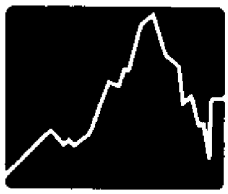
Virginia Board of Nursing
Nurse Aide Education Curriculum
Meeting Agenda
July 17, 2018

3:30 p.m.	Introduction
3:35 p.m.	Vivienne McDaniel – updates on NAEP curriculum
3:45 p.m.	Begin at Chapter 11. Suggested additions to the curriculum by stakeholders and Board staff.
4:45 p.m.	Wrap-up and Next Steps
5:00 p.m.	Adjourn



Department of Health Professions

COMMONWEALTH OF VIRGINIA

VIRGINIA BOARD OF NURSING

Nurse Aide Curriculum

Revised: July 2018

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Provide an overview of health care organizations and long-term care facilities and the methods used for payment of the services that clients receive;
2. Discuss the role of the Nurse Aide in long-term care per OBRA requirements;
3. Explain delegation as it relates to the Nurse Aide; and
4. Explain the impact of Guidance Document 90-55 on potential employment for a Nurse Aide.

Objectives	**Content Outline**
Describe the different types of health care organizations.	I. Long-term Care & Acute Care A. Independent Living B. Home Health Care C. Adult Day Care D. Assisted Living Facility E. Nursing Home F. Hospice G. Continuum of Care Facility H. Rehabilitation I. Hospital (In-patient & Out-patient) J. Dementia/Memory Care
Compare various methods that clients use to pay for long-term care.	II. Payment Options for Long-term care facilities 1. Private pay - client\resident pays for health care from personal resources A. Group insurance - client's\resident's health care is paid for by insurance that the client has previously paid B. Medicaid 1. medical assistance program for low-income clients\residents pays for the client's\resident's healthcare C. Medicare 1. health insurance program for clients\residents over the age of 65 pays for client's\resident's healthcare 2. funded by Social Security 3. Minimum Data Set (MDS) report required for each Medicaid client\resident

Content Outline

III. Role of the Nurse Aide in Long-term Care Facilities

A. Omnibus Budget Reconciliation Act of 1987 (OBRA-87)

1. federal regulation
2. set standards of care for long-term care facilities
3. requires all nurse aides in long-term care facilities to:
   a. complete training program
   b. pass certification exam
4. requires each state to have a registry of nurse aides (see Unit XIV)
   a. available to the public
   b. contains information on nurse aide's performance, including resident abuse
   c. information to be kept minimum of 5 years
5. requires continuing education
   a. minimum of 12-hours in-service each year for nurse aides
6. requires nurse aide who has not worked for 2 consecutive years to retake the certification exam

B. The Health Care Team

1. The Nurse
   a. Registered Nurse (RN)
   b. Licensed Practical Nurse (LPN)
   c. carries out the physician's orders
2. The Nurse Aide
   a. Care for clients/residents
   b. Assist the RN, and LPN
   c. Supervised by the RN or LPN
3. Interdisciplinary Team
   a. Client/resident
   b. physician
   c. dietician
   d. physical therapist
   e. occupational therapist
   f. family member
   g. social worker
   h. licensed nurse
   i. nurse aide

Content Outline

C. Delegation (see Regulations Governing the Practice of Nursing 18VAC90-20-420 to 460)
    1. transferring authority to a person for a specific task
    2. RN may delegate tasks to a Nurse Aide (NA)
    3. criteria for delegation
        a. nurse aide can properly and safely perform task
        b. client\resident health, safety and welfare will not be jeopardized
        c. RN retains responsibility and accountability for care of client\resident and supervises the NA
        d. delegated task communicated to NA on a client\resident-specific basis
        e. clear, specific instructions for performance, potential complications, expected results are given to NA
        f. NA is clearly identified with a name tag
        g. NA may not reassign a task that has been delegated to her/him

D. Common tasks for the Nurse Aide
    1. activities of daily living (ADLs)
        a. bathing
        b. dressing
        c. grooming
        d. mouth care
        e. toileting
        f. eating & hydration
        g. caring for skin; prevention of pressure ulcers
    2. bed making
    3. taking/recording vital signs; height & weight
    4. observing/reporting client changes to supervisor
    5. maintaining safety, including fall prevention
    6. caring for equipment
    7. infection control

Content Outline

E. Professional behavior of the Nurse Aide
    1. attitude
        a. outward behavior
        b. disposition
        c. positive attitude
            1. caring
            2. compassionate
            3. committed to the job
    2. behavior
        a. neatly dressed following facility uniform policy
        b. on time to work
        c. avoid unnecessary absences
        d. use appropriate language
        e. do not gossip about co-workers
        f. keep client\resident information confidential
        g. speak politely
        h. follow facility policies and procedures
    3. grooming
        a. wear clean, neat, unwrinkled uniform
        b. attend to personal hygiene
        c. do not use strongly scented fragrances (perfume, lotions, after-shave, body wash, hair spray)
        d. keep hair away from your face
        e. long hair should be secured at the back of the head or neck
        f. keep beards neat and trimmed
        g. use make-up sparingly
        h. keep nails short
        i. do not wear false nails
        j. keep shoes/laces clean
        k. jewelry should be minimal
    4. Work ethic
        a. attitude toward work
        b. punctual
        c. reliable
        d. accountable
        e. conscientious
        f. respectful of others

Content Outline

g. honest
h. cooperative
i. empathetic

F. Applying for employment as a Nurse Aide
1. considerations
a. type of facility
b. adequate transportation
c. child care
2. complete resumé and application
3. Guidance Document 90-55
a. impact of criminal convictions on potential employment
b. certain convictions prohibit employment in long-term care facilities
c. read and sign personal copy of Guidance Document 90-55
4. interview
a. arrive on time
b. dress appropriately
1.professional attire
2. neat
c. maintain good eye contact
d. be prepared to answer questions
e. be prepared to ask questions
f. thank the interviewer at the end of the interview
g. mail short thank-you note the day after interview

Unit II – Communication and Interpersonal Skills
(18VAC90-26-40.A.1.a)
(18VAC90-26-40.A.5.b)
18VAC90-26-40.A.10)

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Understand the importance of written, verbal and non-verbal communication.
2. Identify barriers to communication.
3. Demonstrate methods used by the Interdisciplinary Health Care Team to communicate among themselves.
4. Demonstrate techniques to communicate with the sensory-impaired client/resident**.**
5. Demonstrate techniques to communicate with the families of client\resident.
6. Develop interpersonal skills to use while functioning as a nurse aide.
7. Demonstrate conflict management strategies.
8**.** Understand boundary violations, use and misuse of social media, and use of cell phones (pictures and texting) as it relates to the care of residents

Objectives	**Content Outline**
Identify three aspects of communication as evidenced by a minimum grade of 80% on the unit test.	I. Elements of communication A. Three components of communication 1. message 2. sender 3. receiver
Demonstrate the ability to listen as evidenced by non-verbal communication such as eye contact, facial expression and verbal feedback.	B. Listening is part of communication 1. hear the message 2. show an interest in the message 3. do not interrupt 4. ask appropriate questions for clarification 5. be patient allowing client\resident time to respond 6. reduce or eliminate distraction 7. use silence appropriately
	C. Non-verbal communication 1. posture 2. appearance 3. eye contact 4. gestures 5. facial expressions 6. touch 7. level of activity
Recognize barriers to communication as evidenced by participation in classroom discussion.	D. Barriers to communication 1. talking too fast or too softly 2. avoiding eye contact 3. belittling client's\resident's feelings 4. physical distance 5. false reassurance 6. changing subject 7. giving advice 8. use of slang/medical jargon

Objectives	Content Outline
Identify the role of the four senses in communication as evidenced by minimum grade of 80% on the unit test.	E. Senses in communication 1. sight a. look for changes in client\resident b. report changes to supervisor 2. hearing a. listen to client\resident and family 3. touch a. touch and feel for any changes in client's\resident's body b. report any changes to supervisor 4. smell a. report any unusual odor
Describe the documents that are used by the health care team to communicate information and needs of the client as evidenced by the ability to locate specific information in a ~~client chart, kardex and MDS~~.designated documentation tool. ~~Please note that CNAs do not have access to residents' charts, physicians' orders, or physician progress notes.~~	II. Communication among the health care team A. client's\resident's medical record (chart) 1. admission sheet 2. health history 3. examination results 4. physician's orders 5. physician's progress notes 6. health team notes 7. lab test results 8. special consents B. ~~Kardex~~/Hard copy of health records or electronic health record (EHR) 1. condensed version of medical record C. Minimum Data Set (MDS) 1. assessment tool 2. provides structured, standardized approach to care 3. helps identify client\resident health care problems
Demonstrate an understanding of the nursing process as evidenced by correctly observing and reporting objective and subjective information related to a specific task identified in the client's/resident's person-centered nursing care plan.	D. Person-centered ~~nursing~~ care plan 1. outlines care that health care team must perform to assist client\resident attain optimal level of functioning 2. written by the nurse (RN or LPN) 3. nurse aide contributes by reporting signs and symptoms he/she observes 4. includes objective and subjective information a. objective – information that can be seen, heard, touched, smelled b. subjective – cannot be observed, may be heard or something the client\resident said

Objectives	Content Outline
	E. the nursing process 1. assessment by the RN a. physical inspection b. medical record c. identifies client\resident's actual or potential health care problems 2. diagnosis 3. plan - sets goals and a plan to meet those goals 4. implementation - providing care to client following the plan 5. evaluation - look carefully to see if the desired goals have been achieved if goals are not achieved care plan should be changed 6. nurse aide observations and reports are vital to meet client goals
	F. reporting and documentation 1. throughout the day report changes in condition to the appropriate ~~supervisor~~ staff per facility policy 2. shift report a. received at beginning of shift from previous shift b. given to on-coming shift before nurse aide leaves unit at end of shift c. includes observations of changes in client's condition or behavior 3. documentation a. all information is confidential b. document immediately after care is given c. never document before providing care d. document care in ~~CareTracker~~ designated documentation tool (i.e. client/resident paper chart or other electronic ~~reporting program~~ health record e. write notes neatly and legibly f. always sign your name and title g. document only facts, not opinions h. use accepted abbreviations i. do not erase or use white-out, draw a single line through and initial any error (follow facility guidelines) 4. ADL record (activities of daily living) – check sheet for routine activities
Demonstrate end-of-shift communication as evidenced by giving an accurate end-of-shift report and documenting with 100% accuracy on the client's\resident's ADL record.	
	G. communicating on the telephone 1. speak clearly and slowly 2. identify your facility and unit 3. identify who you are and your title
Demonstrate the correct way to talk on the telephone as evidenced by completing a client\resident scenario with 100% accuracy.	

Objectives	Content Outlines
	4. listen carefully 5. write any messages 6. end call with "thank you" and "good-bye"
Demonstrate communicating with a hearing-impaired client\resident as evidenced by use of six (6) of the eight (8) strategies identified in class.	III. Communicating with specific populations A. hearing impaired 1. identify any assistive devices that client\resident uses a. hearing aides b. communication boards c. lip reading d. sign language 2. reduce distracting noise a. TV b. radio c. noise in adjacent room 3. get client\residents' attention before speaking 4. speak clearly, slowly 5. maintain eye contact 6. use short, simple words 7. use picture cards 8. write, if necessary
Demonstrate communicating with a visually-impaired client\resident as evidenced by use of six (6) of the eight (8) strategies identified in class.	B. visually impaired 1. identify any assistive devices that client\resident uses 1. glasses 2. special lighting 2. knock on door and introduce yourself when entering room 3. position client\resident so they are not looking into bright light or bright window 4. position yourself where client\resident can see you 5. have adequate light in room 6. encourage client\resident to wear glasses 7. use face of a clock to describe location of items 8. only move items with permission
Describe the characteristics of cognitive impairment (Alzheimer's Association)	C. dementia and Cognitive Impairment ~~and Dementia~~ 1. recognizing the client/resident with cognitive impairment a. memory problems, trouble expressing oneself; not finding the right words to say b. trouble with being in new places; not knowing where one is c. trouble making decisions; confusion and Inability to use logic d. trouble focusing for long; losing a train of thought easily e. most clients/residents' cognitive condition will change over time
Identify causes of cognitive impairment in clients/residents	2. cognitive impairment may be due to:

Objectives

Explain why communication challenges need to be overcome

List methods for overcoming communication challenges

Discuss communicating with families as evidenced by using both strategies discussed in class.

Given specific scenarios, demonstrate appropriate communication with members of the health care team as evidenced by using seven (7) of the nine (9) communication strategies discussed in class.

Discuss important interpersonal skills for the Nurse Aide as evidenced by participation in classroom discussion.

Content Outline

a. Parkinson disease
b. multiple types of dementia including Alzheimer's
c. strokes
d. traumatic brain injuries
e. alcoholism or drug toxicity (can be reversed)
f. depression
g. delirium
h. urinary tract infection (UTI)

3. clients/residents with cognitive impairment may be extremely anxious or frustrated and unable to communicate their needs
   a. cannot get needs met without communicating
   b. client/resident may need pain relief
   c. rights of client/resident may be violated
   d. may be uncooperative with your care if they do not know what you are doing

4. communication skills must be tailored to meet the needs of cognitively impaired clients/residents
   a. be sure to have the client's/resident's attention
   b. explain what you are going to do prior to starting care routine
   c. allow the client/resident opportunities to talk
   d. keep the same routine as much as possible
   e. be honest and reliable to gain client's/resident's trust
   f. know clients'/residents' likes and dislikes
   g. speak slowly, softly, and simply

D. families
   1. respond to requests and complaints
   2. answer questions honestly

E. other members of the health care team
   1. be tolerant of co-workers
   2. be respectful of co-workers
   3. be quiet when others are speaking
   4. listen to ideas of co-workers
   5. approach new ideas with an open mind
   6. use appropriate voice volume
   7. use appropriate language
   8. do not curse or use slang
   9. do not talk about client\residents in a rude or disrespectful manner

IV. Interpersonal Skills for the Nurse Aide
A. accept every client\resident
   1. be tolerant
   2. be patient
   3. be understanding
   4. be sensitive to needs of client\resident

Objectives

Given selected scenarios, identify the stressors for the Nurse Aide and the resources the Nurse Aide may use to deal with the stress as evidenced by participation in classroom discussion.

Demonstrate conflict management strategies discussed in class as evidenced by successful resolution of conflicts in given role-play scenarios.

Content Outline

B. listen to client\resident
C. be prepared to handle disagreement and criticism

V. Conflict Management
A. signs of stress at work
1. anger or abuse displayed toward client\resident
2. arguing with supervisor
3. poor working relations with co-workers
4. complaining about responsibilities of job
5. having difficulty focusing on work
6. experiencing "burn out"

B. resources to assist with stress management
1. family
2. friends
3. supervisor
4. place of worship
5. mental health agency

C. causes of conflict in the workplace
1. misunderstanding
2. misinterpretation
3. stress
4. poor communication

D. who may be involved in conflict
1. client\resident
2. family member
3. visitor
4. staff

E. conflict involving client\resident
1. report to supervisor
2. report to ombudsman
a. legal advocate for client\resident
b. investigates complaints
c. decides action to take if there is a problem
d. educates consumers and care providers
e. appears in court/legal hearings
f. gives information to public

F. strategies for Nurse Aide to manage conflict
1. stay calm, do not become emotional
2. remove yourself from the area of the conflict
3. be aware of your body language
4. do not discuss conflict in front of client\resident
5. speak privately with the person involved in the conflict
6. focus on the conflict
7. use "I" sentences

Objectives

Demonstrate an understanding of boundary violations, use and misuse of social media, and use of cell phones, (pictures and texting) as it relates to the care of residents.

Links to social media boundary violations
http://wgntv.com/2016/07/18/its-just-totally-wrong-nursing-home-workers-share-invasive-pics-and-videos-of-seniors-on-social-media/

https://www.propublica.org/article/inappropriate-social-media-posts-by-nursing-home-workers-detailed

Content Outline

8. listen to the other person
9. ask other person for ideas on how to resolve conflict
10. be open to a solution
11. may be necessary to agree to disagree

G. critical thinking process
1. identify the problem
2. list alternatives to solve the problem
3. list pros and cons to alternative solutions
4. mutually decide on a solution
5. evaluate the solution together

VI. Social media and cell phone use
A. definition of social media – a group of internet-based applications that allow the creation and exchange of user-generated content such as pictures and videos
B. some types of social media
1. Twitter
2. Facebook
3. Snapchat
4. Instagram
5. YouTube
C. CNAs must protect the client's/resident's privacy and confidentiality at all times
1. breaches in privacy or confidentiality can be
a. intentional – i.e. posting a picture on Facebook of a client/resident lying in bed
b. unintentional – posting a picture of self and a client/resident on Facebook
2. Health Insurance and Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) protect clients/residents' personal health information and privacy
3. if you are aware of any violation(s) it should be reported, whether intentional, or unintentional
D. use and misuse of clients/residents' social media
E. boundary violations
1. NEVER post pictures or videos of clients/residents on any type of social media
2. may be subject to criminal penalties and civil sanctions - severe violation up to $250,000 fine and 10 years in federal prison
3. may lose license
4. may be terminated by employer

Unit III – Infection Control
(18VAC90-26-40.A.1.b)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Describe the chain of infection.
2. Identify factors contributing to occurrence of infections.
3. Explain the early signs and symptoms of infection.
4. Describe Standard Precautions.
5. Demonstrate proper hand washing technique.
6. Demonstrate proper technique for donning and removing personal protective equipment.
7. Describe the proper disposal of infectious waste materials in the health care facility.

