bedside commode • Examine how you would feel in any elimination situation and, using empathy, treat those in your care as you would like to be treated • Ask what you can do to help rather than just helping; for example, offer toilet paper rather than just using it quickly yourself	
Documentation • Document measured amount according to facility policy • The quality of output should be documented with any episode of elimination	
Critical Thinking • Notify nurse of abnormal urine, color, odor or amount • Prioritizing the need of a resident to eliminate may sometimes need to be done over your work plan of bed making, etc.	
Employee Behavior (program-specific content)	

Module Z – Threads of Care – Providing Catheter Care and Emptying Urinary Drainage Bag	
Objective • Demonstrate catheter care. • Empty urinary drainage bag. • Promote good health and hygiene.	
Content	**Notes**
Cognition • Explain what nurse aide is planning to do and why in terms resident understands	
Infection Prevention • Follow Standard Precautions. • Clean only in one direction and wipe away from meatus • Clean at least four inches of indwelling catheter nearest the meatus • Use a clean area of the cloth for each cleaning stroke • This is a good opportunity to observe for any redness, swelling or rashes • Be acutely aware of abnormal odor; and if noted, report to nurse and document • Place a barrier on the floor under the graduate measuring device • Do not let the tube emptying the urine touch the graduate • Use an alcohol wipe to clean drain clamp prior to replacing it in its holder • Clean graduate and store it according to agency policy • Catheter bag should always be kept below bladder to prevent flow of urine back into bladder	
Legal • Because catheter care involves touching genital area, obtain person's consent before performing procedure	
Safety • Water temperature should be no higher than 105 degrees; test water with bath thermometer or inside of nurse aide's wrist • Have resident check water temperature and verify comfort	
Ethics (program-specific content)	
Dignity • Always provide privacy • Remember you are working with a person's most private areas and residents from various cultures may react differently	

Module Z – Threads of Care – Providing Catheter Care and Emptying Urinary Drainage Bag	
• Never comment on the odor of concentrated urine	
Rights • The resident has a right to cleanliness • The resident has a right to be free from odors and potential harmful bacteria • The resident has a right to have adequate privacy during the procedure • The resident has the right to refuse catheter care	
Communication • Be aware of nonverbal actions both from resident and nurse aide • Tell resident when you are going to touch the resident	
Family and Family Support • Family should be asked to leave room until procedure is completed unless resident requests their presence	
Appropriate Anatomy and Physiology • Residents with catheters are at increased risk of urinary tract infections; urethra is longer in the male and shorter in the female; as a result, urinary tract infections are more likely in a female • If the male has not been circumcised, the foreskin should be pulled back, so the meatus can be cleaned around the base of the catheter • Urine should normally be light or pale yellow and clear without a foul odor • Some medications may change the color of urine • Urine contains waste products removed from body	
Body Mechanics • Raise the bed to a comfortable working height • Lower the side rail on the side where the nurse aide is working • Raise the head of the bed slightly for the comfort of the resident during the procedure	
Pain • Be aware of the sensitivity of this area of the body • Should pain be evident, report it to nurse	
Person-centered Care • This can be embarrassing for resident • Be mindful of the need for privacy • Demonstrate empathy during procedure • Respect resident's desire to have someone else present during procedure • Respect and honor preferences, if possible	

Module Z – Threads of Care – Providing Catheter Care and Emptying Urinary Drainage Bag	
Documentation • Document any abnormal findings such as pain, cloudy or dark urine, blood or mucus in urine, strong offensive or fruit smelling urine, and report to nurse immediately	
Critical Thinking • The nurse aide should know the implications of washing the catheter in a careful thoughtful manner so not to pull on the catheter	
Employee Behavior • Nurse aides should act in a professional manner while performing catheter care	

Module Z – Threads of Care – Assisting with Dining/Feeding Resident and Measuring and Recording Intake	
Objective • Describe the food groups according to www.choosemyplate.gov. • Recognize components of special diets that may be served to residents. • Describe the importance of sound nutrition. • List ways to identify and prevent dehydration and malnutrition. • Demonstrate how to serve meal trays, between-meal snacks and assist with dining to a variety of residents, with different needs, including use of adaptive devices. • Demonstrate documentation of intake. • Identify intake items that are considered fluids.	
Content	**Notes**
Cognition • Emotions affect eating • Remember that mealtime is a sociable event and should be a pleasurable experience; mealtime is just not a time to eat, but is also a social activity • Providing meals in an environment that encourages and enhances the eating process is beneficial to all residents • Residents that are easily distracted during meals should not be isolated from the rest of the residents; however, they may eat better in a quieter part of the dining room • Resident with dementia may require special measures to meet their nutritional needs • Residents with Alzheimer's disease may have specialized nutritional needs based on their cognitive and physical status o Resident with Alzheimer's sometimes has little awareness of food in mouth and to remind resident to chew, nurse aide may gently move resident's chin or touch the tongue with a fork or spoon o To stimulate swallowing, gently stroke resident's throat o Nurse aide assisting the resident with eating should sit at the resident's level, make eye contact, and talk with resident during meal o Consistency in meal times and seating arrangements will assist in promotion of resident's independence and may decrease behavioral issues during meal service • Dementia may lead to decreases in food and fluid intake o Resident does not realize hunger or thirst o Reduced sense of smell and taste o Difficulty swallowing o Resident does not recognize eating utensils	

Module Z – Threads of Care – Assisting with Dining/Feeding Resident and Measuring and Recording Intake	
o Resident cannot feed self o Loss of coordination o Depression o Resident is restless and unable to remain seated during meals • Water is not the only fluid available to residents; some residents may not like water and should be offered alternative fluids, such as o Milk o Juices o Decaffeinated drinks (tea, coffee, soft drinks) o Popsicles o Ice cream o Gelatins o Fruit o Soups o Broths • Observe residents for the following warning signs to eliminate or minimize mealtime difficulties o Change or difficulty in swallowing or chewing o Poor utensil use o Refusal of food and drinks • Nurse aide must report any changes in resident's ability to feed self, chew, swallow and circumstances surrounding the change to nurse	
Infection Prevention • Wash the nurse aide's and the resident's hands, before and after meal • Never put dirty equipment or supplies, such as bedpans, urinals or specimens on the over-bed table • Be careful not to contaminate ice as it is scooped from ice machine. Store scoop in appropriate place	
Legal • Follow facility policies and procedures	
Safety • Be aware of choking possibility during feeding; be prepared to perform relief of choking • Check mouth for pocketed food; make sure resident has swallowed before offering more food • Use spoon with small amounts when feeding resident • If resident needs it, cut food into small portions • Utilize safe food handling practices throughout the day, for example do not allow resident to save food for later at the bedside if food should be refrigerated, such as	