Objectives	**Content Outline**
List various types of pathogens that cause disease as evidenced by a minimum grade of 80% on the unit test.	I. Overview of Infection A. Microbes that cause disease (pathogens) 1. bacteria a. E. coli (urinary tract infections) b. Staphylococcus aureus (skin infections) c. Group A Streptococcus (strep throat) d. Other bacteria 2. fungus a. yeast infections b. athletes foot c. ringworm 3. virus a. Haemophilus influenzae (Hib) b. common cold c. human immunodeficiency virus (HIV) d. hepatitis e. noro virus (gastroenteritis) 4. parasite a. giardia (intestinal parasite) b. roundworm c. tapeworm d. pinworm e. scabies
Describe the relationship of the pathogens to the chain of infection as evidenced by a minimum grade of 80% on the unit test.	B. Chain of infection 1. microbe (pathogen) 2. reservoir a. place for pathogen to accumulate 3. means for microbe to leave reservoir 4. method of transmission a. how the pathogen spreads 5. portal of entry to host a. how the pathogen enters the new host 6. susceptible host a. person infected

Objectives	Content Outline
Identify factors contributing to the incidence of infection as evidenced by minimum grade of 80% on the unit test.	C. Factors contributing to incidence of infection 1. number of organisms (pathogens) present a. hospital acquired infection - nosocomial 2. virulence of organism or pathogen 3. susceptibility of the host a. age b. illness c. chronic disease d. poor nutrition e. poor hygiene f. stress g. fatigue 4. environmental conditions that foster growth of pathogens a. food – live or dead matter b. moisture c. warm temperature d. darkness
Describe sources and sites of infection as evidenced by participation in classroom discussion.	D. Sources of infection 1. human a. not washing hands after going to the bathroom b. coughing/sneezing into your hands c. poor hygiene 2. animal a. fecal contamination b. cat scratch fever c. deer tick (Lyme disease, Rocky Mountain spotted fever) d. mosquito (West Nile virus, malaria) e. meat that is not prepared to the proper temperature 3. environment a. contaminated water b. contaminated food c. food that is not properly refrigerated E. Sites of infection 1. respiratory system 2. urinary system 3. blood 4. break in the skin 5. intestinal tract
Identify human defenses against infection as evidenced by participation in classroom discussion.	F. Human body defenses against infection 1. external defenses a. the skin b. mucous membranes c. hair in the nose and ears d. keeping the skin clean e. good oral hygiene

Objectives	Content Outline
	2. internal defenses a. immune response 1. blood goes to area to clean away pathogens (redness, swelling, warmth) 2. white blood cells attack pathogen (pus) 3. increased body temperature (fever) helps to destroy pathogens b. antibodies 1. special proteins created by previous exposure to a pathogen 2. created by vaccination to a particular pathogen 3. attack newly arrived pathogen
List early signs of infection and the importance of reporting signs to a supervisor as evidenced by completion of classroom scenario.	G. Early signs/symptoms of infection 1. feeling “unwell” 2. sore throat 3. coughing 4. fever/chills 5. nausea 6. diarrhea 7. drainage from a skin wound 8. report these signs to appropriate supervisor
Explain why the elderly are so susceptible to infection as evidenced by participation in classroom discussion.	H. Why the elderly are so susceptible to infection 1. immune system becomes weaker 2. skin becomes thinner and tears more easily 3. limited mobility increases risk of pressure sores and skin infections 4. decreased circulation slows response of the blood to an infection 5. decreased circulation slows wound healing 6. catheters and feeding tubes are portals of entry for pathogens 7. dehydration increases risk of infection 8. malnutrition decreased body’s defense mechanisms against infection
Describe Standard Precautions guidelines as evidenced by participation in classroom discussion.	II. Prevention of infection A. Standard Precautions 1. all blood, body fluids, non-intact skin and mucous membranes are considered infected a. blood b. tears c. saliva d. sputum e. vomit f. urine g. feces h. pus or any fluid from a wound i. vaginal secretions j. semen

Objectives	Content Outline
	2. always follow Standard Precautions 3. established by Centers for Disease Control (CDC) B. Standard Precaution Guidelines 1. wash hands before putting on gloves 2. wash hands after taking off gloves 3. do not touch clean objects with contaminated gloves 4. immediately wash all skin contaminated with blood and/or body fluids 5. wear gloves if you may come in contact with blood or body fluids 6. wear a gown if your body may come in contact with blood or body fluids 7. wear a mask, goggles and/or face shield if your face may come in contact with blood or body fluids 8. place all contaminated supplies in special containers 9. dispose of all sharp objects in biohazard containers 10. never recap a needle 11. clean all surfaces potentially contaminated with infectious waste
Compare different methods used to achieve medical asepsis as evidenced by 80% minimum grade on unit test.	C. Medical Asepsis 1. physically removing or killing pathogens 2. uses a. soap b. water c. antiseptics d. disinfectants e. heat 3. sanitation a. basic cleanliness b. hand washing c. washing the body, clothes, linen, dishes 4 antisepsis a. kills pathogens or stops them from growing b. rubbing alcohol c. iodine 5. disinfect a. kills pathogen b. cleaning solutions 6. sterilization a. uses pressurized steam to kill pathogens
Demonstrate proper hand washing technique as evidenced by Satisfactory grade on Skills Record.	D. Hand ~~washing~~ Hygiene 1. most important factor in preventing transmission of pathogens 2. alcohol-based solutions are not a substitute for proper hand washing 3. keep fingernails short and clean 4. do not wear artificial nails or tips 5. rings and bracelets collect pathogens and should not be worn

Objective	Content Outline
	6. use lotion to keep skin soft and intact 7. when to wash hands a. arrival at work b. entering client\resident's room c. leaving client\resident's room d. before and after feeding client\resident e. before putting on gloves and after removing gloves f. after contact with blood or body fluids g. before and after handling food h. before and after drinking and eating i. after smoking j. after handling your hair k. after using the bathroom l. after coughing, sneezing or blowing your nose m. before leaving the facility n. when you get home 8. hand washing technique a. use technique in most current Virginia Nurse Aide Candidate Handbook
Demonstrate proper donning and removing technique for personal protective equipment as evidenced by Satisfactory grade on Skills Record.	E. Personal Protective Equipment (PPE) 1. barrier between a person and disease 2. gloves, mask, gown, goggles, face shield 3. don and remove PPE a. use technique in most current Virginia Nurse Aide Candidate Handbook
Identify various types of isolation precautions as evidenced by participation in classroom discussion.	F. Isolation precautions 1. measure taken to contain pathogen/s 2. follow CDC guidelines of facility policy 3. protocols to prevent exposure of other residents/staff to pathogen/s 4. Two levels of isolation precautions a. 1st level - Standard Precautions 1. For all resident care 2. For protection from blood and body fluids which may contain infectious agents b. 2nd level – Transmission based ~~1. Multi-drug resistant organism- microorganism, usually bacteria, that is resistant to commonly used anti-microbial agents (e.g. antibiotics)~~ ~~a. MRSA – methicillin resistant Staphococcus aureus~~ ~~b. VRE – vancomycin resistant enterococcus~~ ~~c. Clostidium difficile (c. diff)~~ ~~2. airborne – transmitted through the air~~ ~~a. TB, chicken pox~~

Objectives

Describe the disposition of infectious waste material in a health care facility as evidenced by minimum of 80% on the unit test.

Content Outline

~~3. droplet – transmitted by droplets from mouth or nose~~
~~– a. flu, strep throat, pneumonia~~

~~4. contact – transmitted by touching~~
~~a. skin/wound infections, feces, respiratory secretions~~

G. Personal Hygiene
1. keep yourself clean
2. wear clean uniform each day
3. keep yourself well-hydrated and well-nourished
4. give yourself adequate rest and sleep
5. if you are ill do not come to work
6. keep hair pulled back and secured
7. follow facility policy and nails and jewelry

H. Disposition of contaminated waste
1. infectious waste
   a. contaminated with blood or body fluids
2. biohazard bags used to dispose of infectious waste
   a. red bags
3. biohazard bags are not disposed with ordinary trash
   a. must be incinerated
4. improper disposal of biohazard waste is dangerous for everyone

1. for residents who may be infected or colonized with certain infectious agents (CDC)
2. Three types
   a.Contact – transmitted by touching such as skin, wound infections, feces, respiratory secretions
   b. Droplet – transmitted by droplets from mouth or nose such as influenza, strep throat, pneumonia
   c. Airborne – transmitted through air such as Tuberculosis, chicken pox
3. Infectious agents commonly seen:
   a. MRSA (Methicillin Resistant Staphlococcus Aureus)
   b. VRE (Vancomycin Resistant Enterococcus)
   -multi-drug resistant bacteria
   -indicative of chronic illness
   c. C.Diff (Clostridium difficile) – a bacterium which causes inflammation of the colon resulting in diarrhea and serious illness

Content Outline

- note hand hygiene must include washing with soap and water versus hand sanitizer
d. Noroviruses – very contagious causing vomiting and diarrhea
e. E. coli (Escherichia coli) – bacteria found all over in environment. Many strains harmless, but some cause severe illness
f. Influenza – Flu can be caused by different strains. Very contagious. Prevention with flu vaccine.

Unit IV – Safety Measures
(18VAC90-26-40.A.1.c)
(18VA 90-26-40.A.7.g)
(18VAC90-26-40.A.9)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Explain the OSHA Bloodborne Pathogen Standards.
2. Identify risk factors for common accidents in health care facilities.
3. Identify safety measures to prevent falls in health care facilities.
4. Discuss measures to prevent various common accidents in health care facilities.
5. Demonstrate how to deal with an obstructed airway.
6. Discuss how to avoid the need for restraints in accordance with current professional standards.
7. Demonstrate how to use good body mechanics when caring for client\residents.
8. Discuss how to prevent and react to fire and other disasters in a health care facility.

Objectives	Content Outline
Demonstrate an understanding of the OSHA Bloodborne Pathogen Standard as evidenced by participating in classroom discussion.	I. Prevention of Common Accidents A. Occupational Safety and Health Administration (OSHA) 1. federal agency 2. responsible for safety and health of workers in USA 3. establishes workplace rules for safety 4. conducts workplace inspections 5. mandates workplace training for safety issues 6. Bloodborne Pathogen Standard a. requires regular in-service training b. identifies steps to take when exposed to bloodborne pathogen c. requires employers to provide PPE for staff, clients\residents, visitors d. requires each client\resident room to have biohazard containers to dispose of contaminated equipment/supplies e. requires employers to provide free hepatitis B vaccine for employees f. examples of bloodborne diseases: AIDS, hepatitis
List risk factors for common accidents as evidenced by minimum grade of 80% on the unit test.	B. Risk factors for common accidents 1. environmental risk factors a. floor – wet, cluttered b. equipment not used properly or correctly c. equipment not kept in good repair d. special precautions e. arrangement of furnishings/equipment to ~~prevent~~ allow for a clear walkway (med cart, O2 tank, etc) f. mirrors g. throw rugs h. shadows **i.** smells/odors **j.** lighting **k.** stairs 2. client\resident risk factors ~~a. age~~ functional ability/frailty b. impaired vision c. impaired hearing d. impaired sense of smell e. impaired sense of touch f. impaired memory g. altered behavior h. impaired mobility i. medications 3. staff risk factors a. use of equipment without proper training b. being in a hurry c. use of poor body mechanics

Objectives	**Content Outline**
	C. Fall prevention 1. fall risks for the ~~elderly~~ client/resident a. impaired vision b. impaired hearing c. decreased balance/unsteady gait d. impaired memory e. disoriented f. confused g. slower reaction time h. slower movements i. tremors j. medications
Identify safety procedures to prevent falls in health care facilities as evidenced by participating in classroom discussion and demonstration in skills lab.	2. measures to prevent falls ~~in the elderly~~ a. keep personal items within reach b. keep call bell within reach c. answer call bell promptly d. encourage client\resident to wear their glasses e. maintain adequate lighting in areas where client\resident will ambulate f. lock brakes on movable equipment g. wear non-skid footwear when walking h. wear clothing and footwear that fits properly – not too big or too long i. toilet client\resident on a regular basis j. keep clear walkway in room and halls k. avoid use of throw rugs l. wipe spills on the floor immediately m. only rearrange client\resident's furnishings with their approval n. report any equipment not in good working order o. report any frayed electrical cords p. report any observations of high risk client\resident behavior
Identify the importance of reporting falls to the appropriate supervisor as evidenced by participating in classroom discussion.	3. report a fall to appropriate supervisor immediately – follow health care facility policy for care of client\resident who has fallen
Discuss measures to prevent various common accidents in health care facilities as evidenced by participation in classroom discussion.	D. prevention of scalds and burns 1. scalds a. burns caused by hot liquid such as water, coffee or tea b. liquid temperature 140° or greater 2. burns a. cigarette burns b. liquid burns c. chemical burns d. electrical burns 3. measures to prevent scalds or burns a. water temperature should be 110°

Objectives	Content Outline
	b. do not have client\resident use toe to check water temperature c. staff should check temperature of water before giving client\resident bath or shower d. use low setting on hair dryers e. do not use microwave oven to prepare a warm soak or application f. encourage client\resident to allow hot drinks to cool before drinking g. if client/resident has tremors, encourage use of closed cup when drinking hot liquids h. pour hot liquids away from client\residents i. require client to follow facility smoking policy j. frequently check electrical cords for fraying and report any that are frayed; use safety outlet plugs k. avoid keeping cleaning chemicals in areas where clients have access 4. report a scald or burn to appropriate supervisor immediately - follow health care facility policy for care of client\resident who has been scaled or burned
Identify the information contained on a ~~Materials~~ Safety Data Sheet as evidenced by accurately reading a specified SDS. https://www.osha.gov/Publications/OSHA3514.html	5. ~~Materials~~ Safety Data Sheets (SDS) a. an OSHA requirement in all health care facilities for any dangerous chemical on site b. all staff should have access and know where these are kept c. information included on SDS 1. chemical ingredient 2. danger of the product 3. PPE to be worn when using chemical 4. correct way to use and clean up the chemical 5. emergency action to take if the chemical is spilled, splashed or ingested 6.safe handling procedures for the chemical
	E. prevention of poisoning 1. risk factors a. personal care items – nail polish remover, soaps, perfume, hair products b. cleaning supplies c. some plants/flowers 2. Poison Control phone number required to be prominently displayed 3. measures to prevent poisoning a. keep cleaning chemicals in locked cabinet b. check drawers for hoarded food that may have spoiled c. keep medications away from the bedside 4. report a poisoning to appropriate supervisor immediately follow health care facility policy for care of client who has been poisoned

Objectives	Content Outline
Demonstrate the procedure for dealing with an obstructed airway as evidenced by successfully performing the procedure on a manikin. https://youtu.be/A80wU5UgS-A	F. prevention of choking 1. object blocks the trachea (windpipe) 2. risk factors a. difficulty swallowing b. disoriented 3. measures to prevent choking a. client\resident in upright position for eating/ feeding b. do not rush client\resident while eating c. cut food into small pieces d. use thickening for liquids if client\resident has difficulty with thin liquids e. make sure dentures fit correctly f. report any problems with swallowing or choking to appropriate supervisor 4. demonstrate how to deal with an obstructed airway a. follow health care facility guidelines for obstructed airway G. prevention of suffocation 1.risk factors a. improperly fitting dentures b. poor feeding technique c. unattended baths d. use of restraints 2.measures to prevent suffocation a. report to appropriate supervisor any dentures that do not fit properly b. always have client\resident in upright position when eating c. never leave client\resident unattended in a bath tub, whirlpool or shower d. avoid use of physical or chemical restraints
Discuss the use of restraints, including the reasons to avoid their use, as evidenced by participation in classroom discussion.	H. Avoiding the need for restraints 1. restraints a. restrict voluntary movement or behavior b. may be physical or chemical 2. physical restraints/protective devices a. examples – vest, wrist/ankle restraints, waist/belt restraint, mitt b. bed side rails c. ~~geriatric table chair~~ any chair that prevents client/resident from rising (geriatric table chair; recliner) 3. chemical restraints - medication that controls client's/ resident's behavior 4. problems with restraints/protective devices a. bruising b. decreased mobility 1. pressure sores

Objectives	Content Outline
	2. pneumonia 3. incontinence 4. constipation 5. social isolation c. stress and anxiety d. increased agitation e. loss of independence f. loss of dignity g. loss of self-esteem h. risk of suffocation 5. use of restraints/protective devices
Explain the importance of and frequency of monitoring the client\resident while restraints/protective devices are in use.	a. requires health care provider order b. illegal to use for convenience of the staff c. client\resident must be continually monitored, at least every 15 minutes d. restraint must be released every 2 hours e. know how to use
Identify alternatives to restraints/protective devices as evidenced by active participation in classroom discussion.	6. restraint alternatives (restraint-free care) - evaluate situation for cause of behavior or problem by anticipating client/resident's needs: ~~is client…~~ 1. is client/resident wet ? 2. is client/resident soiled ? 3. is client/resident tired ? 4. is client/resident thirsty ? 5. is client/resident hungry ? 6. is client/resident bored ? 7. observe for emotional status 8. observe for pain 9. is client/resident confused/disoriented? b. encourage client/resident independence 1. provide meaningful activities 2. ~~allow~~ encourage to participate in activities to best of client's\resident's ability 3. redirect the client's/resident's interests c. reduce boredom ~~keep~~ encourage clients'/residents engagement 1. involve ~~client with~~ in activities/life enrichment appropriate for client/resident 2. take client/resident for walk 3. encourage participation in social activities that are meaningful to the client/resident 4. provide reading materials 5. read to client/resident if desired d. provide a safe area for client/resident to ~~walk~~ ambulate 1. well-lighted 2. free of clutter 3. make sure client wears non-skid footwear 4. provide activity for client who wanders at night

Objectives	Content Outline
	e. reduce tension and anxiety 1. toilet every 2 hours 2. escort client\resident to social activities 3. provide backrub 4. offer snack or drink 5. reduce noise level around client\resident 6. play soothing music f. involve family in client's\resident's care 1. encourage visits 2. encourage participation in care of client\ resident g. other alternatives to restraints 1. bed/chair alarms 2. specially shaped cushions h. report any changes in client's/resident's behavior or mental status to appropriate supervisor i. answer call bells immediately
Demonstrate the use of good body mechanics as evidenced by performance of skills on Skills Record.	II. Workplace Safety A. Body mechanics 1. definitions a. alignment – keeping muscles and joints in proper position to prevent unnecessary stress on them b. balance – keeping center of gravity close to base of support c. coordinated body movement – using your body weight to help move the object 2. lifting a. feet hip distance apart b. back straight c. knees bent d. object close to you e. tighten abdominal muscles f. lift with leg muscles g. keep object close to your body h. keep your back straight 3. client\resident care a. if client\resident is in bed, raise bed to waist height. Remember to lower bed when you are finished b. push, slide or pull rather than lifting, if possible c. avoid twisting when lifting by pivoting your feet d. do not try to lift with one hand e. ask for help from co-workers f. tell client\resident what you are planning to do so they can help you, if possible
Demonstrate the correct way to assist a falling client\resident evidenced by role-playing with a fellow student.	4. assisting the falling client\resident a. do not try to prevent the fall

Objectives	Content Outline
	b. stand behind the client/resident with arms around his torso c. slide client/resident down your body and leg, as sliding board d. ease client\resident to the floor e. protect the head f. stay with client\resident and call for help g. report the incident to the appropriate supervisor as soon as possible
Discuss the importance of and methods for reporting incidents/accidents to the appropriate supervisor as evidenced by accurately documenting an incident or an accident on an Incident Report.	B. Incident/Accident reports 1. incident – accident, problem or unexpected event that occurs while providing client\resident care a. may involve staff, client\resident and/or visitor 2. report should be written as soon as possible after the event a. document exactly what happened b. give time and condition of person involved c. only use facts, not opinions 3. information is confidential 4. report is given to the charge nurse 5. always file an incident report if you are injured on the job a. provides protection for you b. identifies that injury occurred at work
Identify potential causes of a fire in a health care facility as evidenced by participation in classroom discussion.	C. Fire safety 1. fire requires a. object that will burn b. fuel – oxygen c. heat to make the flame 2. potential causes of fire a. smoking b. frayed/damaged electrical cord/wires c. electrical equipment in need of repair d. space heaters e. overloaded electrical plugs/outlets f. oxygen use g. careless cooking h. oily cleaning rags i. newspapers and paper clutter
Identify ways to prevent a fire in a health care facility as evidenced by participation in classroom discussion.	3. ways to prevent fire in a health care facility a. stay with resident who is smoking b. make sure cigarettes and ash are in ashtray c. only empty an ashtray if cigarette and ash are not hot d. report frayed/damaged cords/outlets immediately e. keep fire doors closed and accessible f. Keep halls clear and accessible

Objectives	Content Outline
Discuss the sequence of events to be taken if fire is discovered in a health care facility as evidenced by participation in classroom discussion.	4. RACE a. if fire occurs b. R – remove client\resident from danger c. A – activate alarm d. C – contain fire by closing doors and windows e. E – extinguish fire if possible or evacuate the area
Demonstrate the proper use of a fire extinguisher as evidenced by successful role-play in class.	5. use of a fire extinguisher - PASS a. P – pull the pin b. A – aim at the base of the fire c. S – squeeze the handle d. S – sweep back and forth at the base of the fire
	6. know facility policy/procedure for a fire a. call for help immediately b. know location of fire evacuation plan c. remain calm and do not panic d. remove all persons in the immediate area of the fire **(RACE)** e. if a door is close, always check it for heat before opening it f. stay low in room when trying to escape fire to avoid the smoke g. use wet towels to block doorways to prevent smoke from entering a room h. use covering over face to reduce smoke inhalation i. if clothing is on fire…Stop…Drop…Roll j. never get into an elevator during a fire
Discuss the sequence of events to be taken in the event of a disaster as evidenced by participation in classroom discussion.	D. Safety in a disaster 1. definition a. sudden unexpected event b. hurricane c. ice/snow storm d. flood e. tornado f. earthquake g. acts of terrorism
Explain the importance of the facility policy/procedure manual for fire and disaster, including its location as evidenced by finding the manual and locating the fire and disaster policies and the evacuation plan.	2. know where facility disaster policy/procedure manual is located 3. know your responsibilities during a disaster a. listen carefully to directions b. follow instructions c. know location of all exits and stairways d. know where fire alarms and extinguishers are located e. client\resident safety comes first f. keep calm 4. know facility evacuation plan

Objectives

Discuss the role of the nurse aide and oxygen use in a health care facility as evidenced by accurately role-playing in the skills lab.

Content Outline

E. Safety precautions for oxygen use

1. oxygen use
   a. client\resident with difficulty breathing
   b. prescribed by health care provider
2. role of the nurse aide
   a. observation only
   b. only licensed person (RN or LPN) can adjust the flow rate
3. special safety precautions
   a. post "No Smoking" and "Oxygen in Use" signs in room and on the door to the room
   b. smoking is not permitted in the client's/ resident's room or around oxygen equipment
   c. remove fire hazards from the room such as electrical equipment: razors, hair dryers, radios
   d. remove flammable liquids from client's/ resident's room: nail polish remover, alcohol
   e. do not permit candles, lighters or matches around oxygen equipment
   f. synthetic (man-made fibers), nylon and wool material should not be used around oxygen equipment because they create static electricity which can create a spark and start a fire
   g. check client's/resident's nose and behind their ears for irritation caused by oxygen tubing and report irritation to appropriate supervisor
   h. learn how to turn off oxygen equipment in case of a fire
4. report any changes in the client's/resident's condition to the appropriate supervisor
5. report any problems with the oxygen equipment immediately to the appropriate supervisor

Unit V – Emergency Measures
(18VAC90-26-40.A.1.c)
(18VAC 90-26-40.A.2.f)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Identify the basic steps a nurse aide should take in any emergency situation.
2. Identify client\resident symptoms indicative of an emergency.
3. Demonstrate how a nurse aide responds to an unconscious client\resident.
5. Identify the signs/symptoms of various client\resident medical emergencies.
6. Demonstrate the appropriate nurse aide response to various client\resident medical emergencies
7. (optional) Demonstrate how to perform CPR on an adult client\resident.

Objectives	**Content Outline**
	I. Life-threatening emergency measures A. Emergency 1. definition a. condition requiring immediate medical or surgical treatment to prevent the client from having a permanent disability or from dying
Identify the basic steps a nurse aide should take in any emergency situation as evidenced by participation in classroom discussion.	2. basic steps for nurse aide in an emergency a. collect information from client or situation b. call or send for help c. use gloves and a breathing barrier d. remain calm e. know your limitations f. assist medical personnel after help arrives
Identify symptoms a client\resident may display when experiencing an emergency as evidenced by minimum grade of 80% on the unit test.	3. emergency situations a. change in level of consciousness b. irregular breathing or not breathing c. has no pulse d. severely bleeding e. unusual color or feel to the skin f. choking g. poisoning h. severe pain i. shock j. allergic reaction
Demonstrate the appropriate response to a conscious or unconscious client\resident in an emergency situation as evidenced by role-play in class.	B. Responding to change in level of consciousness 1. definitions a. conscious – mentally alert and aware of surroundings, sensations and thoughts b. confused – disoriented to time, place, and/or person c. unconscious – client is unable to respond to touch or speech 2. responding to conscious client a. has a pulse and is breathing b. observe skin color, warmth, moisture c. call for help

Objectives	Content Outline
	d. question client regarding pain, illnesses, current medical issues e. take vital signs (VS) f. remain calm g. reassure client h. stay with client until help arrives i. document what occurred, the time, and VS 3. responding to an unconscious client a. this is an emergency b. know client's DNR status c. know facility policy/procedure for activating the EMS or 911 d. activate emergency medical system by calling for help or have someone call immediately e. initiate CPR (if facility policy permits) or first aid until EMS or medical personnel arrive 4. responding to a client who is not breathing a. position on the floor b. shake to determine consciousness c. if unconscious, call for help d. open the airway with head tilt-chin lift e. look-listen-feel for 10 seconds to determine if client has signs of life f. if there are signs of life, provide rescue breaths g. if there are no signs of life begin CPR
Demonstrate CPR, including the use of an AED, on an adult manikin as evidenced by Satisfactory grade on Skills Record. (optional)	5. responding to client who has no pulse and is not breathing (if facility policy permits a Nurse Aide to perform CPR and client is not a DNR) a. position on the floor b. shake to determine consciousness c. if unconscious, call for help d. open the airway e. look-listen-feel for 10 seconds to determine if client has signs of life f. if there are no signs of life begin CPR g. provide 30 chest compressions and 2 breaths at a rate of 100 compressions/minute h. repeat 5 cycles of 30 compressions:2 breaths until the AED (automated external defibrillator) arrives i. when AED arrives place pads on chest and follow the prompts from the AED
	II. Basic Emergency Measures
Discuss appropriate nurse aide actions for a client\resident who is bleeding.	A. Bleeding 1. call nurse immediately 2. put on gloves 3. have client lie down 4. apply pressure to source of bleeding with a clean cloth 5. elevate source of bleeding above level of the heart, if

Objectives	Content Outline
	possible 6. place another cloth on top of original cloth if the 1st one becomes saturated 7. when help arrives, remove gloves, wash hands and document what occurred
Discuss appropriate nurse aide actions for a client\resident who is having a nose bleed.	B. Nose bleed (Epistaxis) 1. may be caused by dry air, medical condition, medications 2. notify nurse immediately 3. put on gloves 4. have client tilt head slightly forward and squeeze the nose with your fingers 5. apply pressure until bleeding stops 6. apply ice pack or cool cloth to back of the neck, forehead or upper lip to help slow the bleeding 7. stay with client until bleeding stops 8. remove gloves and document what occurred
Demonstrate appropriate nurse aide actions for a client\resident who has fainted as evidenced by role-play in class.	C. Fainting (Syncope) 1. caused by decreased blood flow to the brain 2. notify nurse immediately 3. assist client to floor 4. if client is in chair, have them place head between their knees 5. elevate feet about 12 inches above level of the heart 6. take VS 7. loosen any tight clothing 8. do not leave client unattended 9. if client vomits, turn on side in recovery position 10. after symptoms disappear have client remain lying down for 5 minutes 11. slowly assist client to seated position 12. document what occurred, the time and VS
Discuss appropriate nurse aide actions for a client\resident who has vomited.	D. Vomiting (Emesis) 1. notify nurse immediately 2. put on gloves 3. use emesis basin, wash basin or trash can 4. wipe client's mouth and nose 5. be calm and reassuring to the client 6. when client is finished offer water or mouthwash to rinse the mouth 8. encourage client to brush teeth or provide oral care to dependent client 9. provide client with clean clothes and/or clean linen as necessary 10. flush vomit down the toilet after showing it to the nurse and wash the basin 10. place soiled linen in proper containers 11. remove gloves and wash hands 12. document time, amount, color, odor and consistency of vomitus

Objectives	Content Outline
Discuss appropriate nurse aide actions for a client\resident who has been burned.	E. Burns (1st, 2nd, & 3rd degree) 1. notify nurse immediately – assist only as directed by lic professional (i.e.-nurse, N.P., physician, P.A.) 2. put on gloves to protect client/resident and self ~~3. for minor burns, place area under cool running water~~ 3. lightly cover with dry, sterile gauze, if directed 4. never apply butter, oil, ~~or~~ ointment, water or any other solution to a burn ~~5. if burn is severe or is caused by a fire, do not apply water~~ ~~a. remove as much clothing around the burn as possible without pulling away clothing that sticks to the burn~~ ~~b. cover burn with dry sterile gauze~~ ~~c.~~5. have client lie down and wait for EMS to arrive ~~d.~~ 6. stay with client until help arrives 7. remove gloves, wash hands and document what occurred per facility policy
Explain the signs/symptoms of a heart attack as evidenced by minimum grade of 80% on unit test. Abbreviations c/o = complaint of SOB = Shortness of breath	F. Most common Signs of a heart attack (myocardial infarction) (MI) (may differ in males and females) 1. ~~complaint of~~ c/o "heaviness" or pain in the chest – female may feel tight discomfort described as a full feeling across entire chest 2. ~~complaint of~~ c/o pain radiating down left arm (either male or female) 3. c/o sharp upper body pain (female) 4. difficulty breathing or SOB 5. sweating – may be mistaken for hot flash in females 6. skin looks pale or bluish 7. complaint of nausea or indigestion 8. stomach cramps (female) 9. jaw pain (female)
Discuss appropriate nurse aide actions for a client\resident who has signs/symptom of a heart attack.	G. Heart attack 1. have client lie down 2. notify nurse immediately 3. this is medical emergency 4. elevate client's head to help him/her breathe better 5. initiate CPR if necessary 6. stay with client until help arrives 7. document what occurred and the time per facility policy
Discuss appropriate nurse aide actions for a client/resident who is having a seizure.	H. Seizure 1. Clear the immediate area of objects that may cause harm 2. Assist client/resident to the floor 3. Notify nurse immediately 4. protect the head, but allow remainder of body to move 5. note time seizure began

Objectives	Content Outline
	~~6. notify nurse immediately~~ 6. do not try to put anything in client's mouth 7. after seizure, turn client on side in recovery position 8.document time seizure began, what occurred per facility policy
Explain the signs/symptoms of a stroke as evidenced by minimum grade of 80% on unit test. Discuss appropriate nurse aide actions for a client/resident who is having a stroke. Observe and report (Using Mnemonic) **F** FACE: Does one side of the face droop? **A** ARMS: Does one arm drift downward when both arms are raised? **S** SPEECH: Is speech slurred or strange? **T** TIME: If you observe any of these signs, report to appropriate staff member immediately. This is a medical emergency; follow facility policy for activating 9-1-1. Discuss definition of and causes of shock.	I. Signs of a ~~stroke (CVA~~)cerebral vascular accident (CVA) such as stroke. Remember to act FAST and report to nursing supervisor of appropriate licensed Staff immediately. 1. change in level of consciousness 2. complaint of severe headache 3. drooping on one side of the face 4. weakness on one side of the body 5. sudden on-set of slurred speech J. Stroke 1. notify nurse immediately 2. this is medical emergency 3. have client lie down 4. note time of on-set of symptoms 5. stay with client until EMS arrives 6. document time of on-set of symptoms and what occurred K. Shock 1. definition a. lack of adequate blood supply to body organs b. medical emergency 2. causes a. bleeding b. heart attack c. severe infection d. low blood pressure e. exposure to environmental changes
Identify the signs/symptoms of shock as evidenced by minimum grade of 80% on unit test. Discuss appropriate nurse aide actions for a client/resident who is in shock.	3. signs/symptoms a. pale or bluish skin b. staring c. increased pulse and respirations d. decreased blood pressure e. extreme thirst 4. care of client experiencing shock a. notify nurse immediately b. have client lie down c. control any bleeding that you can see d. check VS e. if no respirations or pulse begin CPR f. cover client with blanket to maintain temperature g. elevate feet about 12 inches

Objectives	Content Outline
	h. do not give client anything to eat or drink i. remain with client until EMS arrives j. document what occurred
Explain the signs/symptoms of hypoglycemia as evidenced by minimum grade of 80% on unit test.	L. Diabetic reactions 1. low blood sugar (hypoglycemia) a. signs/symptoms 1. nervous 2. dizzy 3. hungry 4. headache 5. rapid pulse 6. disoriented 7. cool, clammy skin 8. unconscious
Discuss appropriate nurse aide actions for a client/resident Who is hypoglycemic.	b. care of client with low blood sugar 1. notify the nurse immediately 2. if conscious, give glass of orange juice or something to eat that has sugar or complex carbohydrates 3. know facility policy for low blood sugar 4. stay with client until feels better 5. document what symptoms you saw, when they occurred and what you did
Explain the signs/symptoms of hyperglycemia as evidenced by minimum grade of 80% on unit test.	2. high blood sugar (hyperglycemia) a. signs/symptoms 1. increased thirst 2. increased urination 3. increased hunger 4. flushed, dry skin 5. drowsy 6. nausea, vomiting 7. unconscious
Mnemonic Hot and dry; sugar high Cold and clammy; need some candy	
Discuss appropriate nurse aide actions for a client/resident who is hyperglycemic.	b. care of client with high blood sugar 1. notify nurse immediately 2. follow nurses instructions 3. document what symptoms you saw, when they occurred and what you did

Unit VI – Client Rights
(18VAC90-26-40.A.1.d)
(18VAC 90-26-40.A.1.e)
(18VAC 90-26-40.A.4.b)
(18VAC 90-26-40.A.4.h)
(18VAC 90-26-40.A.7.a,b,c,d,e,f)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Identify the basic rights of all clients.
2. Identify specific rights of clients in long-term care facilities.
3. Explain how HIPAA effects practice of the nurse aide.
5. Demonstrate actions of the nurse aide that promote client rights in long-term care facilities.
6. Discuss strategies to provide privacy and maintain confidentiality.
7. Define mistreatment including, abuse, neglect, and exploitation including misappropriation of client's/resident's property.
8. Recognize indicators of abuse, neglect, and exploitation including misappropriation of client's/resident's property.
8. Identify actions the nurse aide can take to avoid accusations of ~~abuse,~~ mistreatment including adult abuse, neglect, ~~and~~ neglect and/or exploitation and misappropriation of client's/resident's property ~~toward clients~~.
8. Describe the consequences of a report of ~~abuse,~~ mistreatment, including adult abuse, ~~or~~ neglect or exploitation against a nurse nurse aide
9. Describe strategies the nurse aide can use to promote client independence.
10. Explain how the nurse aide can modify care of the client to promote culturally sensitive care.
11. Identify developmental tasks for each age group.
12. Discuss how the changes of late adulthood effect the psychosocial and physical care of the client in long-term care.