Module Z – Threads of Care – Assisting with Dining/Feeding Resident and Measuring and Recording Intake	
mayonnaise-based foods • Position residents properly • Do not rush residents through meals and be patient with residents • Check for right resident, right meal tray	
Ethics • Treat resident's tray as you would like yours treated • Don't eat resident's leftover food or outside food brought in by family intended for resident	
Dignity • Be aware that food and eating preferences differ • Time procedures so they don't interfere with mealtimes • Don't do things for residents that they can do for themselves • Dentures need to be clean and in place before resident dines • Respect residents' mealtime rituals • Use the term "clothing protector" instead of bib; respect resident's wishes regarding clothing protector	
Rights • Resident has a legal right to make choices about food • Respond promptly to resident's request for beverages; ignoring a request for a drink may be neglect	
Communication • Say positive things about the food • Make conversation with residents even if resident does not talk • Give short and clear verbal cues to prompt resident to feed self • Speak clearly, slowly and directly with face-to-face contact when possible; sit down as appropriate • Refrain from using childish gestures when feeding residents, for example, "here comes the airplane" • Tell blind residents where food is located using face of an imaginary clock	
Family and Family Support • Check with the nurse before the resident eats food brought in from home, if the resident is on special diet • Reinforce special diet guidelines with family members	
Appropriate Anatomy and Physiology • It is easier for the resident to choke on thin liquids than on thick liquids • Thickening improves ability to control fluid in the mouth	

Module Z – Threads of Care – Assisting with Dining/Feeding Resident and Measuring and Recording Intake	
and throat of residents with swallowing problems; check with the nurse for specific residents' needs • Ability to taste, smell and recognize thirst may diminish with age	
Body Mechanics • Sit at resident's eye level when feeding resident	
Pain • Report pain associated with eating or drinking to nurse	
Person-centered Care • Offer a trip to the bathroom or help with toileting prior to eating • Residents should be clean and well groomed before dining • Oral care should be performed before and/or after, per resident's preference • Be mindful of cultural and religious considerations related to nutrition	
Documentation • Document quantity of the resident's food and fluid intake per facility policy and procedure • There are a variety of methods for documenting nutritional intake on the resident's medical record; follow facility procedure • Accurate documentation impacts medical plan of care and nutritional status of resident	
Critical Thinking • Fluids are usually measured in milliliters (mL); ounces (oz) are converted to milliliters; to convert ounces to milliliters, multiply by 30	
Employee Behavior • Follow facility policies and procedures • Promoting healthy eating is important part of the nurse aide's job	

Module Z – Threads of Care – Range of Motion Exercises	
Objective • Document the maintenance and/or improvement of resident's range of motion • Demonstrate active and passive range of motion	
Content	**Notes**
Cognition • ROM often gives hope of improvement in resident's current physical condition, thereby many times also improves individual's mental attitude • Promoting independence improves resident's overall condition	
Infection Prevention • Observe Standard Precautions	
Legal • Must have a doctor's order, of course, but it is a team approach across the entire caring team • When using Passive ROM, the nurse aide should always check nursing care plan for guidance • Causing pain during range of motion can be considered abuse	
Safety • It is important to be sure bed or wheelchair brakes are locked • No more or no less ROM is used than is ordered and found in nursing care plan • Do not exercise a joint that has a dressing, cast, or special tubing • Do not exercise a joint with skin abnormalities	
Ethics • As always, the treatment is between you and the resident • Perform care per facility guidelines and nursing care plan	
Dignity • Privacy is important and should be maintained • Care should be taken to drape bed linen for privacy, exposing only body part being exercised	
Rights • The resident has a right to refuse	
Communication • Each joint movement should be explained to resident before beginning	
Family and Family Support • Family may be trained by nurse to provide ROM • Reinforce the nurse's instructions on providing ROM to family and on the complications of immobility	

Module Z – Threads of Care – Range of Motion Exercises	
Appropriate Anatomy and Physiology • Complications of immobility can be permanent • Support of ROM joint during the procedure is vital	
Body Mechanics • It is important to position the bed or wheelchair in a comfortable position for both nurse aide and resident	
Pain • No ROM exercise should produce pain • If pain is encountered, the exercise should be discontinued immediately, and pain should be reported to nurse	
Person-centered Care • Encouraging resident to do own active ROM exercises is possible and desirable • Performing own exercises increases resident's self-esteem	
Documentation • Be sure to document, per facility policy, that ROM exercises were performed per nursing care plan • It is important to document any reports of pain by resident	
Critical Thinking • Stop exercise if any joint pain occurs	
Employee Behavior (program-specific content)	

Module Z – Threads of Care – Transferring from Bed to Wheelchair	
Objective • Demonstrate the proper technique of transferring a resident in a safe, competent manner, from a supine position, to an upright position in a wheelchair.	
Content	**Notes**
Cognition • Explain to resident in terms the resident understands what nurse aide is planning to do and why • Older adults require extra time and assistance during transfer • Residents may fear falling and may have limited mobility • Residents with cognitive impairment generally have difficulty following directions regarding transfer • Keep instructions simple and give only one direction at a time • Use demonstrations to help with verbal instructions when necessary	
Infection Prevention • Wash hands before and after transfer to reduce transmission of microorganisms • Wear gloves if chance of possible contact with body fluids	
Legal • Inappropriate transfer technique can cause injury which can lead to possible legal action	
Safety • Being in bed for long periods may cause weakness on rising and sometimes dizziness • Most frequent complication in transferring a resident is falling during the transfer • A possible hazard during transfer is pulling on or pulling out indwelling tubes or catheters • Put on braces and other supportive devices before getting out of bed • Have resident wear shoes or nonskid slippers • Plan to transfer across the shortest distance • Make sure the stronger leg (when applicable) is nearest the chair, to which the resident is transferring • Make sure bed and wheelchair wheels are locked • Place wheelchair on resident's strongest side	
Ethics • Value resident wishes • Acknowledge and value resident suggestions, as appropriate	

Module Z – Threads of Care – Transferring from Bed to Wheelchair	
Dignity • Ensure that resident is properly dressed and discreetly covered, while in wheelchair • Provide grooming and application of makeup, jewelry, as appropriate, and per wishes of resident • Be respectful, courteous and explain what nurse aide plans to do	
Rights • The resident has the right to refuse to get up in the wheelchair • The resident has the right to privacy during transfer • The resident has the right to be free from abuse and neglect	
Communication • Explain what will be done, step-by-step, so resident can help as much as possible, to reduce anxiety and increase cooperation • Watch for signs of non-verbal indications that resident is not tolerating sitting in wheelchair	
Family and Family Support • After demonstration of use of wheelchair brakes and navigation of wheelchair, permit family members to transport resident to activities, if directed by the nursing care plan or after consultation with nurse	
Appropriate Anatomy and Physiology • Activity improves muscle tone, increases venous return to the heart, and stimulates peristalsis • By the seventies or eighties, muscle strength, endurance, and coordination decline • Older adults need to maintain as much mobility as possible to prevent disability • Bone demineralization increases risk of falls • Range of motion of joints decreases • Muscle strength lessens, and gait may be unsteady • Residents may have contractures that may affect ability to transfer safely and ability to sit in wheelchair comfortably • Older residents may have thin, fragile skin which may lead to injury	
Body Mechanics • Concentrate on how nurse aide is using body when moving and positioning residents • Use strongest and longest muscles to prevent injuries • Half of all health care providers' back pain is associated	