Objectives	**Content Outline**
Identify the four (4) basic rights of all clients as evidenced by a minimum grade of 80% of the unit test.	I. Basic Rights of All Clients A. right to be treated fairly and with respect B. right t3o live in dignity C. right to be free from fear D. right to pursue a meaningful life
Explain client rights identified in the Omnibus Budget Reconciliation Act (OBRA) and the Health Insurance Portability and Accountability Act (HIPAA) as evidenced by participation in classroom discussion.	II. Rights of clients of long-term care facilities A. part of Omnibus Budget Reconciliation Act (OBRA) B. client has right to: 1. make decisions regarding care 2. privacy 3. be free from physical or psychological abuse, including improper use of restraints 4. receive visitors and to share room with a spouse if both partners are residents in the same facility 5. use personal possessions 6. control own finances 7. confidentiality of his/her personal and clinical records 8. information about eligibility for Medicare or Medicaid funds 9. information about facility's compliance with regulations, plan changes in living arrangement and available services

Objectives	Content Outline
	~~9. remain in facility unless transfer or discharge is required by change in clients health, ability to pay or the facility closes~~ 10. voice grievances without discrimination or reprisal 11. examine results of recent survey 12. exercise his/her rights as a citizen or resident of the U.S. 13. remain in facility unless transfer or discharge is required by change in client's/resident's health, ability to pay, or the facility closes 14. organize and participate in groups organized by other residents or families of residents including social, religious and community activities 15. choose to work at the facility either as a volunteer or a paid employee, but cannot be obligated to work C. HIPAA (Health Insurance Portability and Accountability Act) 1. Federal law since 1996 (Privacy Rule 2000 & Security Rule 2003, Enforcement 2. identifies protected health information that must remain confidential 3. only those who must have information for care or to process records can have access to this information 4. nurse aide must never share protected health information with anyone not directly involved in care of client/resident (including family members or other clients/residents) 5. do not give information over the telephone unless you know you are speaking with an approved staff member 6. do not share client information on any social Media, including photos, videos, texts, and emails 7. do not discuss client/resident in public area 8. set standards for use of individually identifiable health information use, and electronic records 9.set standards for reporting vilolations
Identify nurse aide actions that maintain client privacy and confidentiality as evidenced by accurate participation in classroom scenarios.	
	D. actions of the nurse aide to promote client rights 1. right to privacy and confidentiality a. pull curtain or close door when providing personal care b. cover lap of client sitting in chair/wheelchair c. allow client to use bathroom in private d. allow alone-time with family and visitors
Identify nurse aide actions that promote the client's right to make personal choices to accommodate their individual needs as evidence by accurate participation.	

Objectives	Content Outline
	e. allow client to have personal alone-time f. only discuss client/resident information with other health care team members when there is a need to know. Do not share information with unauthorized family members or with other clients/residents g. do not share client information on any form of social media, including photos, videos, texts and emails
	2. right to make personal choices to accommodate individual needs a. client has right to make choices about their care 1. may choose own physician 2. participate in planning their therapies, treatments and medications 3. right to refuse care, medication b. encourage client to make choices during personal care 1. when to bathe/shower 2. what to wear 3. how to style hair c. encourage client to make choices at mealtime 1. filling out menu 2. order in which food is eaten 3. what fluids offered d. encourage client to choose activities and schedules e. honor client choices regarding when to get up and when to go to bed f. permit client enough time to make choices g. make a habit of offering client choices while providing care h. offer input to Interdisciplinary Care Team regarding client choices i. freedom of sexual expression/gender identity
Identify nurse aide actions that assist the client with their right to receive assistance resolving grievances and disputes as evidenced by accurate participation in classroom scenarios	3. assistance resolving grievances and disputes a. listen to client 1. obtain all the facts 2. report facts to charge nurse 3. follow up with the client b. avoid involvement in family matters 1. do not take sides 2. do not give confidential information to family members 3. report disagreements to charge nurse
Describe the role of the ombudsman in a long-term care facility as evidenced by accurate participation in classroom scenarios.	c. remember the nurse aide is the client advocate d. involve the ombudsman of the facility 1. legal problem solver on behalf of client 2. listens to client and decides what

Objectives	Content Outline
	action to take 3. telephone number is listed in the facility e. client may not be punished or fear retaliation for voicing concerns or complaints
Identify nurse aide actions that provide the client with assistance necessary to participate in client and family groups and other activities as evidenced by accurate participation in classroom scenarios.	4. provide assistance necessary to participate in client and family groups and other activities a. provide client with calendar of daily activities b. allow time to make choices c. be flexible with client schedule to permit participation in activities d. encourage client to participate in activities e. encourage family to visit f. procure appropriate assistive devices to be able to attend activities 1. wheelchair 2. walker 3. cane g. assist client to dress appropriately to attend activities 1. glasses 2. hearing aid 3. ~~attractive~~, clean, appropriate clothing 4. hair care and grooming h. assist client to toilet before attending activities i. provide means to attend activities in facility 1. escort or take client to activities in facility 2. return client to room after activities in facility j. families have right to meet with other families to discuss concerns, suggestions and plan activities
Identify nurse aide actions that maintain the care and security of the client's personal possessions as evidenced by accurate participation in classroom scenarios.	5. maintaining care and security of client's personal possessions a. mark all clothing with name and room number b. encourage family to take valuable items and money home c. if client wants to keep valuable, encourage use of lock box or facility safe d. honor privacy of client regarding their possessions e. assist client to keep personal possessions neat and clean f. permit client right to decide where personal items are kept, if possible g. be careful when working around client personal items h. complaint of stolen, lost or damaged property must immediately be reported and investigated

Objectives	Content Outline
	i. avoid placing client personal possessions in areas where nursing care is performed
	6. promoting client's (vulnerable adults) right to be free from mistreatment, including ~~and~~ abuse, neglect, exploitation ~~and/or~~ including misappropriation of client/resident property and the need to report any instances of such treatment to appropriate staff and/or Adult Protective Services (APS) a. philosophy of APS. Vulnerable adults (client/resident has the right to: 1. to be treated with dignity 2. refuse assistance if he/she is capable of making decisions 3. make their own choices regarding how and where they live 4. privacy b. vulnerable adults are persons 18 years of age or older who are incapacitated, or persons 60 years of age or older c. mandatory reporting of suspicion of willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm or mental anguish – Elder Justice Act d. mandatory reporters include, but are not limited to 1. any person licensed, certified or registered, by health regulatory boards (except veterinarians), any mental health service provider, any person employed by or contracted with a facility working with adults in a administrative, supportive, or direct care capacity, any law enforcement officer 2. reports should be made immediately to the local Department of Social Services or toll-free 24-hour APS hotline 1-888-832-3858. As a caregiver, you are uniquely suited to observe mistreatment. 3. If there is harm/injury, reporting ??? made timely within 2 hours and reports within 24-hours If there is harm/injury local law enforcement must be notified
According to APS, reports are made immediately Find your local APS http://www.dss.virginia.gov/localagency/index.cgi	
Define the types of adult abuse recognized in Virginia	7. Define abuse a. abuse – the intentional infliction of physical pain or injury. This also includes mental anguish and extends to unreasonable confinement – physical or chemical restraints, isolation, or other means of confinement without medical orders, when such confinement is used for purposes other than providing safety and well-being of client/resident or those around the individual b. mental (psychological) anguish – indicated by a state of emotional pain or distress resulting from activity (verbal or behavioral) or a perpetrator. The intent of the activity is to threaten or intimidate, to cause sorrow, or fear, to humiliate, change behavior or ridicule. Evidence must show that the
Objectives	

Recognize the indicators of physical abuse of older or incapacitated adults

Discuss the definition of neglect of vulnerable or incapacitated adults (clients/residents)

Recognize the indicators of neglect of vulnerable or incapacitated adults (clients/residents)

Discuss the definition exploitation of vulnerable or incapacitated adults (clients/residents)

Recognize the indicators of exploitation of vulnerable or incapacitated adults (clients/residents)

mental anguish was caused by the perpetrator's activity.
c. sexual abuse – unwanted sexual activity including, but not limited to, an act committed with the intent to sexually molest, arouse, or gratify another person against that person's will, that occurs by force, threat, intimidation, or advantage.
d. indicators of physical abuse
1. multiple and/or severe bruises, burns, and welts
2. unexplained injuries
3. a mix of old and new bruises (may indicate abuse over time)
4. signs of broken bones and fractures (may complain of pain or weakness)
e. indicators of unreasonable confinement
1. restraints used on chairs or bed
2. an adult who is placed or locked in a room
3. social isolation
4. pressure sores from prolong stays in a restrained position

f. indicators of mental of psychological abuse
1. verbal assaults, threats, or intimidation by a caregiver
2. the client/resident demonstrates fear of the caregiver
3. the caregiver doesn't allow anyone to visit with the adult alone
4. adult is withdrawn/doesn't communicate in the presence of the caregiver

8. Define neglect
a. any condition that threatens the client's/resident's physical and mental health and well-being. Neglect can include medical neglect in the form of a caregiver withholding medications or aids such as hearing aids, glasses, walkers, or failure to obtain needed medical treatment.
b. indicators of neglect
1. untreated medical or mental health problems
2. medication not taken or administered as prescribed
3. dehydration and malnourishment – including not Providing adults with necessary special dietary needs

9. Define exploitation
a. the illegal use of an adult's resources for profit or advantage. Typically relates to financial exploitation and include misuse or theft of funds, inappropriate use of property, or the threat to withhold services or care unless financial resources are made available to the other person
a. Indicators of exploitation
1. misappropriation of client's/resident's possession; taking money or personal items that belong to the client/resident
2. deceiving client/resident into signing documents that benefit you (titles of possessions, bank signature cards, credit card applications)

Objectives	Content Outline
Define negligence as it relates to nurse aides providing care to clients/residents	3. personal belongings, especially those of value are missing after a visit with family or friends 3. if you are aware that anyone is attempting to exploit a client/resident, i.e. client/resident tells you a relative made him/her sign papers but he/she doesn't know what was signed, you should report it. 10. Define Negligence a. causing harm or injury to another person without the intent to cause harm b. client falls and breaks a hip when transferring from wheelchair to bed because nurse aide forgot to lock brakes on the wheelchair
NEED TO DECIDE IF YOU WANT TO KEEP ALL OF THIS IN AS ABUSE, NEGLECT, AND EXPLOITATION HAS ALREADY BEEN ADDRESSED	~~8. Signs of mistreatment, including abuse, neglect, and/or exploitation~~ ~~1. abuse – repeated, deliberate infliction of injury to another person~~ ~~a. physical abuse – striking, biting, hitting, slapping, shaking~~ ~~b. emotional mental abuse – threatening with physical harm, cruel teasing, yelling at, taunting, involuntary seclusion, causing person to feel afraid, cursing at person~~ ~~1.slander – saying untrue Statements that hurt another person's reputation~~ ~~2. libel – writing untrue statements that hurt another person's reputation~~ ~~3. assault~~ ~~a. threatening or attempting to touch a person without his consent~~ ~~b. causing a person to fear bodily harm~~ ~~c. "If you get out of that chair I will tie you into it"~~ ~~c. sexual abuse – forcing another person to engage in sexual behavior~~ ~~1. non-consenual sexual contact of any kind with a client/resident~~ ~~2. allowing someone else to have non-consensual sex with a client/resident~~ ~~2. negligence~~ ~~c. causing harm or injury to another person without the intent to cause harm~~ ~~d. client falls and breaks a hip when transferring from wheelchair to bed~~

Objectives

Content Outline

~~because nurse aide forgot to lock brakes on the wheelchair~~

~~a. exploitation – taking advantage of another person~~

~~b. misappropriation of personal possessions – taking money or personal items that belong to the client~~

~~3. exploitation – taking advantage of another person~~

~~a.misappropriation of client's/resident's possession; taking money or personal items that belong to the client/resident~~

~~b.deceiving client/resident into signing documents that benefit you (titles of possessions, bank signature cards, credit card applications)~~

~~4. false imprisonment – unlawfully confining or restraining client against their will~~

~~a. includes both the threat of restraining and the actual act of restraining~~

~~5. assault~~

~~a. threatening or attempting to touch person without his consent~~

~~b. causing person to fear bodily harm~~

~~c. "If you get up out of that chair I will tie you into it."~~

~~6. battery~~

~~a. touching person without their consent~~

~~b. performing a procedure on a client without their consent~~

~~7. negligence~~

~~e. causing harm or injury to another person without the intent to cause harm~~

~~f. client falls and breaks a hip when transferring from wheelchair to bed because nurse aide forgot to lock brakes on the wheelchair~~

8. malpractice

~~a. negligence committed by licensed personnel (LPN, RN, MD)~~

~~b. nurse aide may not be charged with malpractice~~

Identify actions of the nurse aide that constitute client/resident mistreatment including adult abuse, neglect and/or ~~mistreatment~~ exploitation as evidenced by accurate participation in classroom discussion.

b. actions of the nurse aide that constitute abuse
   1. yelling at client
   2. directing obscenities toward client
   3. threatening client with
      a. physical injury

Objectives	Content Outline
	b. false imprisonment c. withdrawal of food or fluids d. withdrawal of physical assistance 4. hitting 5. shaking 6. biting 7. ~~failure to turn and reposition a bed-ridden client~~ 8. forced isolation 9. teasing in a cruel manner 10. inappropriate sexual comments or acts 11~~. taking money or possessions that are not yours~~ c. actions of the nurse aide that constitute neglect 1. inadequate personal care 2. inadequate nutrition 3. inadequate hydration 4. failure to turn and reposition a bed ridden client/resident 5. living areas not kept neat and clean d. actions of the nurse aide that constitute ~~mistreatment~~ exploitation ~~1. treating client as a child~~ taking client/resident possessions 2. forcing client to perform activities in exchange for care 3.asking for or borrowing money from a client/resident ~~3. making fun of client~~ 4.forging client/resident's signature for personal gain 5.unauthorized receipt of gifts or gratuities 6. accepting money beyond normal compensation
Identify signs and symptoms that indicate client abuse, neglect or exploitation as evidenced by accurately participating in classroom discussion.	11. signs and symptoms that client has been abused, neglected or exploited a. unexplained bruising b. unexplained broken bones c. bruising/broken bones that occur repeatedly d. burns shaped like the end of a cigarette e. bite or scratch marks f. unexplained weight loss g. signs of dehydration such as extremely dry and cracked skin or mucous membranes h. missing hair i. broken or missing teeth j. blood in underwear k. bruising in the genital area l. unclean body and/or clothes m. strong smell of urine n. poor grooming and hygiene o. depression or withdrawal

Objectives	Content Outline
	p. mood swings q. fear or anxiety when a particular caregiver is present r. fear of being left alone
Describe the nurse aide's role as a mandated reporter as evidenced by a minimum grade of 80% on unit test.	12. nurse aide is a mandated reporter a. definition 1. required by law to report suspected or observed abuse ~~or~~ neglect or exploitation b. immediately report suspected or observed adult abuse ~~or~~ neglect to appropriate supervisor and/or Adult Protective Services c. civil penalty may be imposed for failure to report d. immunity from criminal or civil liability for making a report in good faith
Describe the consequences of a report of abuse, ~~mistreatment~~ or neglect against a nurse aide as evidenced by a minimum grade of 80% on the unit test.	e. protection from employer retaliation from reporting. Employers cannot prevent an employee from reporting directly to APS. f. know your facility policy/procedure for reporting suspected or observed abuse, ~~or~~ neglect, and/or exploitation g. suspected elder abuse, mistreatment, neglect and/or ~~neglect~~ exploitation is reported to local Adult Protective Service, Department of Social Services or to the 24-hour APS hotline h. if the perpetrator is registered, certified or licensed by the Virginia Board of Nursing an investigation will be initiated i. 18VAC90-25-100(2)(e) Virginia Board of Nursing Regulations Governing Nurse Aides identifies disciplinary provisions for nurse aides (Abuse, neglect, and abandoning clients/residents) j. 18VAC90-25-100(2)(h) Virginia Board of Nursing Regulations Governing Nurse Aides identifies disciplinary provisions for nurse aides (Obtaining money or property of a client/resident by fraud, misrepresentation or duress) k. 18VAC90-25-81identifies actions nurse aide may take to remove a finding of neglect from certification based on a single occurence
Explain how the nurse aide can help the client meet their basic needs described by Maslow as evidenced by participating in classroom discussion.	III. Holistic needs of clients in long-term care facilities A. Maslow's Hierarchy of Needs 1. physical needs a. oxygen b. water c. food d. elimination e. rest f. nurse aide helps client meet these needs by encouraging eating, drinking and adequate rest and assisting with toileting, if necessary 2. safety and security

Objectives	Content Outline
	a. shelter b. clothing c. protection from harm d. stability e. nurse aide helps client meet these needs by listening, being compassionate and caring 3. need for love a. feeling loved b. feeling accepted c. feeling of belonging d. nurse aide helps client meet these needs by welcoming client to facility, encourage interaction with other clients 4. need for self-esteem a. achievement b. belief in one's own worth and value c. nurse aide helps client meet these needs by encourage client independence, praise success, promote dignity 5. need for self-actualization a. need to learn b. need to create c. need to realize one's own potential d. nurse aide helps client meet these needs by accepting client's wishes regarding their activities 6. each level of need must be accomplished before person can move on to the next level
Discuss strategies the nurse aide can use to promote client independence.	B. Promote client/resident independence 1. Person-centered care a.Value each unique person b. Respect personal preferences c. Encourages client/resident to direct his/her care d. Encourages meaningful engagement e. Helps client/resident feel at home f. Encourages friendships and relationships 2. individualized person-centered ~~nursing~~ multidisciplinary care plan ~~a.~~ written by ~~nursing staff with input from nurse aide~~nurses and other members of the team b. based on MDS (Minimum Data Set) and other important client/resident data c. Nurse aides are important members of the team d. ~~should~~ Care Plan includes 1. client/resident strengths and routines 2. eating skills 3. incontinence management ~~4.~~ skin ~~at risk~~care ~~5. progressive mobility~~cognition

Objectives	Content Outline
~~Explain how the nurse aide can modify care of the client to promote culturally sensitive care as evidenced by role-play in various classroom scenarios.~~	~~6. cognitive orientation~~functional status and mobility ~~7. progressive self-care~~Assistive devices 3. strategies nurse aide can utilize to promote client independence a. praise every attempt at independence b. overlook failures c. tell client that nurse aide has confidence in their ability d. allow client time to do for self e. develop the patience to wait for client to do for self f. attend to other tasks while waiting for client to attempt to do for self g. encourage progressive mobility h. assist with active and passive range of motion i. promote social interaction j. encourage activity k. report progress and/or needs of independence to the appropriate supervisor
Define culture, and what represents culture.	C. Provide culturally sensitive care 1. Culture - definition ~~– learned beliefs, values and behaviors~~the arts, beliefs, customs, and institutions of a certain group of people at a particular time a. Culture represents the ideas, learned beliefs, values, behaviors attitudes groups possess 1. gender 2. faith 3. sexual orientation 4. socioeconmic status 5. race 6. ethnicity
Describe cultural sensitivity awareness, ethnic cultures, and national cultures.	~~2. ethnic cultures~~Cultural sensitivity awareness – the knowledge and interpersonal skills that allow you to understand, appreciate, and embrace individuals from cultures and ethnicity other than your own ~~a. African-American~~ ~~b. Hispanic~~ ~~c. Caucasian~~ 3. Ethnic cultures in the United States a. numerous ethnic cultures b. some ethnic groups may live in the same area c. value and respect each unique person d. learn to embrace cultural differences 4. national cultures- various cultures from different parts of the world. Ethnicity is usually by country of origin. ~~a. Italian~~ ~~b. Irish~~

Objectives	Content Outline
	~~c. German~~ ~~d. Indian~~ ~~e. Pakistani~~ ~~f. Kenyan~~ ~~g. ethnic by country of origin~~ ~~5. religious cultures~~ ~~a. Jewish~~ ~~b. Muslim~~ ~~c. Christian~~ ~~d. Hindu~~ ~~e. Buddhist~~ ~~f. other religions~~ ~~g. atheist~~ ~~6. cultural dietary restrictions~~ ~~a. Jewish~~ ~~1. kosher requirements~~ ~~2. no pork products~~ ~~b. Muslim~~ ~~1.halal requirements~~ ~~2.no pork products~~ ~~c. Hindu~~ ~~1. no beef products~~
Recognize cultural differences as it relates to clients/residents, and their family members.	5. cultural differences that impact nursing care a. Religious differences – respect client's/resident's beliefs b. Ethnicity – you will encounter people from different backgrounds c. language barrier – provide available interpreter services per facility policy ~~d. spatial distance~~ ~~e. interaction of genders~~ ~~f. generational interaction~~ d. cultural and religious diets – residents may not eat foods that are unfamiliar; family may bring traditional meals; know cultural diet restrictions e. spatial distance – some cultures are uncomfortable when you their personal space f. interaction of genders – approach client/resident according to his/her preferred gender identification g. generational interaction – each generation has its own set of values, beliefs, and life experiences. Take time to learn from others h. fear of the unknown or what is different i. death and dying j. post mortem care
Identify strategies to provide culturally sensitive care	6. strategies to provide culturally sensitive care a. always respect client/resident b. honor client/family requests to follow cultural guidelines c. provide client/family privacy d. ask client/family if they have specific ways of celebrating holidays

Objectives	Content Outline
	e. ask if client has special dietary guidelines to follow f. respect differences in cultural values g. self-awareness of your own culture h. do not stereotype – do not assume because a client/resident is from a certain culture that he/she will behave in a certain way i. Do not engage in gossip about clients/residents because of gender preferences or any differences
Identify developmental tasks for each age group described by Erikson as evidenced by a minimum grade of 80% on the unit test	D. Stages of Human Growth and Development A. Eric Erikson's Development Tasks 1. birth to 1 year a. receives care and develops trust b. sense of security 2. toddler (1-3 years) a. learns self-control (bowel and bladder control) b. and develops autonomy (self-identity) 3. preschool (3-6 years) a. explores the world b. develops initiative, ambition 4. school age (6-9years) a. gains skills, learns to get along with others b. develops industry (work) 5. late childhood (9-12 years) a. gains confidence b. develops moral behavior 6. teenage or adolescence (13-18) a. changes in the body b. develops identity (individuality and sexuality) 7. young adult (18-40) a. starts family b. develops close relationships and intimacy 8. middle adulthood (40-65) a. pursues career b. physical changes c. develops generatively (productivity) 9. late adulthood (65 and older) a. reviews own life b. resolves remaining life conflicts c. accepts own mortality without despair or fear d. represents major change of focus from previous life tasks
List psychosocial changes occurring in late adulthood as evidenced by a minimum grade of 80%on the unit test. Discuss how the changes of late adulthood affect the psychosocial and physical care of the client in long-term care as evidenced by participation in classroom discussion.	B. Psychosocial changes in late adulthood 1. self-esteem threatened by physical changes a. graying hair or loss of hair b. wrinkles c. slow movement d. weight e. loss of sex drive and/or decreased libido

Content Outline

2. autonomy threatened by
    a. change in income
    b. decreased ability to care for self
3. relationships and intimacy are threatened by
    a. death of spouse
    b. death of family and friends
4. coping with aging depends on
    a. health status
    b. life experiences
    c. finances
    d. education

Unit VII – Basic Skills
(18VAC90-26-40.A.2.a)
(18VAC 90-26-40.A.2.b)
(18VAC90-26-40.A.2.c)
(18VAC90-26-40.A.2.d)
(18VAC90-26-40.A.2.e)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Explain the beginning and ending steps for the nurse aide when providing care to a client.
2. Recognize changes in body functioning and the importance of reporting these to the appropriate supervisor.
3. Describe how the nurse aide should care for the client's room and his environment in the long-term care facility
4. Demonstrate how to correctly make an occupied and an unoccupied bed, including disposal of linen.
5. Demonstrate how to accurately measure, record and report vital signs, height and weight.
6. Demonstrate various methods to identify and report client pain.
7. Demonstrate accurate measurement, recording and reporting fluid intake and output.
8. Demonstrate accurate measurement and recording of food intake.

Objectives	**Content Outline**
Explain the beginning and ending steps for the nurse aide when providing care to the client as evidenced by Satisfactory rating on the Skills Record.	I. How to begin and end when providing care to client A. Beginning steps 1. before entering client's room, knock on the door a. client's room is his home 2. identify yourself a. client has right to know who is going to be caring for them 3. identify client a. shows respect b. use client's name, not "honey", "sugar", "Bubba" c. assures you have the correct client 4. wash your hands a. Standard Precautions b. prevent spread of infections 5. explain what you are going to do a. speak clearly, slowly and directly to the client b. client has right to know what to expect c. encourages client independence and cooperation 6. provide for privacy a. client has right to privacy b. promotes client dignity c. pull privacy curtain or close the door 7. use good body mechanics a. raise bed to waist height

Objectives	Content Outline
	b. lock wheels on the bed c. if using a wheelchair, lock the wheels d. only use side rails if specifically ordered B. Ending steps 1. ~~assure~~ ensure client is comfortable a. sheets are wrinkle-free and crumb-free b. helps to prevent pressure sores c. replace pillows and blankets d. client's body should be in good alignment 2. put bed in low position a. promotes client safety 3. if side rails were used as part of the procedure, return them to the position ordered for the client 4. remove privacy measures a. open privacy curtain b. open door c. bath blanket 5. place call bell within reach of client a. permits client to communicate with staff as needed 6. announce to client/resident when you are leaving the room 7. wash your hands before leaving client room a. prevents spread of micro-organisms b. Standard Precautions 8. report any changes to supervisor a. physical or mental changes observed while providing care
Identify changes in mental status that the nurse aide might observe as evidenced by participation in classroom discussion.	II. Recognizing changes in body functioning and the importance of reporting these changes to the appropriate supervisor A. Changes in mental status 1. confusion 2. combativeness 3. agitation 4. restlessness 5. extreme or unusual verbalization 6. expression of fear 7. complaints of hallucinations 8. being very quiet or withdrawn 9. report changes to appropriate supervisor
Identify changes in physical appearance that the nurse aide might observe as evidenced by participation in classroom discussion.	B. Change in physical appearance 1. Swelling/edema ~~of~~ (i.e. hands, ~~or~~ feet, face, abdomen, or any body part) 2. Pallor, pale skin, yellow skin

Objectives	Content Outline
	3. blue lips, hands or feet 4. an expression of pain 5. change in a mole or wart 6. any change in bowel or bladder contents 7. any change in breast such as dimple or lump 8. any change in genitalia such as discharge 9. unusual grimace or drooling of saliva 10. report changes to appropriate supervisor
Identify changes in appetite that the nurse aide might observe as evidenced by classroom discussion.	C. Change in appetite 1. increase in appetite 2. decrease in appetite 3. report changes to appropriate supervisor
Identify signs of infection that the nurse aide might observe as evidenced by classroom discussion.	D. Signs of infection 1. elevated temperature 2. chills and/or sweating 3. skin hot or cold, flushed or bluish 4. area of skin that is inflamed (warm, red, swollen) 5. delirium/confusion/change in mental status
Discuss changes to the skin and hair that occurs in geriatric clients/residents.	~~E.~~ Age-related changes to skin and hair ~~and what to report to appropriate supervisor~~ 1. Wrinkles (due to less elasticity) 2. Hair – grey/white, balding 3. age spots 4. fragile, ~~dry~~ thinner skin 5. dry, itchy skin – due to less oil production ~~6. thickening of the nails~~nails – harder, thicker, brittle, fungus, discoloration 7. what to report to the appropriate licensed nurse a. skin that is abnormally pale, bluish, yellowish, or flushed b. rash, abrasion, bruising c. mole that has changed in appearance d. redness over a pressure point that does not go away within 5 minutes e. area over a pressure point that has become pale or white f. drainage from a wound g. wound that does not heal h. blisters i. swelling j. c/o pain, tingling, numbness, burning k. weight changes
Identify signs and symptoms that should be reported to the appropriate supervisor. or the appropriate licensed nurse during daily care as evidenced by accurate completion of clinical observation report. or other reporting system.	
c/o = complaint of	
Describe changes to the musculoskeletal system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	F. Age-related changes to the musculoskeletal system ~~and what to report to appropriate supervisor~~ 1. osteoporosis 2. loss of muscle mass 3. arthritis

Objectives	Content Outline
	4. what to report to the appropriate licensed nurse a. client has fallen b. area of body that is swollen, red, bruised or painful to touch c. complaints of pain when moving a joint d. range of motion for a joint that has decreased movement e. client limps or has pain when walking or repositioning
Identify changes to the respiratory system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	G. Age-related changes to the respiratory system and what to report to appropriate supervisor 1. short of breath- lung strength and capacity decrease, voice weakens 2. more susceptible to respiratory infections (cold, pneumonia, influenza) 3. what to report to the appropriate licensed nurse a. persistent cough, nasal congestion b. change in respiration c. cough produces sputum that is yellowish, greenish or pinkish d. sudden onset of difficulty breathing e. client experiences wheezing or gurgling respirations f. skin has blue or gray tinge
Discuss changes to the cardiovascular system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	H. Age-related changes to the cardiovascular system and what to report to appropriate supervisor 1. heart beats less effectively 2. heart rate slows or speeds up 3. fluid may accumulate in hands and feet 4. orthostatic hypotension 5. chest pain due to lack of oxygen to the heart muscle 6. high blood pressure or low blood pressure 7. what to report a. complaints of chest pain or pressure b. difficulty breathing c. rapid, slow or erratic pulse d. blood pressure that is unusually low or high e. face, lips or fingers are bluish f. shortness of breath on exertion g. complaints of chest or leg pain on exertion h. unusual pain, swelling or redness in legs i. bluish or cool/cold areas on the legs or feet
Describe changes to the nervous system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	I. Age-related changes to the nervous system and what

Objectives	Content Outline
	to report to appropriate supervisor 1. slowed reaction time 2. poor balance 3. difficulty remembering recent events 4. loss of sensation in hands and feet 5. reduced grip strength 6. what to report a. change in level of consciousness b. suddenly becomes confused or disoriented c. speech becomes slurred d. eyelid or corner of the mouth begins to droop e. sudden onset of severe headache f. sudden onset of numbness, tingling, loss of sensation in arm, leg or face
Discuss changes to the eyes and ears that may occur in geriatric clients/residents, and what to report to the licensed nurse.	J. Age-related changes to the eyes and ears and what to report to appropriate supervisor 1. eyes adjust more slowly to change in light 2. becomes more difficult to read small print 3. lens becomes cloudy and cataracts form decreasing ability to see 4. less tears are produced causing eye to become dry and irritated 5. what to report about the eyes a. drainage from eyes b. complaints of dryness c. redness in or around the eyes d. glasses that are broken or do not fit 6. outer ear continues to grow 7. hearing decreases 8. what to report about the ears a. drainage from the ears b. changes in ability to hear ~~c.~~ hearing aide ~~batteries that do not work~~not functioning properly (batteries, wax filters or other maintenance)
Describe changes to the digestive system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	K. Age-related changes to the digestive system and what to report to appropriate supervisor 1. poor teeth cause less efficient chewing 2. decrease in saliva and stomach acids causes poor breakdown of food 3. decrease motility in intestinal tract causes constipation 4. what to report a. teeth that are loose or painful b. dentures that do not fit or are broken c. choking while eating d. complaints of constipation or

Objectives	Content Outline
	abdominal pain e. changes in bowel patterns f. blood in stool
Identify changes to the urinary system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	L. Age-related changes to the urinary system and what to report to appropriate supervisor 1. kidneys less efficient at filtering waste from the blood 2. loss of muscle tone increases risk of urinary incontinence (particularly in women) 3. enlarged prostate in men causes a. difficulty starting urine stream b. dribbling between voids c. increased risk of urinary tract infections 4. what to report a. complaint of pain or burning upon urination b. frequent complaints of urgency and then unable to void or voids small amount c. urine with a strong or unusual odor d. episodes of dribbling before getting to the toilet e. presence of blood in urine
Discuss changes to the endocrine system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	M. Age-related changes to the endocrine system and what to report to appropriate supervisor 1. adult onset diabetes mellitus 2. what to report a. increased thirst b. increased urination c. increased appetite d. drowsiness and confusion e. cold, clammy skin f. shaky with increased perspiration g. complaint of headache h. sweet smelling breath i. seizure j. loss of consciousness
Describe changes to the reproductive system that may occur in geriatric clients/residents, and what to report to the licensed nurse.	N. Age-related changes to the reproductive system and what to report to appropriate supervisor a. menopause b. breast cancer c. prostate cancer d. what to report a. unusual vaginal discharge b. change in breast tissue 1. dimpling, lump, thickening of skin c. discharge from breast or nipple d. discharge from penis

Objectives	Content Outline
	e. pain or burning with urination for male client f. change in skin of the scrotum g. lump in scrotum
Discuss six (6) conditions that effect the client's environment as evidenced by participation in classroom discussion.	III. Caring for the clients' environment A. Conditions that effect client's environment 1. cleanliness a. reflection of quality of care b. this is client's home c. impedes spread of micro-organisms d. everyone's responsibility, not housekeeping 2. odor control a. follow facility policy for handling of waste and soiled linens b. close laundry and waste receptacle lids c. empty urinals, bedside commodes, and bedpans promptly d. flush toilets promptly e. use air fresheners as appropriate, per facility policy f. assist client to maintain personal care and good oral hygiene g. be aware of your personal hygiene, particularly if you are a smoker 3. ventilation a. may create drafts b. position client away from draft c. provide sweaters, blankets and/or lap covers if needed to keep client warm 4. room temperature a. 71° to 81° is OBRA regulation for temperature in long-term care facility 5. lighting a. general lighting 1. light from the window 2. ceiling lights 3. ask client for preference 4. encourage light from windows during the day and closed curtains at night b. task lighting 1. overbed light 2. light focused on a chair for reading 3. night light 6. noise control a. provide quiet times for ~~afternoon~~ nap or at night time for restful sleep b. answer call bells and telephones promptly

Objectives	Content Outline
Identify the six (6) OBRA requirements for a client room in a long-term care facility as evidenced by minimum grade of 80% on the unit test.	B. Features of a long-term care room 1. OBRA requirements for room in long-term care facility a. one window b. call system c. odor free d. pest free e. bed wheels lock f. personal supplies are labeled and stored appropriately
Describe the furnishings located in a typical client room in a long-term care facility as evidenced by minimum grade of 80% on unit test.	2. bed a. when client is unattended always keep bed in low position with the wheels locked b. adjustable height, positioning of head and feet c. basic bed positions 1. Fowler's 3. semi-fowler's 4. Trendelenburg 5. reverse Trendelenburg d. practice how to use bed 1. raise and lower bed 2. lock the wheels 3. raise and lower head 4. raise and lower feet e. siderails (see facilty policy) 3. overbed table a. fits over bed or chair b. height can be adjusted c. holds personal care items and/or meal tray d. considered a "clean" area e. do not put used urinal or bedpan on overbed table 4. bedside table a. stores personal care items, basins, bedpans c. surface area should be kept neat and tidy 5. personal furniture a. clients encouraged to bring own furniture to make the room more like home (chairs, chest of drawers, tables, wardrobes) b. keep personal furniture well cared for, dusted and clean 6. call bell/intercom system a. communication link between client and staff b. call bell should always be kept within

Objectives	Content Outline
	easy reach of client c educate client/resident on use of call bell 7. privacy curtain/room dividers a. divide one room into multiple client areas b. use to provide privacy when giving client personal care
Demonstrate the nurse aide's responsibilities for care of the client's environment as evidenced by satisfactory performance in the skills lab.	C. Nurse Aide's responsibilities for care of the client's environment 1. always knock before entering client's room 2. assist client to keep room neat and clean 3. clean up spills immediately 4. assist client to keep personal items in good condition 5. label all items upon admission 6. keep clutter to a minimum 7. always straighten up the client's area after meals and procedures 8. assist client to keep room at comfortable temperature 9. do not place urinals on tables used for eating 10. flush toilets and empty beside commodes and urinals as soon as they have been used 11. use lighting to provide good illumination so client can see to get around the room 12. keep noise in hallways to minimum especially at rest times to promote client's ability to sleep/rest 13. always have call bell within easy reach of the client 14. use care when dealing with client's clothing and personal items so damage, loss or misplacement does not occur 15. re-stock client's supplies every day and prn 16. refill water pitcher every shift unless the client has a fluid restriction
prn = as needed	
Describe what the nurse aide should report to the supervisor regarding the client's room as evidenced by participation in classroom discussion.	D. What Nurse Aide should report to the supervisor 1. piece of equipment or furniture that is not working properly 2. client injured by piece of equipment or furniture in the room 3. staff injured by a piece of equipment or furniture in the room 4. suspicion that client is storing unwrapped food in his room 5. signs of pests or insects 6. client or family member complains that personal items are missing 7. belongings from other clients/residents found in room 8. personal item belonging to client is accidentally

Objectives

Discuss the difference between an unoccupied, closed and open bed, and an occupied bed.