Module Z – Threads of Care – Transferring from Bed to Wheelchair	
with lifting or turning residents • Allow the strong muscles of legs to do the lifting • Maintain center of gravity and provide leverage that reduces lower back strain • Prevent twisting of body when moving resident • Be realistic about how much weight nurse aide can safely lift • Practice good body mechanics always during procedure • Maintain resident's center of gravity as close to you as possible • A broad base of support increases stability during transfer • Positioning resident well back into seat provides a broader base of support and greater stability • Wide stance increases stability and minimizes strain on back • Avoid putting pressure directly on axilla due to risk of nerve damage	
Pain • Notify nurse if pain is verbalized • Observe for non-verbal signs of pain by resident and report any complaints of pain to nurse and document per facility policy	
Person-centered Care • Encourage resident to assist as much as possible • Determine level of dependence on assistance o Completely independent o Requires use of assistive devices o Needs minimal help o Needs assistance or unable to assist	
Documentation • Per facility policy, document following information: time of transfer, length of time in wheelchair, abnormal occurrences (during transfer), and/or abnormal complaints (while in wheelchair)	
Critical Thinking • Determine if an additional person is needed to safely transfer resident to wheelchair	
Employee Behavior • Be sympathetic to various emotions resident may be experiencing due to dependency on others • Nurse aide should prioritize work so resident repositioning will be done at appropriate intervals • Nurse aide should ask for clarification if unsure of how to	

Module Z – Threads of Care – Transferring from Bed to Wheelchair	
safely transfer resident to wheelchair	

Module Z – Threads of Care – Moving Up in Bed Using Turning Sheet and Positioning Resident on Side	
Objective • Discuss the importance of correct positioning and use of a turn sheet. • Demonstrate positioning resident on side. • Demonstrate moving a resident up in bed using a turning sheet.	
Content	**Notes**
Cognition • Explain what nurse aide is planning to do in terms the resident understands • Residents with dementia may require special measures prior to and during being moved and positioned	
Infection Prevention • Follow Standard Precautions. • Observe for signs of skin discoloration, swelling, and rashes • Promptly change soiled linens	
Legal • Turn and position resident per nursing care plan to prevent possible abuse and neglect charges	
Safety • Place call signal within resident's reach • Exercise caution and protect resident's head when moving up in bed	
Ethics • Change linens if soiled or wet even if nurse aide is only one aware of soiled linens • Avoid leaving resident in the same position for long periods of time	
Dignity • Always provide privacy • Refrain from commenting or teasing resident about size or weight, no matter how easy or difficult the resident may be to move or position • Encourage resident to participate as much as possible • Be respectful, courteous and explain what nurse aide plans to do	
Rights • Residents have the right to privacy • Residents have the right to refuse to be positioned • Residents have the right to be free from complications associated with prolonged bed rest	
Communication • Use positive approach and tell resident what nurse aide	

Module Z – Threads of Care – Moving Up in Bed Using Turning Sheet and Positioning Resident on Side	
plans to do prior to touching resident	
Family and Family Support • Permit assistance from family if requested by resident	
Appropriate Anatomy and Physiology • Movement of resident may cause shearing or friction and may tear fragile skin • Movement of resident increases and promotes circulation • Repositioning every two hours is important in preventing skin breakdown • Proper alignment of resident's body helps prevent complications of immobility, such as contractures and atrophy • Constant pressure on bony areas can cause resident to be at high risk for pressure injury	
Body Mechanics • Ask for extra assistance as resident's condition requires • Raise bed to a comfortable working height • Remember to return bed to lowest position following repositioning of resident is completed • Use good body mechanics	
Pain • Report any complaints of pain to nurse and document per facility policy	
Person-centered Care • Be courteous and respectful of resident wishes at all times • Respect and honor resident positioning preferences, if possible	
Documentation • Follow facility policy on documentation	
Critical Thinking (program-specific content)	
Employee Behavior • Be sympathetic to the various emotions the resident may be experiencing due to dependency on others • Nurse aide should prioritize work so resident repositioning will be done at appropriate intervals	

Module Z – Threads of Care – Assisting with Ambulation	
Objective • Demonstrate the proper technique when assisting with ambulation using a gait belt, cane or walker.	
Content	**Notes**
Cognition • Explain to resident in terms the resident understands what the nurse aide is planning to do and why	
Infection Prevention • Be aware of the potential of body fluids and observe standard precautions	
Legal • Use gait belt according to manufacturer guidelines and per facility policy • Properly identify resident prior to ambulation	
Safety • Being in bed for long periods may cause weakness on rising and sometimes dizziness • Always return bed and side rails to original position once ambulation is complete • Make sure bed or chair wheels are locked before resident attempts to stand • Nurse aide should check nursing care plan to determine ambulatory needs, such as transfer belt (per facility policy) and number of people needed to ambulate safely • For ambulation with a cane, the cane should be positioned on stronger side • Check rubber tips on canes and walkers for snug fit before use • When assisting a resident, nurse aide stays on weaker side, and slightly behind resident • If resident starts to fall, be prepared to gently lower resident to the floor • During crutch walking, remind resident to bear weight on hands and arms, and not under the arms • Use handrails on the walls, if available • Resident should wear rubber sole slippers	
Ethics • Assist with ambulation per facility guidelines	
Dignity • Ensure that resident is properly dressed and discreetly covered during ambulation • Honor resident's grooming wishes such as combing hair	
Rights	

Module Z – Threads of Care – Assisting with Ambulation	
• The resident has the right to refuse to ambulate	
Communication • Watch for signs of non-verbal indications that resident is not tolerating ambulation • Give clear step by step directions as to ambulatory expectations	
Family and Family Support • Family may enjoy ambulating with resident if nursing care plan allows	
Appropriate Anatomy and Physiology • Regular ambulation is important because it improves resident's skin, circulation, strength, sleep, appetite, elimination, and oxygen level • Physical conditions, such as osteoporosis and arthritis, may affect resident's ability to stand up straight • Physical conditions, such as sinus infections may affect balance	
Body Mechanics • Use good body mechanics when assisting resident to stand, dangle, and ambulate	
Pain • Any complaints of pain during ambulation should be reported to nurse	
Person-centered Care • Encourage resident to select area for ambulation	
Documentation • Document distance ambulated and tolerance according to facility policy • Document any verbalized pain per facility policy	
Critical Thinking • Distances may need to be adjusted based on tolerance	
Employee Behavior • Each nurse aide should be familiar with and understand use of a variety of ambulatory assistive devices – cane, walker, crutches • The nurse aide should ask for clarification if unsure of how to safely assist with ambulation	