~~Tina to "word smith" for dementia patients~~

Describe the different types of linen the nurse aide uses to make a bed in a long-term care facility as evidenced by obtaining the correct linen before beginning to make the client's bed.

Content Outline

broken
9. room and/or bathroom is not properly cleaned
10. waste receptacles are not consistently emptied
11. there is an odor in the room that will not go away

E. Making the bed
1. unoccupied bed
    a. no one is in the bed
    b. closed bed
        1. when client is out of bed all day
        2. completely made with bedspread, blankets and pillows in place
    c. open bed
        1. linen is folded down to the foot of the bed
        2. makes it easier for client to get into be by himself

~~b. surgical bed~~
~~1. prepared for client returning to bed from a stretcher~~

2. occupied bed
    a. made while the client is in the bed

3. linen required to make a bed
    a. mattress pad
        1. makes mattress more comfortable
        2. protects mattress from liquid spills
    b. top and bottom sheets
        1. bottom sheet is often fitted
        2. top sheet is flat
    c. draw sheet
        1. small, flat sheet placed over the middle of the bed
        2. goes from client's shoulders to below buttocks
        3. used to help lift or turn client
        4. sides are tucked under the mattress
    d. bed protector
        1. absorbent fabric-backed waterproof material
        2. used with clients who are incontinent
    e. blankets
        1. may be personal or provided by facility
    f. bedspread
        1. adds decorative look to room
        2. may be personal or provided by facility
    g. pillow and pillowcases
        1. for comfort and for positioning client
        2. pillows always covered with pillowcase
    h. bath blanket

Objectives	Content Outline
	1. keep client warm during bed bath or linen change
Identify various devices used on the bed in a long-term care facility as evidenced by minimum grade of 80% on unit test.	4. other bed equipment a. pressure-relieving mattresses 1. egg-crate mattress 2. alternating air mattress b. bed board 1. wood board placed under the mattress to make bed more firm c. bed cradle 1. metal frame that prevents top linen from placing pressure on the feet and causing foot drop d. foot board 1. piece of wood placed at foot end of mattress to keep the feet in proper anatomical alignment e. fall mats
Demonstrate correct handling of linen as evidenced by Satisfactory rating on Skills Record.	5. how to handle linen a. wash hands b. collect linen in order they will be used on the bed c. do not take linen from one client room to another d. when carrying linen, take care not to touch linen to your uniform e. wear gloves to remove soiled linen f. when removing linen from the bed turn it from the ends of the bed toward the center of the bed g. NEVER place used linen on the floor h. do not have used linen come in contact with your uniform i. place used linen in receptacle per facility policy j. wash hands
Demonstrate how to make a closed bed as evidenced by satisfactory performance in skills lab.	6. make a closed bed a. wash hands b. obtain linen and place on chair or table in client's room c. flatten bed and raise to waist level d. loosen used linen and place in hamper or linen bag e. remake the bed starting with the bottom sheet with the seams down f. place end of bottom sheet flush with bottom end of mattress, tuck in at top of mattress and make mitered corners at top of mattress g. place draw sheet if appropriate

Objectives	Content Outline
	h. place top sheet, seams up, with end of sheet flush with head of mattress, tuck in bottom of sheet, make mitered corners at foot of mattress i. place blanket on bed, flush with top of sheet, fold down blanket and sheet as one at head of bed about 6 inches, tuck blanket under mattress at foot of bed, make mitered corners at foot of bed j. place clean pillowcase on pillow, and pillow at head of bed k. cover pillow and blanket with bedspread and tuck under the pillow l. return bed to low position m. place call bell where client can reach it n. dispose of used linen o. wash hands
Demonstrate how to make an open bed as evidenced by Satisfactory performance in skills lab.	7. make an open bed a. follow steps a-j for closed bed above b. standing at head of bed, grasp top sheet, blanket, bedspread and fold down to foot of bed and then bring them back up the bed to make a large cuff c. place clean pillowcase on pillow, and pillow at head of bed d. return bed to low position e. place call bell where client can reach it f. dispose of used linen g. wash hands
Demonstrate making an occupied bed as evidenced by Satisfactory rating on Skills Record.	8. make an occupied bed a. identify yourself by name b. wash hands c. explain procedure to client d. provide for client privacy e. place clean linen on clean surface within reach f. adjust bed to waist height g. put on gloves h. loosen top linen from end of bed on side you will work on first i. unfold bath blanket over top sheet to cover client and remove top sheet keeping client covered at all times j. raise side rail on far side of bed to protect client from falling out of bed while you are making it k. after raising side rail, go to other side of bed and assist client to turn onto side away from you toward the raised side rail l. loosen bottom soiled linen, mattress pad, and

Objectives	Content Outline
	protector on the working side m. roll bottom soiled linen toward client, soiled side inside and tuck it snugly against client's back n. place mattress pad on bed, attaching elastic corners on working side o. place and tuck in clean bottom linen. Finish with bottom sheet free of wrinkles. p. smooth bottom sheet out toward client. Roll extra material toward client. Tuck it under client's body. q. if using a draw sheet, place it on the bed and tuck in on your side, smooth it and tuck as you did with the other bedding r. raise side rail nearest you. Go to the other side of bed, lower side rail on that side and help client turn onto clean bottom sheet s. loosen soiled linen. Roll linen from head to foot of bed avoiding contact with your skin or uniform. Place in laundry hamper or bag. NEVER place linen on the floor. t. pull clean linen through as quickly as possible starting with mattress pad. Pull and tuck in clean bottom linen just like the other side. Finish with bottom sheet free of wrinkles. u. assist client to turn onto back. Keep client covered and comfortable with pillow under head. Raise side rail. v. Unfold top sheet and place over client centering it. Slip bath blanket or old sheet out from underneath and put in hamper or bag. w. place blanket over top sheet, matching top edges. Tuck bottom edges of top sheet and blanket under bottom of mattress. Miter corners and loosen top linens over client's feet. Fold top sheet over blanket at top of bed by about 6 inches. x. remove pillow and change pillowcase placing soiled one in hamper or bag. y. remove and discard gloves z. position client in comfortable position. Return bed to low position. Return side rails to appropriate position and place call light within client's reach. aa. take laundry hamper/bag to proper area bb. wash hands cc. report any changes in client to nurse dd. document procedure using facility guidelines
Discuss the importance of measuring and recording routine vital signs on geriatric clients/residents	IV. Vital Signs (VS) A. Purpose of VS 1. measurement of body functions that are

Objectives	Content Outline
	automatically regulated 2. change may indicate body is out of balance 3. indicate if the body is healthy or not healthy
Demonstrate the knowledge of types and use of thermometers to accurately measure and record client's temperature as evidenced by satisfactory performance in skills lab and clinical.	B. When are VS measured? 1. upon admission to long-term care facility (baseline VS) 2. weekly, monthly according to facility policy 3. before and after certain medications as ordered by the health care provider ~~a. will be ordered by health care provider~~ 4. after diagnostic procedure or surgery 5. after a fall 6. during an emergency
	C. Temperature 1. Types of thermometers and/or methods of taking temperature a. oral – by mouth b. tympanic – in the ear c. NCIT (no contact infrared thermometer) – forehead d. rectal - by rectum (usually distinguished by red to deter use in mouth) e. axillary – under the armpit (axilla) 2. measures the warmth of the body a. adult oral temperature 97.6° - 99.6° b. adult tympanic temp 96.6° - 99.7° c. adult NCIT (forehead) 97.2° - 100.1° d. adult rectal temp. 98.6° – 100.6° e. adult axillary temp. 96.6° – 98.6°
Report abnormal readings or changes to the appropriate supervisor as evidenced by satisfactory performance in skills lab and clinical.	3. may be affected by a. age – less fat and decreased circulation lowers the temperature b. exercise – exercise increases body temp. c. circadian rhythm – client has higher temp. during active times of the day d. stress – increases body temperature e. illness – increases body temperature f. environment – cold environment lowers body temp.(hypothermia), hot environment raises body temperature (hyperthermia) 4. signs of hypothermia a. shivering b. numbness c. quick, shallow breathing d. slow movements e. mild confusion f. changes in mental status g. pale/bluish skin 5. signs of hyperthermia a. perspiration

Objectives	Content Outline
	b. excessive thirst c. change in mental status 6. signs of elevated temperature due to infection a. headache b. fatigue c. muscle aches d. chills e. skin warm and flushed f. axillary – under the arm in the armpit g. most facilities use digital thermometers 7. measure, record, and report temperature a. follow facility policy for taking temperature b. follow facility policy for recording c. report changes to supervisor
Identify specific factors that may affect the accuracy of the temperature reading as evidenced by participation in classroom discussion.	8. factors that can affect temperature a. that raise the temperature 1. eating/drinking something hot 2. smoking 3. wait 10-15 minutes to take temp. 4. physical activity 5. heavy clothing or blankets b. that lower the temperature c. eating/drinking something cold (wait 10-15 minutes to take temp.) d. incorrect placement of thermometer e. not waiting long enough for thermometer to read temperature 9. special considerations for taking temperatures a. do not force a rectal thermometer b. do not force tympanic thermometer c. if the temperature seems questionable repeat the process. You may need to use a different thermometer
Describe the circulation of blood from the heart, to the periphery of the body and back to the heart as evidenced by a minimum grade of 80% on the unit test.	D. Anatomy of the cardiovascular system 1. heart a. muscle b. pumps blood throughout the body 2. arteries a. blood vessels that carry blood from heart to every part of the body b. transport oxygen to cells of the body 3. veins a. blood vessels that carry blood from the cells of the body back to the heart b. transport carbon dioxide from cells back to the lungs 4. capillaries a. tiny vessels that connect arteries to veins 5. blood a. red blood cells carry oxygen to the cells

Objectives	Content Outline
	b. white blood cells fight infection c. platelets form clots to stop bleeding
Explain what the pulse measures as evidenced by a minimum grade of 80% on the unit test.	E. Pulse 1. description a. heart contracts pushing blood out of heart b. that push is the pulse or beat of the heart c. can be felt by applying pressure over an artery d. tells how many times the heart is contracting or beating in 1 minute e. normal adult rate 60-100 beats/min f. tachycardia > 100 beats/min g. bradycardia < 60 beats/min
	2. location of pulse points a. radial pulse is on thumb-side of the wrist b. brachial pulse on little finger side of the elbow space c. carotid – either side of the windpipe in the neck d. apical – left ventricle of heart, 5th intercostal space on left side of chest e. femoral – in groin where leg attaches to torso f. popliteal – in space behind the knee
Demonstrate how to count and record radial pulse as evidenced by Satisfactory rating on Skills Record. Report any changes or abnormal pulse rates to the appropriate supervisor as evidenced by satisfactory performance in skills lab.	3. measure, record, and report pulse a. follow the procedure for "Counts and records radial pulse" in the most current edition of Virginia Nurse Aide Candidate Handbook b. use stethoscope to listen to, then count and record apical pulse c. report any changes or abnormal rate to appropriate supervisor
Identify specific factors that may affect the accuracy of the pulse rate as evidenced by participation in classroom discussion.	4. factors that affect pulse rate a. age – decreases pulse b. sex – males have lower pulse than females c. exercise – increases pulse d. stress – increases pulse e. hemorrhage (bleeding) – increases pulse f. medications – depending on medication may increase or decrease pulse rate g. fever/illness – increases pulse rate
Explain what the blood pressure measures as evidenced by a minimum grade of 80% on the unit test.	F. Blood Pressure (BP) 1. definitions a. measures force applied to walls of arteries as the heart contracts pushing blood away from the heart b. measured in mm Hg (mercury)

Objectives	Content Outline
Identify equipment needed to take a blood pressure.	c. systolic – top number when BP is reported and recorded 1. measures force applied to walls of arteries as the left ventricle contracts pushing blood away from the heart 2. normal adult range less than 120 mm Hg d. diastolic – bottom number when BP is reported and recorded 1. measures pressure in the arteries when the heart is resting between contractions 2. normal range less than 80 mm Hg e. hypertension (elevated) 1. high blood pressure 2. > ~~140/~~90130/80 of higher f. hypotension 1. low blood pressure 2. < 90/60 g. orthostatic hypotension 1. when client changes position from lying to sitting, or sitting to standing the BP drops 2. when BP drops, client becomes dizzy, lightheaded and may faint
Demonstrate how to measure and record blood pressure as evidenced by Satisfactory rating on Skills Record. Report any changes or abnormal blood pressure to the appropriate supervisor as evidenced by satisfactory performance in skills lab.	2. equipment needed to take BP a. stethoscope b. blood pressure cuff 1. size of cuff should match size of client/ resident's arm 2.placement of cuff c. sphygmomanometer 1. electronic 2. aneroid d. alcohol wipe 3. measure and record blood pressure a. follow the procedure for "Measures and records blood pressure" per facility policy b. report any changes or abnormal blood pressure to appropriate supervisor
Identify specific factors that may affect the BP reading as evidenced by participation in classroom discussion.	4. considerations for where to take BP a. do not take BP in arm with an IV (intravenous line) present b. do not take BP in arm with a shunt used for dialysis c. do not take BP in arm on same side as mastectomy surgery for breast cancer d. do not take BP in arm paralyzed due to stroke (CVA) e. do not take BP in extremity with an amputation f. do not take BP in an arm with a cast g. if both arms have a dialysis shunt or client/

Objectives	Content Outline
	resident has had double mastectomy take BP in thigh using the popliteal pulse
Identify specific factors that may affect the accuracy of BP reading as evidenced by participation in classroom discussion.	5. factors affecting BP a. age – increases BP b. exercise – decrease or increase c. stress – increases d. race – ethnicity may affect BP (i.e. -African-Americans more likely to have high BP than Caucasians) e. heredity – familial tendency to high BP f. obesity – increases BP g. alcohol – high intake may increase BP h. tobacco – may increase BP i. time of day – BP lower in morning and higher in the evening j. illness – diabetics and clients/residents with kidney disease may have high BP k. medications
Define the physiology of respirations, how respirations are measured, and terminology related to respirations.	6. factors affecting accuracy of BP reading a. wrong size cuff b. not inflating cuff sufficiently c. releasing cuff pressure too quickly d. taking BP multiple times in rapid succession in same arm e. cuff placement f. using cuff over clothing g. client talking h. most recent physical activity
Demonstrate how to count and record Respirations as evidenced by Satisfactory rating on Skills Record. Report any changes or abnormal respirations to the appropriate supervisor as evidenced by satisfactory performance in skills lab.	G. Respirations 1. Definitions a. inspiration – taking air and oxygen into the lungs (inhale), chest rises b. expiration – letting air and carbon dioxide out of the lungs (exhale), chest falls c. respiration – 1 complete inhalation and exhalation d. measured in breaths/minute e. normal adult respiratory rate 12-20 breaths/min f. apnea – absence of breathing g. dyspnea – difficulty breathing 2. measure and record respirations a. follow the procedure for “Counts and records respirations” in the most current edition of Virginia Nurse Aide Candidate Handbook b. report any changes or abnormal respiratory rate to appropriate supervisor
Discuss pain management, the pain scale, and questions the nurse aide may asked to understand the client’s/resident’s pain level. Describe observations that the nurse aide can make to understand the client’s pain level as evidenced by participation in classroom discussion.	H. Pain Management 1. definitions

Objectives	Content Outline
	a. fifth vital sign b. different for every person (some clients have higher pain tolerance than others) c. Pain Scale – i. know facility's pain scale ii. some pain scales are 0-10 and some are 1-10 objective value to sensation of pain 2. questions to ask to understand client's pain a. where is the pain? b. when did pain start? c. does the pain go away with rest? d. how long does pain last?
Describe comfort measures the nurse aide can perform in response to the client's pain.	e. describe the pain…sharp, shooting, dull, ache, burning, electric-like, constant, comes and goes 3. observations nurse aide may make that indicate client is experiencing pain a. increased P, R, BP b. sweating c. nausea d. vomiting e. tightening the jaw f. frowning g. groaning on movement h. grinding teeth i. increased restlessness j. agitation k. change in behavior l. crying m. difficulty moving n. guarding/protecting an area 4. report any complaints or observations of pain to appropriate supervisor 5.actions nurse aide can do to alleviate pain a. offer back rub b. assist to change position c. offer warm bath or shower d. encourage slow, deep breaths e. be patient, caring and gentle
Demonstrate how to measure and record height of a client as evidenced by a rating of Satisfactory on Skills Record.	V. Height and Weight A. Height (per facility policy) 1. usually performed on admission 2. assist to step onto the scale and measure height by extending height rod 3. if unable to stand, may use tape measure while client is lying on bed 4. record accurately in feet and inches
Demonstrate how to measure and record weight of Ambulatory client as evidenced by a rating of satisfactory on skills record.	B. Weight 1. performed on admission and at regular intervals afterwards (per facility policy)
Report any changes in weight to the appropriate supervisor as evidenced by satisfactory performance in skills lab.	
Measure and record fluid intake as evidenced by Satisfactory rating on Skills Record.	

Objectives	Content Outline
	2. ambulatory client uses standing scale 3. portable wheelchair scale, lift & tub scales, and/or bed scale may be available 4. measured in pounds or kilograms, per facility policy 5. uses a. data on nutritional status of client b. calculate correct medication dosage 6. measure and record weight a. follow the procedure for "Measures and records weight of ambulatory client" in the most current edition of Virginia Nurse Aide Candidate Handbook b. report any changes in weight to appropriate supervisor
Identify the major anatomical structures of the urinary system as evidenced by minimum grade of 80% on unit test.	VI. Measure and Record Fluid Intake and Output A. Measure and record fluid intake 1. fluid taken into the body a. fluid that client drinks b. liquids that are eaten: soup, jello, pudding, ice cream, popsicles 2. measurement a. milliliter (ml) b. ounce (oz) c. 1 oz = 30 ml
Describe the fluids that can be recorded as fluid output as evidenced by minimum grade of 80% on unit test.	3. measure and record fluid intake a. convert all fluid measurements into milliliters b. add together all fluid taken into the body c. at end of shift record all fluid intake per facility policy d. fluid taken into the body should be approximately equal to the amount of fluid that the body eliminated
Identify equipment used to measure fluid output as evidenced by satisfactory participation in skills lab.	B. Urinary system 1. kidneys - filter waste products and water out of blood to make urine 2. urethra - carry urine from kidneys to bladder 3. bladder - collects and hold urine 4. ureters - carries urine from bladder to the outside of body 5. urine - water and waste products that kidneys filtered out of the blood
	C. Fluid output 1. fluid that is eliminated by the body a. urine b. vomit (emesis) c. blood d. wound drainage

Objectives	Content Outline
	e. diarrhea 2. measured in ml or cc 3. at end of shift record all fluid output per facility policy 4. fluid taken into the body should be approximately equal to the amount of fluid that the body eliminated
Demonstrate accurate measurement and recording of urinary output as evidenced by Satisfactory rating on Skills Record.	D. Measure and record urinary output 1. equipment a. graduate b. commode hat c. urinal d. catheter drainage bag
Report any changes in urinary output to the appropriate supervisor as evidenced by satisfactory performance in skills lab.	2. measuring output a. 1ml = 1cc (cc=cubic centimeter) b. 30 ml = 1 oz c. always measure fluid output in graduate, not in urinal, commode hat or catheter drainage bag d. urinary output should not be less than 30ml per hour e. always wear gloves to measure output
Identify factors that may affect the client's urinary output as evidenced by participation in classroom discussion.	3. measure and record urinary output a. follow the procedure for "Measures and records urinary output" in the most current edition of Virginia Nurse Aide Candidate Handbook b. report unusually low or high urinary output to appropriate supervisor 4. factors affecting urinary output a. decreased intake of fluids b. fever (increased temperature) c. increased salt in diet d. excessive perspiration e. medical condition f. medications
Demonstrate accurate measurement and recording of food intake as evidenced by Satisfactory rating in skills lab.	E. Measure and record food intake 1. know facility policy a. percentage methods – percentage of each food item 1. calculated by dietician 2. record percentage (%) of each item on meal tray eaten 3. add together all the percentages and record total percent of meal eaten b. some facilities use percentage of entire meal rather than percentage of each item on meal tray 2. be accurate and consistent 3. at end of shift record all food intake per facility policy 4. report unusually small or large food intake to appropriate supervisor
Report any changes in food intake to the appropriate supervisor as evidenced by satisfactory performance in skills lab.	

Unit VIII – Personal Care Skills
(18VAC90-26-40.A.3.a, b, c, d, e, f, g)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Identify the components of personal care.
2. Explain routine personal care for both morning and bedtime.
3. Describe the guidelines for assisting the client with personal care.
4. Demonstrate how to provide a modified bed bath.
5. Demonstrate how to provide mouth care.
6. Demonstrate how to clean upper or lower dentures.
7. Demonstrate proper grooming of a client.
7. Demonstrate how to provide fingernail care.
8. Demonstrate how to provide foot care.
9. Demonstrate how to dress client with weak side.
10. Demonstrate how to provide perineal care for a female client
11. Demonstrate how to measure and record urine output.
12. Demonstrate how to provide catheter care for a female client
13. Demonstrate how to assist the client with a bedpan.
14. Describe how to collect urine and stool specimens.
15. Demonstrate how to feed client who cannot feed self.
16. Measure and record food intake
17. Accurately describe actions of the nurse aide to prevent client dehydration.
18. Discuss pressure sores, including formation, staging, prevention and reporting responsibilities of the nurse aide.
19. Demonstrate the various positions for the client in bed.
20. Demonstrate moving and positioning a client in bed with and without a drawsheet.
21. Demonstrate transfer of client from bed to wheelchair using a transfer belt.
22. Demonstrate assisting the client to ambulate using transfer belt.
23. Demonstrate courteous and respectful demeanor to client at all times.

Objectives	**Content Outline**
	I. Guidelines for assisting with personal care A. Definitions 1. hygiene a. methods of keeping the body clean 2. grooming a. hair, nail and foot care b. shaving facial hair 3. diaphoretic a. perspired, sweaty
Identify the components of personal care as evidenced by participation in classroom discussion.	B. components of personal care 1. bathing 2. oral hygiene 3. shaving 4. back rub 5. dressing and undressing 6. hair care 7. nail care 8. elimination

Objectives	Content Outline
	9. bed-making
Explain routine personal care for both morning and bedtime as evidenced by participation in classroom discussion.	C. Routine personal care (with attention to client preference) 1. early AM care b. after waking and before breakfast c. going to the bathroom d. washing hands, face e. mouth care 2. morning (AM) care – preparing for the day a. take client to bathroom or assist with elimination b. assist to wash hands c. before or after breakfast (client preference) assist with mouth care/denture care d. assist with bathing e. provide a back rub f. helping client to dress in day-time clothes g. assisting client with hair care, shaving, hand care, foot care, make-up h. make bed i. tidy room 3. evening (PM) care – preparing for bedtime a. offer bedtime snack and fluid, if appropriate b. take client to bathroom or assist with elimination c. assist with bathing, if client preference; otherwise assist to remove make-up, if appropriate, wash hands and face d. help with mouth care/denture care e. help with hair care f. assist to put on night clothes g. provide back rub h. prepare bed for client i. tidy room
Describe person-centered care (PCC) Explain why it is important to provide PCC in the long-term care environment	D. Person-centered care (PCC) promotes choice, purpose and meaning in daily life 1.clients/residents can direct care and services 2. client/resident choice fosters engagement and improves quality of life 3.Client/residents live in an environment of trust and respect 4.client/residents are in a close relationship with staff that are attuned to their changes and can respond appropriately 5.clients/residents continue to live in a way that is meanin them
Describe the guidelines for assisting the client with person-centered personal care as evidenced by participation in classroom role-play or discussion.	E. Guidelines for assisting with personal care in a person-centered home-like environment 1. promote client dignity

Objectives

Explain what the nurse aide is able to observe while assisting the client with personal care as evidenced by accurate reporting during classroom and skills lab role-play.

Identify different pain scales (per facility policy)

Identify the purposes of bathing as evidenced by a minimum grade of 80% on the unit test.

Identify the supplies required for bathing as evidenced by successful preparation for bathing skills in skills lab and in clinical.

Content Outline

a. address by name
b. treat as an adult
c. explain what you will be doing
d. provide privacy during personal care

2. promote client independence
   a. encourage client to perform tasks
   b. provide time for client to perform tasks
3. respect client preferences
   a. permit client to make choices regarding clothing, hair style, make-up
   b. allow client to choose when to take bath or perform mouth care
4. follow client's routine
   a. routine may be comforting
   b. allows client choice in care
5. follow care plan instructions
   a. consistency among staff helps to prevent behavior problems
   b. assures that client receives all the care and assistance they require

F. Observation during personal care
1. skin
   a. areas that are red, white, bluish
   b. areas of broken skin
   c. bruises
   d. edema
   e. condition of fingernails and toenails
   f. blisters
   g. odors
2. mobility
   a. difficulty walking
   b. difficulty raising arms to dress
   c. difficulty repositioning
3. flexibility
   a. difficulty bending a joint
4. complaint of pain (verbal or nonverbal)
   a. location of pain
   b. cause of pain
   c. description of pain
   d. duration of pain
   e. what causes pain to cease
5. change in level of consciousness
   a. drowsy
   b. confused
   c. disoriented to person, place, time
   d. not able to arouse

II. Bathing
A. Purpose
1. clean the skin
2. eliminate body odor

Objectives

Describe the safety guidelines the nurse aide should follow when assisting the client to bathe as evidenced by successful completion of role-play in classroom and skills lab.

Perform the partial bed bath skill according to the most current edition of Virginia Nurse Aide Candidate Handbook

Content Outline

3. relax and refresh client
4. exercise muscles
5. stimulate blood flow to skin
6. improves client self-esteem
7. nurse aide can observe skin

B. Supplies
1. soap (client may have personal preference for type of soap used)
2. wash clothes
3. bath towels
4. clean clothes
5. non-skid footwear
6. gloves
7. ~~hand~~ lotion/cream/oil
8. deodorant
9. shampoo

C. Types of baths
1. shower
2. tub bath
    a. uses a whirlpool or bath tub
3. partial
    a. face, underarms, hands, perineal area, feet
    b. can be performed in bathroom or while client is in bed
4. bed bath
    a. client unable to leave bed
    b. entire body washed while client in bed

D. Safety guidelines during bathing
1. follow nursing care plan for special instructions
2. if nurse aide cannot handle client alone, ask for help
3. gather all supplies before entering the bathing area and put them where they are easily accessible
4. client should wear non-skid shoes to and from the bathing area
5. keep client covered on way from room to bathing room
6. have bathing room warm before bringing client to room
7. follow facility policy for cleaning bathing area before and after client use
8. make sure floor in bathing area is dry before client walks on it
9. use non-slip mats in tub
10. hand rails and grab bars should be sturdy and secured to the walls
11. do not leave client unattended in bathing area
12. check water temperature before client tests water (should not be greater that 105°F.). Test on inside of wrist or elbow

Objectives

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Explain the importance of following the correct sequence of bathing as evidenced by participation in classroom discussion.

Demonstrate how to give a shower as evidenced by a Satisfactory rating on the Skills Record during the clinical experience.

Content Outline

13. Have client check water temperature (not too hot; not too cold)
14. ~~14.~~ wear gloves to bathe client ~~if there is any broken skin or nurse aide is washing perineum~~
15. do not have electrical items (razors, hair dryers) near water source
16. remember to report any observations of changes in client's condition or behavior to appropriate supervisor

E. Order of bathing
1. clean to dirty to prevent transferring micro-organisms from one part of the body to another
2. eyes first – nose to temple (no soap)
3. face (no soap)
4. ears
5. neck
6. arms, underarms (axilla), hands – from torso outward
7. chest
8. abdomen
10 legs, feet – from torso downward
11. back
12. perineum
13. buttocks

F. Giving a shower
1. Supplies
    a. Soap (client may have personal preference for type of soap used
    b. washcloths
    c. towels
    d. clean clothes
    e. non-skid footwear
    f. gloves
    g. lotion/cream/oil
    h. deodorant
    i. shampoo
2. make sure shower room is clean, including shower chair
3. explain procedure to client
4. with client's input gather clean clothing, personal toiletries
5. have client wear non-skid footwear
6. transport client to shower room, making sure client is fully covered and warm
7. lock wheels of shower chair when client has been transported to shower
8. test temperature of water before running water on client
9. put on gloves
10. assist client to undress, removing non-skid footwear last

Objectives	Content Outline
Accurately document performance of a shower on facility ADL Form as evidenced by Satisfactory rating on Skills Record.	11. encourage client to wash face, arms, chest, abdomen, and hands 12. wash client's back, legs, feet and perineum 13. rinse, being careful to remove all soap residue 14. cover client's back with towel after washing and rinsing to keep client warm 15. unlock shower chair wheels, roll client to dressing area and dry with bath towels, including under breasts and between the toes 16. place bath blanket around shoulders to keep client warm 17. apply deodorant and lotion per client's request and as needed 18. remove gloves and wash hands 19. assist client to put on clean clothes, including non-skid footwear 20. return client to room 21. assist with remainder of grooming: hair care, shaving, nail care 22. help client to comfortable positin 23. place call bell within reach 24. wash hands 25. be courteous and respectful to client at all times 26. report any observations of changes in client's condition or behavior to appropriate supervisor 27. document on ADL (Activities of Daily Living) Form or designated documentation tool per facility policy
Demonstrate how to give a tub bath as evidenced by a Satisfactory rating on the Skills Record during the clinical experience.	G. Giving a tub bath 1. equipment is the same as shower 2. make sure tub room is clean, including the bathtub 3. explain procedure to client 4. with client's input gather clean clothing, personal toiletries 5. have client wear non-skid footwear 6. ambulate or transport client to tub room, making sure client is fully covered and warm 7. lock wheels of tub chair or tub lift when client has been safely transfer to chair or lift 8. test temperature of water and fill tub half-full with warm water 9. put on gloves 10. assist client to undress, removing non-skid footwear last 11. encourage client to wash face, arms, chest, abdomen, and hands 12. wash client's back, legs, feet and perineum 13. rinse, being careful to remove all soap residue 14. cover client's back with towel after washing and rinsing to keep client warm 15. remove client from tub and dry with bath towels, including under breasts and between the toes

Objectives

~~Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.~~
Accurately document performance of a tub bath on facility ADL Form as evidenced by Satisfactory rating on Skills Record.

Demonstrate how to give a partial bed bath as evidenced by a Satisfactory rating on the Skills Record during the clinical experience.

~~Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.~~

Content Outline

16. place bath blanket around shoulders to keep client warm
17. apply deodorant and lotion per client's request and as needed
18. remove gloves and wash hands
19. assist client to put on clean clothes, including non-skid footwear
20. return client to room
21. assist with remainder of grooming: hair care, shaving, nail care
22. help client to comfortable position
23. place call bell within reach
24. wash hands
25. be courteous and respectful to client at all times
26. report any observations of changes in client's condition or behavior to appropriate supervisor
27. document on ADL (Activities of Daily Living) Form or designated documentation tool per facility policy

H. Giving a partial bath
1. used on days client does not receive complete bath or shower
2. explain procedure to client
3. with client's input gather clean clothing, personal toiletries
4. have client wear non-skid footwear
5. transport client to bathroom, making sure client is fully covered and warm
6. lock wheels of chair when client has been transported to bathroom
7. if giving a partial bed bath, raise level of bed to waist-height of the nurse aide (lock bed wheels)
8. test temperature of water at sink or before filling bath basin about half-full
9. Have client test water temperature (Not too hot; not too cold)
10. put on gloves
11. assist client to undress, removing non-skid footwear last
12. encourage client to wash face, underarms, and hands
13. assist client to wash perineum remembering to wash front to back, rinse front to back and dry front to back
14. help client to rinse being careful to remove all soap residue
15. apply deodorant and lotion per client's request and as needed
16. Remove any wet bed linens
17. remove gloves and wash hands
18. assist client to put on clean clothes, including non-skid footwear
19. remake bed, if needed
20. assist with remainder of grooming: hair care,

Objectives

Accurately document performance of a partial bed bath on facility ADL Form as evidenced by Satisfactory rating on Skills Record.

Demonstrate how to give a complete bed bath as evidenced by a Satisfactory rating on the Skills Record during the clinical experience.

Content Outline

shaving, nail care

21. help client to comfortable position chair or bed)
22. place call bell within reach
23. if partial bed bath was given, return bed to low position
24. wash hands
25. be courteous and respectful to client at all times
26. report any observations of changes in client's condition or behavior to appropriate supervisor
27. document on ADL (Activities of Daily Living) Form, or designated documentation tool per facility policy

I. Giving a complete bed bath

1. supplies are the same as above with addition of bath basin
2. explain procedure to client
3. provide client privacy be pulling privacy curtain or closing client's door
4. with client's input gather clean clothing, personal toiletries
5. test temperature of water at sink before filling bath basin about half-full and taking to bedside
6. have client verify water temperature is OK
7. raise level of bed to waist-height of the nurse aide and lock wheels of bed
8. cover client with bath blanket to maintain warmth and remove night clothing
9. put on gloves
10. beginning with eyes, wash eyes with wet washcloth (no soap) using different area of washcloth for each eye, washing from the nose toward the temple
11. wash remainder of face
12. dry face with towel
13. keeping client covered with bath blanket, expose 1 arm placing a clean, dry towel under the exposed arm
14. with soap on the washcloth, wash arm, hand and underarm
15. rinse arm, hand, underarm and pat dry with towel and place under bath blanket
16. repeat process for 2nd arm
17. expose client's chest and abdomen and with soap on washcloth wash chest (including under the breasts) and abdomen
18. rinse and dry chest and abdomen and cover with bath blanket
19. expose one leg and foot and place clean, dry towel under leg
20. with soap on the washcloth, wash leg and foot (including between the toes) and rinse
21. dry leg and foot with towel that is underneath leg

Objectives

~~Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.~~

Accurately document performance of a complete bed bath on facility ADL Form as evidenced by Satisfactory rating on Skills Record.

Demonstrate how to give modified bed bath (face, 1 arm, hand and underarm) as evidenced by Satisfactory rating on Skills Record.

Identify terms associated with oral hygiene as evidenced by a participation in classroom discussion.