Module Z – Threads of Care – Applying Restraints	
Objective • Demonstrate the application of physical restraints according to manufacturers' instructions. • Apply physical restraints according to nursing care plan and facility policies and procedures.	
Content	**Notes**
Cognition • Restraints can lead to increased confusion and agitation in residents with dementia • Even if a resident is oriented to time, place and person, restraint use can lead to anger, delirium, depression, loss of self-respect and withdrawal	
Infection Prevention • Replace restraints when soiled • Do not share restraints among residents	
Legal • Restraints are used to protect resident only after all other measures have been • Restraints require a doctor's order • Restraints may be used if resident is danger to self, to others or for a medical procedure • Restraint use is based on resident's need, not the needs of the staff; restraints are not used for convenience of staff or as punishment for resident • The nurse aide uses a restraint only if and when nurse directs nurse aide to do so • Nurse aide must be taught how to apply and secure any type of restraint before application • Informed consent is required from resident before use of restraints o If resident is unable to participate in decision to apply restraints, a designated family member is consulted o Only in an emergency situation and under facility's policies and procedures will nurse decide to use restraints without informed consent	
Safety • Restraints can cause serious injury or even death from strangulation • Never use force when applying restraint • Always use slipknot, if restraint has ties • Check to make sure restraint is not too tight • Place call signal within resident's reach • Perform a visual check on resident every 15 minutes	

Module Z – Threads of Care – Applying Restraints	
• Release resident from restraints at least every two hours for 15 minutes of care, such as elimination, nourishment, skin care or range of motion • Check for blue-tinged, gray or pale skin, which means lack of oxygen; for dark-skinned residents, skin may appear purple or darkened	
Ethics • Only you will know if you checked resident in restraints every 15 minutes and released restraints for 15 minutes of care every two hours	
Dignity • A resident might feel lonely, isolated, humiliated and punished o Resident may ask, “What did I do wrong?” o Resident might ask, “Why am I being punished?” o Use of restraints can lead to loss of dignity, self-respect, anger, agitation for the resident • Treat the resident with kindness, respect and care before, during and after application • Position resident and resident’s linen or clothing so that restraints are not evident to everyone	
Rights • Residents have the right to be free from restraint or seclusion	
Communication • Before applying a restraint, nurse aide should explain what is going to be done in words that resident understands • Explain what is being done step-by-step • After applying restraint, ask resident if restraint is too tight or painful; nurse aide should adjust restraint to ensure it is secure keeping in mind resident is comfort • Nurse aide should make sure resident can communicate with staff after nurse aide leaves room o Since restraints limit movement, call signal should be within resident’s reach at all times	
Family and Family Support • Reinforce nurse’s explanation about use of restraints to family • Encourage family to ask questions about need for restraints; relay questions to the nurse or direct family to speak directly with the nurse	
Appropriate Anatomy and Physiology • A restraint can act as a tourniquet if applied too tightly	

Module Z – Threads of Care – Applying Restraints	
• Restraints can cause friction and shearing of skin if applied directly to skin • Restraints can restrict breathing, block airway, cause strangulation • Restraints can cause swelling, redness, pain and damage to extremities	
Body Mechanics • Position resident in good body alignment before applying restraints	
Pain • If resident complains of pain while restrained, check for tightness of restraint and loosen if needed; if pain persists, notify nurse at once	
Person-centered Care • A restraint free environment is preferred • The type of restraint should be customized to resident's needs – after consulting the nursing care plan and/or nurse for instructions • Treat resident with respect and reaffirm his/her value as a person	
Documentation • Complete documentation as taught/instructed according to facility policies to include dates and times of release, actions to address personal needs (elimination, repositions, range of motion) and reapplication	
Critical Thinking • If there is a life-threatening emergency such as strangulation, release restraint at once/cut restraint off; notify nurse immediately	
Employee Behavior • In addition to state and federal laws, follow facility policies and procedures • Staff must work as a team to take care of residents with restraints • Know who is restrained and where they are in the facility • Physically look in resident's room, check on their status and answer call signal promptly	

Module Z – Threads of Care – Applying Anti-embolism (Elastic) Stockings	
Objective • Demonstrate application of knee-high anti-embolism (elastic) stockings consistent with manufacturers' instructions.	
Content	**Notes**
Cognition • Applying anti-embolism stockings may threaten a resident with dementia which may result in agitation or combativeness o Nurse aide must be calm, patient and soothing o Should not rush process o Be gentle o Let resident help, if possible, even if it is holding stocking that is not in use o Try again later if resident continues to resist application	
Infection Prevention • Resident usually has two pairs of stockings; one pair can be washed and dried while resident wears the other pair • Never share stockings among residents	
Legal – not applicable	
Safety • Check circulation, skin color and skin temperature of toes, through opening in toe area and report any changes to nurse • Inspect skin for breakdown, skin tears and discoloration after removing stockings • Make sure stockings do not have any twists; these can affect circulation • Make sure stockings have no creases or wrinkles; these can cause skin breakdown • Stockings that are too tight or folded over at top can block blood flow • Loose stockings do not promote blood circulation • Report to nurse when stockings are too loose or tight • Make sure after stockings have been applied that the resident has on foot coverings with non-skid soles while ambulating	
Ethics (program-specific content)	
Dignity (program-specific content)	

Module Z – Threads of Care – Applying Anti-embolism (Elastic) Stockings	
Rights (program-specific content)	
Communication • Nursing care plan will indicate when to remove stockings and for how long • Report observations and specific concerns to nurse immediately • Report the following to nurse: changes in skin color and temperature, leg and foot swelling, signs of skin breakdown and complaints of tingling, numbness or pain	
Family and Family Support • Families can encourage the resident to wear the stockings according to the doctor's orders	
Appropriate Anatomy and Physiology • Anti-embolism stockings can increase blood circulation and reduce fluid retention by applying even compression to the veins of legs • Anti-embolism stockings help prevent blood clots in legs that could result in stroke or death • Individuals who are on bed rest, are older or pregnant or have heart or circulatory problems or recent surgery are at risk for blood clots • Apply stockings before individual gets out of bed; legs and feet are less swollen at that time and stockings easier to apply	
Body Mechanics • Do not force joints (toes, foot, ankle, knee and hip) beyond their range of motion when applying stockings • Support the foot/ankle during application of stockings	
Pain • Do not force the joints to point of pain when applying stockings • Report complaints of pain to the nurse and document per facility policy	
Person-centered Care • Use the color of anti-embolism stockings preferred by the resident, if colors are available	
Documentation • Document observations of skin color, skin breakdown or pain	
Critical Thinking • Be familiar with and understand the use of anti-	

Module Z – Threads of Care – Applying Anti-embolism (Elastic) Stockings	
embolism stockings; understand that stockings are fitted according to the measurements taken from the resident's lower extremities • Check stockings to ensure they belong to the right resident • The nurse aide should ask for clarification if unsure of how to apply stockings	
Employee Behavior • Apply stockings in a manner that would be acceptable to you if you were required to wear them	

Threads of Care – Teaching Tip Attachment #4Z – *Mouth Care without a Battle*®
Vocabulary

Alzheimer's disease – the most common type of dementia

Anti-microbial rinse – alcohol-free mouth care product that kills bacteria and improves gum inflammation; requires a prescription; may only be used for 6 weeks; example is chlorhexidine solution

Aspiration – inhaling liquid

Aspiration of plaque – one of the most common causes of pneumonia in nursing homes

Biotene rinse – alcohol-free mouth care product that is especially helpful for people with dry mouth

Calculus – hardened plaque of at least 10 days which can only be removed by a dentist

Dementia – brain disease which causes the resident to gradually lose the ability to remember, do simple tasks (even tooth brushing), understand, and communicate, lasting as long as eight years or more and progresses through three stages – early, middle, and late

End tuft brush – a smaller toothbrush that allows the nurse aide to get to hard to reach areas of a resident's mouth

Fluoride – a mouth care product that may be purchased in a store or by prescription that comes in paste or rinse form and is applied to the surfaces of the teeth and along the gum line to helps protect teeth from tooth decay and cavities

Gingivitis – the tender red or reddish-blue tinting of the gum due to inflammation caused by bacteria in the plaque that attacks the gum tissue and may result in loss of teeth

Interdental brush (also called a go-between) – devices used to floss or clean the tiny spaces in-between the teeth

Jiggle and sweep – the motion of the toothbrush during mouth care

Listerine – an alcohol-free product that kills bacteria during mouth care and safe for daily use; does not foam like toothpaste

Partial dentures – an appliance used by residents with some teeth and are fastened to teeth by metal clasps

Plaque – sticky film of food, bacteria, and saliva usually found along the gum line which can be removed by brushing and hardens within 48 hours

Toothpaste – a mouth care product which causes foam when used and requires a swish and spit technique by the resident; some have fluoride which can reduce tooth decay and cavities

Water – a mouth care product which may be used and has been found to work just as well as applying toothpaste because it is the motion of the toothbrush that removes plaque and not the product

Threads of Care – Teaching Tip Attachment #5Z– *Mouth Care without a Battle*®
Worksheet

DVD 1: Module 1 Part 1 Mouth Care Basics (Basic Steps of Mouth Care)

Always wear _____ when providing mouth care and/or denture care.

Mouth care is not merely _____, but a vital part of infection control and health promotion.

Basic steps of mouth care include:
- Remove food from the mouth
- Brush the surfaces of the teeth (inside/outside/biting surfaces)
- Clean between the teeth
- Brush the tongue and
- Apply fluoride protection to teeth (per facility policy)

Remove left over food from the mouth to facilitate brushing teeth without food in the way:
- Use a piece of gauze dipped in water
- Squeeze off excess liquid
- Wrap gauze around gloved finger and
- Feel around cheeks for extra food removing as much as possible with the gauzed finger

Brush the inside and outside of teeth using proper brushing technique and a soft toothbrush (hard bristles can _____ the teeth and _____ gums creating more places for bacteria to grow):
- Hold toothbrush at a _____^{o} angle to gum line
- _____ back and forth, then _____ plaque away from the gum line

Brush the biting surfaces of teeth using proper brushing technique and a soft toothbrush. As a review, why should a soft toothbrush be used when providing mouth care?

_____
_____
_____
_____
_____
_____

While brushing the biting surfaces:
- Use _____ back and forth strokes

- Be sure and brush behind the _____ on both the top and bottom because the far back area of the mouth is commonly missed and the site of plaque build-up

Use a smaller brush (end-tuft brush) or a child's toothbrush to get to hard to reach places or for people who cannot open their mouths wide. If one or the other special brushes are not available, use the resident's regular toothbrush and do the best you can.
Replace toothbrushes every 3 months or when the bristles become _____ or _____.

Review the terms plaque, calculus, and gingivitis on the vocabulary list
REMEMBER: It is the motion of the _____ and not the toothpaste that cleans teeth – jiggle and sweep, jiggle and sweep. The _____ loosens the plaque and the _____ removes the plaque.

Consult with a health care professional or follow facility policy when choosing a mouth care product; the decision is based on the resident's ability and needs.
Mouth care products include:

- Toothpaste
- Water
- Listerine
- Biotene rinse and
- Anti-microbial rinse

Review each of the mouth care products listed above on the vocabulary list

Why would it be alright to use water as a mouth care product?
_____
_____
_____
_____
_____
_____
_____
_____
_____

Simply brushing the teeth does not get in-between teeth. People should also _____ between the teeth using an interdental brush, also called a go-between.

Why is it important to clean between teeth?
_____
_____

_____
_____
_____
_____
_____
_____

It is important to not stick a hand in a resident's mouth to floss the teeth. Why?

_____
_____
_____

It is important to clean the tongue because it has bacteria on it which is a common cause of ___ _____ and may have a heavy coating or be discolored.

Two easy ways to clean tongue include:

- Using a toothbrush, dip brush in product, then start with front of tongue and brush forward with _____strokes, then slowly work way to back of tongue while being careful not to make the resident gag; may also use scraper on the back of the toothbrush if available
- Using a gauze pad dipped in product and wrapped around a cotton swab, rub along the tongue of residents who cannot open their mouths wide

Apply a fluoride product to teeth per facility policy.

When mouth care is complete, perform one last check inside the resident's mouth by gently sweeping the gloved finger through the mouth to check for other food that may remain and observing for irritation of the _____, _____, and _____.

Finally, the nurse aide cleans up after performing mouth care by discarding disposable materials that were used, disinfecting and putting personal supplies away, disinfecting the workspace, and washing hands.

DVD 1 Module 1 Part 2: Beyond the Basics (Dealing with Special Situations)

Denture care – tips for removing dentures

- Upper – grasp with middle and index _____ behind front teeth and _____ outside front teeth; gently rock denture _____ and _____, _____ to _____; once loosened, pull _____ and toward you
- Lower – grasp middle of bottom teeth between thumb and middle finger; gently rock denture _____ and _____; once loosened, pull _____ and toward you
- Partial – grasp the clasps and work gently until the denture is unhooked from the teeth and denture is easy to remove and
- After removal of dentures, put in cup with clean cool water, making sure both top and bottom dentures are immersed

Always check for irritation in the mouth after dentures are removed and then clean inside of the resident's mouth. This must also be done if the resident has no teeth at all:

- Dip cotton gauze in mouth care product and squeeze excess liquid
- Wrap gauze around gloved finger and rub gloved finger inside cheeks, under tongue, and on gums
- Use sweeping motion to remove food (might need to use several sweeping motions if there is a lot of food) and
- While cleaning gums, let the resident spit in a cup when necessary

Denture care – tips for cleaning dentures:

- According to best practices (and per facility policy), never use toothpaste
- Line the sink with a paper towel over drain to prevent damage if dentures are accidentally dropped
- Take lower denture and brush teeth with toothbrush under cool running water, using _____ and _____ technique to remove loosened food and plaque; brush all other surfaces that come into contact with mouth; rinse toothbrush and denture under _____ running water; then place in denture cup
- Take top denture and brush teeth with toothbrush under cool running water, using _____ and _____ technique to remove loosened food and plaque; brush all other surfaces that come in contact with mouth; rinse toothbrush and denture under cool running water; then place in denture cup
- Ensure both dentures are submerged in_____ water in denture cup after denture cup has been rinsed

Dentures – other important concepts:

- Best practice discourages use of toothpaste to clean dentures (follow policy of facility)

- Adhesive – use as little as possible; if dentures fit _____, adhesive is not needed
- Keep dentures out of mouth for at least 4 hours a day, preferably longer. Why?
  _____
  _____
  _____To be sure dentures are removed daily, it is easiest to take out dentures just before _____; while out always keep them in cool water or denture cleaner. What can happen if dentures dry out?
  _____
  _____Store dentures away from direct sunlight and heat. Why?
  _____
  _____. Before inserting dentures – check for redness, swelling, irritation of gums where dentures come in contact; _____ may be a sign the dentures are not fitted properly; report raw area or ulcer to supervisor immediately.

Other situations:

- People without teeth (edentulous) – mouth care identical with residents with dentures
- Missing teeth – mouth care as describe previously for remaining teeth and exposed gums
- Loose tooth – notify supervisor; if safe and as directed, steady loose tooth with other hand and use short light strokes when brushing; if next to other teeth, hold it steady when cleaning between teeth
- Loose tooth falls out during care – do not replace; apply _____ to area with clean gauze to stop bleeding; and notify supervisor
- Broken teeth – use _____ and not toothbrush; dip swab in cleaning product and rub around broken teeth removing plaque and debris
- Swallowing disorders – provide mouth care _____; do not use toothpaste; use very little liquid in mouth; always dip toothbrush in liquid and dab on gauze pad to get rid of excess water; brush as normal; encourage resident to spit into medicine cup when necessary
- Tube feeding – treat the same as residents with swallowing disorders

DVD 1 Module 2: Providing Mouth Care in Challenging Situations

Review the terms, dementia and Alzheimer's disease, on the vocabulary list
Always remember when caring for a resident with dementia:

- Behavior has a _____
- Behavior is a form of _____ because the disease has robbed the resident of the ability to make words

7 Stages of Dementia		
Stage	**Communication**	**Behaviors/Needs**
Stage 1 No Impairment	• Can express needs	• Alzheimer's disease is not evident • No memory Problems
Stage 2 Very Mild Decline	• Minor memory problems	• Lose things around the house • Unlikely to be noticed by family members
Stage 3 Mild Decline	• Family members and friends may begin to notice cognitive problems	• Difficulty finding the right word during conversations • Difficulty organizing and planning • Difficulty remembering names of new individuals
Stage 4 Moderate Decline	• Poor short-term memory (may not recall what they ate for lunch)	• Difficulty with simple math • Inability to manage finances
Stage 5 Moderately Severe Decline	• Maintain functionality • Still know their family members • Inability to recall simple details, such as their own address or telephone number • Significant confusion	• Usually able to bathe and toilet independently • Difficulty dressing appropriately
Stage 6 Severe Decline	• Confusion or unawareness of environment and surroundings • Inability to remember most details of personal history • Major personality changes	• Need constant supervision, usually require professional care • Loss of bladder and bowel control • Possible behavior problems • Need assistance with bathing and toileting • Wandering
Stage 7 Very Severe Decline	• Lose ability to communicate or respond to their environment • May be able to utter words or phrases • No awareness regarding their condition	• Final stage and nearing death • Need assistance with all activities of daily living • May lose their ability to swallow

It is important for the nurse aide to understand what stage of dementia a resident is in because of the need to adjust the approach to mouth care.

The nurse aide should get started with mouth care by first making a _____ with simple, respectful activities towards the resident:

- Knock
- Approach from front
- Say hello and introduce yourself
- Move and speak slowly
- Make eye contact
- Make small talk (“You look nice.”)
- Explain why you are there
- Ask permission

The Resident Refuses Mouth Care

Refusing mouth care – what the nurse aide does in response to the resident depends on the _____but remember – never force mouth care on the resident and never totally avoid mouth care!

Facts about refusals:

- Occurs more at first. Why?
  _____
  _____
  _____T
  he nurse aide may need to adjust the time to provide the mouth care that the resident wants (resident preference) – some prefer before a meal and some after a meal
- It may work to phase in mouth care by first brushing just the front of the teeth, later brushing the back of the teeth, later cleaning the tongue, and ultimately building up to full mouth care; the nurse aide also may start every other day – just establish some type of routine

Reason: resident does not understand what the nurse aide wants to do (due to being hard of hearing or dementia)

- Talk to the resident at eye level and speak slowly and clearly
- Show equipment and supplies to be used
- Use different words (clean, instead of brush)
- Use gestures to act out the behavior (model opening your own mouth and brushing your own teeth)

Reason: resident has a fear of loss of control or pain

- Explain what you are doing and why; give a reason (“Your mouth will feel better.” “Let me get the food from your teeth so you’re more comfortable.”)

- Provide reassurance (“I’ll be careful not to hurt you.” “If anything bothers you, tell me, and I will stop.”
- For middle stage or advanced dementia, give the resident something he/she likes to hold (blanket, stuffed animal)
- Attend to needs

Reason: bad timing (resident is tired)
- Determine preferred time (morning, bedtime, before or after meals?)
- Come back later

The nurse aide may face other challenges when attempting to provide mouth care to a resident.

The Resident Will Not Sit Down

Reason: resident does not understand
- Put a chair behind the resident’s legs and say, “please sit down.”
- Nurse aide sits down to demonstrate desired behavior
- Get the resident’s attention by facing him/her, making eye contact, and stating name
- Talk with the resident
- Provide mouth care standing up
- Stand up in front of sink with mirror to model past behavior

The Resident Will Not Open Mouth

Reason: resident does not understand
- Touch the cheek, mouth and/or lower jaw to suggest to resident to open mouth
- For late stage dementia, slowly approach the mouth with toothbrush, gently slide brush into the mouth, and begin brushing
- Sing a song which causes the resident to open the mouth

Reason: resident does not want care
- Be patient
- Make small talk
- Give a reason (“Your mouth will feel better;” “Let me get the food from your mouth so you’re more comfortable”)
- Ask resident if he/she wants to brush teeth by self
- Simply come back later

The good news is, once the _____ is open, it usually stays open and the nurse aide can complete mouth care

The Resident Grabs at the Nurse Aide or the Toothbrush

For the resident with middle stage of dementia who grabs the nurse aide or toothbrush, stop the care and figure out the reason for the behavior.

Reason: resident does not understand
- Speak loudly and clearly
- Repeat self using simple words
- Talk to the resident at eye level
- Use gestures and props

Reason: resident is in pain
- Be gentle
- Talk through the procedure
- Slow down and stop when necessary

Reason: resident wants control
- Give resident toothbrush and guidance
- Use hand over hand technique

Reason: resident is anxious or afraid
- Provide reassurance by explaining what the nurse aide is doing and why ("I will be careful not to hurt you;" "If anything bothers you, tell me and I will stop.")
- Give resident something to hold (cup, teddy bear, or other similar object)
- Redirect resident by talking, singing, playing music, providing a favorite drink/food, gently touching and massaging shoulders or arms

The Resident Hits the Nurse Aide

Reason: for a resident with middle stage dementia, hitting may be sudden and come as a surprise
- At the earliest sign of agitation when resident is observed getting upset, stop and see what is going on (most residents will not hit if this is done)
- Redirect resident by talking, singing, playing music, providing a favorite drink/food, gently touching and massaging shoulders or arms
- If resident continues to hit, the nurse aide should stop with mouth care and come back later

The Resident Bites Down on the Toothbrush and Will Not Let Go

Reason: during middle or late dementia, possibly a reflex to chew was stimulated
- Gently wiggle the toothbrush or swab
- Gently rub cheek and massage the jaw
- If the nurse aide feels comfortable, rub along inside of cheek, but outside of the teeth area

The Resident Sucks on the Nurse Aide's Finger, Gauze, or Toothbrush

Reason: during late dementia, a reflex to chew was stimulated
- Explain what you are doing because the resident may think it is food
- Stop if it is a reflex and then start again
- Redirect resident by talking, singing, playing music, providing a favorite drink/food, gently touching and massaging shoulders or arms

Reason: during late dementia, mouth area hurts
- Recognize pain
- Be gentle
- Provide reassurance

The Resident Spits Water on the Floor Instead of a Cup

Reason: the resident associates the cup with drinking and not spitting into
- Provide mouth care near a sink and instruct resident to spit into the sink
- Tilt cup forward under the chin to suggest the resident to spit

Dentures

For residents with early to middle dementia, it is best if the resident can remove/replace dentures; the nurse aide should tell the resident what to do, touch the resident's lip, and finally use patience, flexibility, and good humor.

Resident needs to have his/her dentures removed from mouth, but refuses
- Use verbal prompts and display patience
- Residents with early dementia – persuade with a simple reason ("A clean denture feels so much better.")
- Ask when a better time would be to return

Resident needs to have his/her dentures placed in mouth, but refuses
- Use verbal prompts and display patience
- Try touching cheek or lip with denture
- Determine if resident will put in denture and then nurse aide can adjust

The key to providing mouth care without a battle is to understand that challenges are a form of _____.

The nurse aide must remember to be a _____ and individualize _____.

Summary

- Know the person
- Approach from the _____

- Get _____ first
- Focus on the person, not the _____
- Listen for _____ about the person's needs
- Encourage participation
- Give simple step-by-step _____
- Explain each _____ beforehand
- Be patient and repeat if necessary
- Give _____ feedback and encouragement
- Use _____ touch and reassurance
- Establish a routine with the same caregiver

DVD 1 Module 1 Part 2: Beyond the Basics (Dealing with Special Situations)

Denture care – tips for removing dentures

- Upper – grasp with middle and index fingers behind front teeth and thumb outside front teeth; gently rock denture back and forth, side to side; once loosened, pull downward and toward you
- Lower – grasp middle of bottom teeth between thumb and middle finger; gently rock denture back and forth; once loosened, pull upward and toward you
- Partial – grasp the clasps and work gently until the denture is unhooked from the teeth and denture is easy to remove and
- After removal of dentures, put in cup with clean cool water, making sure both top and bottom dentures are immersed

Always check for irritation in the mouth after dentures are removed and then clean inside of the resident's mouth. This must also be done if the resident has no teeth at all:

- Dip cotton gauze in mouth care product and squeeze excess liquid
- Wrap gauze around gloved finger and rub gloved finger inside cheeks, under tongue, and on gums
- Use sweeping motion to remove food (might need to use several sweeping motions if there is a lot of food) and
- While cleaning gums, let the resident spit in a cup when necessary

Denture care – tips for cleaning dentures:

- According to best practices (and per facility policy), never use toothpaste
- Line the sink with a paper towel over drain to prevent damage if dentures are accidentally dropped
- Take lower denture and brush teeth with toothbrush under cool running water, using jiggle and sweep technique to remove loosened food and plaque; brush all other surfaces that come into contact with mouth; rinse toothbrush and denture under cool running water; then place in denture cup
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- Ensure both dentures are submerged in cool water in denture cup after denture cup has been rinsed

Dentures – other important concepts:

- Best practice discourages use of toothpaste to clean dentures (follow policy of facility)
- Adhesive – use as little as possible; if dentures fit well, adhesive is not needed

- Keep dentures out of mouth for at least 4 hours a day, preferably longer. Why? Tissue in the mouth needs to be exposed to air to breathe and to stay healthy.
- To be sure dentures are removed daily, it is easiest to take out dentures just before bedtime; while out always keep them in cool water or denture cleaner. What can happen if dentures dry out? If dentures dry out, they can change shape and stop fitting well
- Store dentures away from direct sunlight and heat. Why? Sunlight and heat can change denture shape
- Before inserting dentures – check for redness, swelling, irritation of gums where dentures come in contact; irritation may be a sign the dentures are not fitted properly; report raw area or ulcer to supervisor immediately

Other situations:

- People without teeth (edentulous) – mouth care identical with residents with dentures
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- Loose tooth – notify supervisor; if safe and as directed, steady loose tooth with other hand and use short light strokes when brushing; if next to other teeth, hold it steady when cleaning between teeth
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- Broken teeth – use cotton swab and not toothbrush; dip swab in cleaning product and rub around broken teeth removing plaque and debris
- Swallowing disorders – provide mouth care sitting up; do not use toothpaste; use very little liquid in mouth; always dip toothbrush in liquid and dab on gauze pad to get rid of excess water; brush as normal; encourage resident to spit into medicine cup when necessary
- Tube feeding – treat the same as residents with swallowing disorders

DVD 1 Module 2: Providing Mouth Care in Challenging Situations

Review the terms, dementia and Alzheimer's disease, on the vocabulary list
Always remember when caring for a resident with dementia:

- Behavior has a reason
- Behavior is a form of communication because the disease has robbed the resident of the ability to make words

7 Stages of Dementia		
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It is important for the nurse aide to understand what stage of dementia a resident is in because of the need to adjust the approach to mouth care.

The nurse aide should get started with mouth care by first making a connection with simple, respectful activities towards the resident:

- Knock
- Approach from front
- Say hello and introduce yourself
- Move and speak slowly
- Make eye contact
- Make small talk ("You look nice.")
- Explain why you are there
- Ask permission

The Resident Refuses Mouth Care

Refusing mouth care – what the nurse aide does in response to the resident depends on the reason for refusal but remember – never force mouth care on the resident and never totally avoid mouth care!

Facts about refusals:

- Occurs more at first. Why? The resident is not used to mouth care either at all, or by the nurse aide, or how it is being done, plus it may hurt at first.
- The nurse aide may need to adjust the time to provide the mouth care that the resident wants (resident preference) – some prefer before a meal and some after a meal
- It may work to phase in mouth care by first brushing just the front of the teeth, later brushing the back of the teeth, later cleaning the tongue, and ultimately building up to full mouth care; the nurse aide also may start every other day – just establish some type of routine

Reason: resident does not understand what the nurse aide wants to do (due to being hard of hearing or dementia)

- Talk to the resident at eye level and speak slowly and clearly
- Show equipment and supplies to be used
- Use different words (clean, instead of brush)
- Use gestures to act out the behavior (model opening your own mouth and brushing your own teeth)

Reason: resident has a fear of loss of control or pain

- Explain what you are doing and why; give a reason ("Your mouth will feel better." "Let me get the food from your teeth so you're more comfortable.")
- Provide reassurance ("I'll be careful not to hurt you." "If anything bothers you, tell me, and I will stop."

- For middle stage or advanced dementia, give the resident something he/she likes to hold (blanket, stuffed animal)
- Attend to needs

Reason: bad timing (resident is tired)
- Determine preferred time (morning, bedtime, before or after meals?)
- Come back later

The nurse aide may face other challenges when attempting to provide mouth care to a resident.

The Resident Will Not Sit Down

Reason: resident does not understand
- Put a chair behind the resident's legs and say, "please sit down."
- Nurse aide sits down to demonstrate desired behavior
- Get the resident's attention by facing him/her, making eye contact, and stating name
- Talk with the resident
- Provide mouth care standing up
- Stand up in front of sink with mirror to model past behavior

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- For late stage dementia, slowly approach the mouth with toothbrush, gently slide brush into the mouth, and begin brushing
- Sing a song which causes the resident to open the mouth

Reason: resident does not want care
- Be patient
- Make small talk
- Give a reason ("Your mouth will feel better;" "Let me get the food from your mouth so you're more comfortable")
- Ask resident if he/she wants to brush teeth by self
- Simply come back later

The good news is, once the mouth is open, it usually stays open and the nurse aide can complete mouth care

The Resident Grabs at the Nurse Aide or the Toothbrush

For the resident with middle stage of dementia who grabs the nurse aide or toothbrush, stop the care and figure out the reason for the behavior.

Reason: resident does not understand
- Speak loudly and clearly
- Repeat self using simple words
- Talk to the resident at eye level
- Use gestures and props

Reason: resident is in pain
- Be gentle
- Talk through the procedure
- Slow down and stop when necessary

Reason: resident wants control
- Give resident toothbrush and guidance
- Use hand over hand technique

Reason: resident is anxious or afraid
- Provide reassurance by explaining what the nurse aide is doing and why ("I will be careful not to hurt you;" "If anything bothers you, tell me and I will stop.")
- Give resident something to hold (cup, teddy bear, or other similar object)
- Redirect resident by talking, singing, playing music, providing a favorite drink/food, gently touching and massaging shoulders or arms

The Resident Hits the Nurse Aide

Reason: for a resident with middle stage dementia, hitting may be sudden and come as a surprise
- At the earliest sign of agitation when resident is observed getting upset, stop and see what is going on (most residents will not hit if this is done)
- Redirect resident by talking, singing, playing music, providing a favorite drink/food, gently touching and massaging shoulders or arms
- If resident continues to hit, the nurse aide should stop with mouth care and come back later

The Resident Bites Down on the Toothbrush and Will Not Let Go

Reason: during middle or late dementia, possibly a reflex to chew was stimulated
- Gently wiggle the toothbrush or swab
- Gently rub cheek and massage the jaw
- If the nurse aide feels comfortable, rub along inside of cheek, but outside of the teeth area

The Resident Sucks on the Nurse Aide's Finger, Gauze, or Toothbrush

Reason: during late dementia, a reflex to chew was stimulated
- Explain what you are doing because the resident may think it is food
- Stop if it is a reflex and then start again
- Redirect resident by talking, singing, playing music, providing a favorite drink/food, gently touching and massaging shoulders or arms

Reason: during late dementia, mouth area hurts
- Recognize pain
- Be gentle
- Provide reassurance

The Resident Spits Water on the Floor Instead of a Cup

Reason: the resident associates the cup with drinking and not spitting into
- Provide mouth care near a sink and instruct resident to spit into the sink
- Tilt cup forward under the chin to suggest the resident to spit

Dentures

For residents with early to middle dementia, it is best if the resident can remove/replace dentures; the nurse aide should tell the resident what to do, touch the resident's lip, and finally use patience, flexibility, and good humor.

Resident needs to have his/her dentures removed from mouth, but refuses
- Use verbal prompts and display patience
- Residents with early dementia – persuade with a simple reason ("A clean denture feels so much better.")
- Ask when a better time would be to return

Resident needs to have his/her dentures placed in mouth, but refuses
- Use verbal prompts and display patience
- Try touching cheek or lip with denture
- Determine if resident will put in denture and then nurse aide can adjust

The key to providing mouth care without a battle is to understand that challenges are a form of communication.

The nurse aide must remember to be a detective and individualize care.

Summary

- Know the person
- Approach from the front
- Get permission first
- Focus on the person, not the task
- Listen for clues about the person's needs
- Encourage participation
- Give simple step-by-step directions
- Explain each step beforehand
- Be patient and repeat if necessary
- Give positive feedback and encouragement
- Use gentle touch and reassurance
- Establish a routine with the same caregiver