Content Outline

22. cover leg and foot with bath blanket
23. repeat process for 2nd leg and foot
24. wash front of perineum, front to back
    a. use clean area of washcloth for each stroke
    b. using clean washcloth, rinse soap from perineum, front to back using clean area of washcloth for each stroke
25. dry perineum, front to back with towel
26. return bed to low position
27. empty bath basin and refill with clean, warm water
28. raise bed to comfortable level for the nurse aide and raise side rail on opposite side of bed
29. turn client on side toward raised side rail and wash rectal area with clean washcloth and soap front to back with clean area of washcloth for each stroke
30. dry with towel
31. reposition client
32. apply deodorant and lotion per client's request and as needed
33. remove gloves and wash hands
34. assist client to put on clean clothes, including non-skid footwear, if appropriate
35. assist with remainder of grooming: hair care, shaving, nail care
36. help client to comfortable position
37. place call bell within reach
38. return bed to low position
39. empty, rinse, dry basin and store per facility policy
40. dispose of soiled washcloths, towels and linen per facility policy
41. be courteous and respectful to client at all times
42. report any observations of changes in client's condition or behavior to appropriate supervisor
43. document on ADL (Activities of Daily Living) Form, or designated documentation tool per facility policy

J. Give a modified bed bath
1. skill required for NNAAP testing
    a. follow the procedure for "Gives Modified Bed Bath" in the most current edition of Virginia Nurse Aide Candidate Handbook

III. Oral Hygiene
A. Definitions
1. oral hygiene
    a. teeth
    b. gums
    c. tongue
    d. bridge
    e. dentures
2. periodontal disease - diseases of the gums

Objectives

Demonstrate an understanding of the importance of oral hygiene as evidenced by participation in classroom discussion.

Describe observations that the nurse aide may make while providing oral hygiene to a client as evidenced by accurate documentation on client observation form during role-play in skills lab.

Identify the guidelines for good oral hygiene as evidenced by a minimum grade of 80% on unit test.

Content Outline

3. plaque
    a. sticky, colorless deposit that forms on teeth
    b. develops when food containing carbohydrates is left on the teeth
    c. bacteria live in plaque and destroy the tooth enamel causing tooth decay
4. tartar
    a. plaque left on teeth more than 26 hours hardens into tartar
    b. promotes tooth decay and gum disease, gingivitis
5. gingivitis
    a. inflammation of gums caused by bacteria and plaque that remain on teeth
    b. can be prevented with regular brushing, flossing and cleaning by a dentist
6. periodontitis
    a. inflammation of gums becomes more severe
    b. gums pull away from teeth allowing bacteria and food to accumulate
    c. gums become infected
    d. teeth become loose and fall out or must be removed
7. halitosis
    a. bad breath
    b. caused by poor oral hygiene
    c. bacteria and plaque build-up around un-brushed teeth producing odor
8. bridge
    a. may be permanent or removable
    b. bridge a gap between client's own teeth with a false tooth/teeth
    c. attach to client's own teeth
9. edentulous - toothless
10. dentures
    a. removable replacement for teeth and gums
    b. all client's teeth are removed
    c. may have upper – replaces teeth in upper jaw
    d. lower denture – replaces teeth in lower jaw

B. Purpose of oral hygiene
1. Keep mouth clean
2. remove food and bacteria from teeth, tongue, gums, cheeks
3. prevent tooth decay and gum disease
4. prevent bad breath

C. Observations to make while assisting with oral care
1. lips
    a. dry
    b. cracked

Objectives	Content Outline
	c. bleeding d. chapped e. cold sores (fever blisters) 2. tongue, gums, and cheeks a. red, white or swollen areas b. sores or white spots c. bleeding 3. teeth a. loose b. cracked c. chipped d. broken e. discolored f. missing 4. dentures (partial, upper, lower) a. chipped b. cracked c. fit poorly 5. breath a. bad breath that does not go away with brushing b. fruity aroma to breath 6. difficulty swallowing a. gagging b. choking
Demonstrate how to provide mouth care as evidenced by Satisfactory rating on skills Record for skills lab and for clinical.	7. client complains of pain in mouth
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	D. Guidelines for good oral hygiene 1. brush teeth after each meal and at bedtime 2. floss once a day 3. rinse dentures after each meal 4. remove dentures at bedtime and soak overnight in soaking solution
Accurately document performance of mouth care on facility ADL form as evidenced by Satisfactory rating on Skills Record.	E. Supplies to provide oral care 1. toothbrush 2. toothpaste 3. emesis basin 4. gloves 5. towel 6. glass of water 7. denture cup for client with dentures 8. floss 9. mouthwash
Demonstrate how to provide mouth care For an edentulous client as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.	F. Provide mouth care 1. consider the toothbrush as a “clean” instrument throughout procedure 2. encourage client to be as independent as he can 3. independent client may only need assistance gathering supplies or transport to the bathroom
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	
Accurately document performance of mouth care on facility ADL form as evidenced by Satisfactory rating on Skills Record.	
Demonstrate how to floss a client’s teeth as evidenced by Satisfactory practice in skills lab.	

Objectives	Content Outline
	4. follow the procedure for "Provides Mouth Care" in the most current edition of Virginia Nurse Aide Candidate Handbook 5. document procedure on Activities of Daily Living form, or designated documentation tool per facility policy **6. report any observations of changes in client's condition or behavior to appropriate supervisor**
	G. Provide mouth care for edentulous client 1. even though teeth are absent, mouth care is important 2. use foam-tipped applicators moistened with mouthwash or half-strength mouthwash/hydrogen peroxide to clean gums 3. use applicators to clean tongue 4. rinse mouth with mouthwash 5. document procedure on Activities of Daily Living form, or designated documentation tool per facility policy 6. report any observations of changes in client's condition or behavior to appropriate supervisor
Demonstrate how to provide denture care as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. Accurately document performance of denture care on facility ADL form as evidenced by Satisfactory rating on Skills Record. Demonstrate how to provide mouth care For an unconscious client as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	H. Flossing teeth 1. purpose a. cleans food and bacteria from between teeth where toothbrush cannot reach 2. equipment a. dental floss b. gloves c. towel d. water for client to drink e. emesis basin 3. procedure a. identify yourself to client b. explain what you will be doing c. provide privacy d. wash hands e. gather supplies f. place client in upright sitting position with towel over chest 1. if client in bed, raise bed to waist-height and lower side rail closest to you g. put on gloves h. wrap ends of floss securely around each of your index fingers i. beginning with back teeth, using a sawing motion, move floss up and down between teeth j. gently slip floss into space between gum and tooth k. repeat on each side of the tooth l. after every 2 teeth, unwind floss and use a new area of floss m. offer client water to drink and provide

Objectives	Content Outline
Perform the "provide denture care" according to the most current edition of Virginia Nurse Aide Candidate Handbook	emesis basin to spit the water into n. clean client's mouth with towel o. return bed to low position, replace side rail as appropriate p. place call bell within reach of client q. clean and return supplies to appropriate storage area r. remove and dispose of gloves and used floss s. wash hands t. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy u. report any observations of changes in client's condition or behavior to appropriate supervisor I. Provide denture care 1. always wear gloves when handling dentures 2. dentures are very expensive, handle with care 3. always store in water a. prevents cracking 4. follow the procedure for "Cleans Upper or Lower Denture" in the most current edition of Virginia Nurse Aide Candidate Handbook 5. document procedure on Activities of Daily Living form or designated documentation tool, per facility policy 6. report any observations of changes in client's condition or behavior to appropriate supervisor J. Provide oral care for unconscious client 1. require frequent mouth care a. prevent mucous membranes from drying b. keep teeth and gums moist c. keeps lips moist to prevent cracking 2. supplies a. toothbrush or foam-tipped applicator b. toothpaste or cleaning solution c. gloves d. towel e. emesis basin f. lip lubricant 3. procedure a. identify yourself to client and explain what you will do, even though client is unconscious b. provide client privacy c. wash hands d. gather supplies e. raise bed to waist-height and lock wheels of bed f. lower side rail closest to you g. turn client on side, facing you h. put on gloves
Accurately document performance of mouth care on facility ADL form as evidenced by Satisfactory rating on Skills Record.	
Identify the components of personal grooming as evidenced by a minimum grade of 80% on the unit test.	
Explain how to shampoo a client's hair As evidenced by Satisfactory rating on the Skills record during clinical experience.	

Objectives	Content Outline
	i. place towel under client cheek and chin j. place emesis basin next to cheek and chin to catch fluid from mouth k. using moistened toothbrush or foam-tipped applicator gently clean teeth, gums, tongue l. rinse and remoisten brush or applicator as needed m. when finished use towel to dry client's face n. remove towel and basin o. apply lip lubricant p. reposition client q. replace side rail to appropriate position r. return bed to low position s. place call bell within client's reach t. clean and store equipment u. dispose of linen v. remove gloves and wash hands w. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy x. report any observations of changes in client's condition or behavior to appropriate supervisor
	IV. Grooming A. Maintaining neat, clean, and well groomed appearance 1. hair care 2. shaving 3. make-up 4. fingernail care 5. foot care
Demonstrate how to provide hair care as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.	B. Hair care 1. shampooing client's hair a. always ask client if they want hair shampooed b. many facilities have beauty shop for resident/ clients to use weekly or bi-weekly c. easiest to perform during shower 1. provide client cloth to cover/protect eyes 2. with hand-held shower head, wet hair with warm water 3. apply client's preferred shampoo and lather, gently massaging scalp 4. thoroughly rinse shampoo from hair 5. towel dry hair and wrap hair in towel to transport client back to room 6. document procedure on Activities of Daily Living form, per facility policy 7. report any observations of changes in client's condition or behavior to appropriate supervisor d. shampoo in bed (some facilities have shampoo
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	

Objectives	Content Outline
Accurately document performance of hair care on facility ADL form as evidenced by Satisfactory rating on Skills Record.	basin for use in bed) e. dry, powder shampoo may be used for bed-ridden client 2. daily hair care a. improves self-esteem b. ~~permit~~ client to choose how to style their hair c. brushing hair massages scalp d. prevents tangles 3. equipment a. client's own comb and/or brush b. mirror c. towel d. hair care items requested by client
Explain guidelines for nurse aide when shaving a client as evidenced by participation in classroom discussion.	4. procedure to provide hair care a. identify yourself to client and explain what you will be doing b. gather supplies c. wash hands d. provide for client privacy e. place towel over shoulders to collect hair that comes out while combing/brushing f. gently comb/brush hair starting at the ends and working toward the scalp g. remove tangles first h. then brush hair from scalp to ends of hair i. style as client prefers j. clean hair from comb and/or brush and return equ to appropriate storage k. dispose of towel per facility policy l. position client comfortably m. place call bell within client's reach n. wash hands o. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy **p. report any observations of changes in client's condition or behavior to appropriate supervisor**
Describe the different types of razors including how the nurse aide would use each type as evidenced by satisfactory practice in the skills lab.	C. Shaving 1. guidelines for shaving ~~men~~ facial hair a. respect client preference b. follow the facility policy for shaving c. some ~~men~~ client/residents do not wish to shave daily d. always wear gloves when giving a shave e. before shaving with safety or disposable razor, soften facial hair with warm, moist cloth f. always shave in same direction as the hair grows g. follow client preference for shaving and
Demonstrate how to shave a client/resident as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.	

Objectives

Accurately document shaving on facility ADL form as evidenced by Satisfactory rating on Skills Record

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Discuss procedure for shaving a female client/resident

Explain why make-up may be important for the client.

Content Outline

after-shave products

h. discard disposable razors in the biohazard container

i. never cut or trim client's ~~beard or mustache~~ facial hair without their permission

1. Supplies

a. electric razor

1. safest
2. does not require shaving cream or soap
3. prevents nicks and cuts
4. should be used if client receiving anti-coagulant medications
5. do not use near water source or when oxygen is in use

b. disposable razor

1. requires shaving cream or soap
2. may make nicks or cuts because they are very sharp

c. safety razor

1. requires shaving cream or soap
2. blades need to be changed when become dull
3. dispose of old blades in biohazard container
4. may make nicks or cuts because they are very sharp

d. towels

e. washcloth

f. mirror

g. shaving cream or soap

h. gloves

3. procedure for shaving male client/resident

a. identify yourself and explain what you will be doing

b. gather supplies

c. fill basin half-full of warm water for use with client in bed

d. provide for client privacy

e. if client is in bathroom, position him in front of mirror

f. if client is in bed, raise bed to waist-height, lower side rail closest to you and raise head of bed to sitting position

g. put on gloves

h. for safety or disposable razor

1. drape towel over client's chest
2. moisten beard with warm, moist cloth
3. apply shaving cream or lathered soap to cheeks, chin and front of neck
4. holding skin taut shave in direction hair grows (downward on face, upward on neck)

Objectives

Identify the importance of fingernail care as evidenced by participation in classroom discussion.

Describe guidelines the nurse aide should Follow when providing nail care as Evidenced by Satisfactory rating on Skills Record during skills lab and clinical.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

.

Demonstrate how to provide fingernail care as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical

Content Outline

5. rinse razor frequently to get rid of excess cream/soap/whiskers
6. offer mirror to client for approval
7. wash, rinse and dry face and neck
8. apply after-shave per client preference
9. remove and dispose of towel
10. remove gloves and wash hands

i. for electric razor

1. do not use near the sink
2. place towel on client's chest
3. put on gloves
4. apply pre-shave lotion per client preference
5. holding skin taut shave with smooth, even, circular motions if razor has 3 heads, otherwise go back and forth in direction of hair growth (downward on face and upward on neck)
6. offer mirror to client for approval
7. apply after-shave per client preference
8. remove and dispose of towel
9. remove gloves and wash hands

j. remove any loose hairs from client
k. position client comfortably
l. if in bed, return bed to low position
m. place call bell within client's reach
n. clean razor of hair and/or soap
o. return equipment to appropriate storage
p. document procedure on Activities of Daily Living form, per facility policy
q. **report any observations of changes in client's condition or behavior to appropriate supervisor**

4. procedure for shaving a female client/resident
a.always obtain client consent
b.some women want to shave unwanted facial
c. hair, underarm hair and/or leg hair
follow same procedure as for male client

D. Make-up
1. important for sense of well-being and self-esteem
2. follow client's wishes regarding make-up
3. encourage independence but assist as required
4. many clients/residents also like to wear jewelry during the day: necklace, pin
5. take time to follow client's preferences

E. Fingernail care
1. purpose of nail care
a. nails collect micro-organisms
b. long, jagged nails can scratch client, care giver or another client
c. improves self-esteem

Objectives	Content Outline
Accurately document performance of fingernail care on facility ADL form as evidenced by Satisfactory rating on Skills Record.	2. guidelines for nail care a. do not cut with scissors or trim with nail clippers b. file nails straight across using emery board and shape the nail c. no shorter than the end of the finger d. never share nail equipment between clients
Discuss the importance of foot care as evidenced by participation in classroom discussion.	3. observations nurse aide may make a. pain or tenderness in hands/fingers b. dry, cracked skin c. bruising d. discolored nail beds
Identify guidelines for foot care as evidenced by Satisfactory rating on Skills Record during skills lab and clinical.	4. Supplies a. orangewood stick b. emery board (nail file) c. lotion d. basin with warm water e. soap f. gloves g. towel
Discuss observations that the nurse aide may make while providing foot care as evidenced by accurately documenting foot care practiced in skills lab and in clinical.	5. provide fingernail care a. identify yourself by name b. wash your hands c. explain procedure to client d. provide for privacy with curtain, screen or door e. if client is in bed, adjust bed to safe level, usually waist high and lock the wheels f. fill basin halfway with warm water, no warmer than 105° and place basin at comfortable level for client (have client check water temperature) g. put on gloves h. soak client's hands and nails in water at least 5 minutes i. remove one hand from water, wash with soapy wash cloth. Rinse. Pat dry with towel, including between fingers j. place hand on towel k. gently clean under each fingernail with the orangewood stick, wiping orangewood stick on towel after cleaning under each nail l. repeat steps i-k for the second hand m. wash and rinse both hands again and dry thoroughly between fingers n. shape fingernails with emery board or nail file o. finish with nail smooth and free of rough edges p. apply lotion from fingertips to wrists q. empty, rinse and dry basin before placing in designated supply area or returning to storage per facility policy r. place soiled clothing and linens in proper containers s. remove and discard gloves before washing your hands t. make client comfortable u. return bed to low position and remove privacy measures v. place call bell within reach of client w. wash hands
Demonstrate how to provide foot care as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.	
Accurately document performance of foot care on facility ADL form as evidenced by Satisfactory rating on Skills Record.	

Objectives	Content Outline
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	x. document procedure on Activities of Daily Living form, per facility policy y. report any observations of changes in client's condition or behavior to appropriate supervisor
Describe the importance of daily dressing as evidenced by participation in classroom discussion Discuss guidelines the nurse aide should follow when helping a client to dress as evidenced by satisfactory rating on Skills Record in lab and in clinical.	F. Foot care 1. purpose a. prevent foot odor b. prevent infection c. prevent pressure ulcer d. prevent complications of diabetes mellitus e. provides nurse aide opportunity to observe feet and toes f. long toenails make wearing shoes uncomfortable 2. guidelines of foot care a. nurse aide may not cut toenails, corns or calluses b. always dry feet thoroughly, including between the toes c. put on clean socks every day 3. observations the nurse aide may make during foot care a. dry skin b. breaks or tears in the skin (including between toes) c. ingrown nails d. red areas on the feet, heels, or toes e. drainage or bleeding f. change in color of skin or nails g. heels that are soft or whitish or discolored h. corns, blisters, calluses, warts i. complaints of pain, burning or tenderness in feet, heels, or toes j. rash k. unusual odor
Identify assistive devices that are useful for clients when they are dressing themselves as evidenced by using these devices appropriately in skills lab and in clinical.	4. supplies a. basin b. towels c. soap d. lotion e. gloves f. washcloth g. clean socks
Explain observations the nurse aide may make when assisting the client to dress as evidenced by participation in classroom discussion.	5. provide foot care a. follow the procedure for "Provides Foot Care on One Foot" in the most current edition of Virginia Nurse Aide Candidate Handbook b. document procedure on Activities of Daily Living form, per facility policy c. report any observations of changes in client's
Identify safety measures and precautions the nurse aide should be aware of when assisting the client to dress as evidenced by participation in classroom discussion.	

Objectives

Demonstrate how to dress client with affected (weak) right arm as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document dressing on facility ADL form as evidenced by Satisfactory rating on Skills Record.

Content Outline

condition or behavior to appropriate supervisor

V. Dressing

A. purpose
1. everyone should dress in clean clothes every day
2. promotes self-esteem
3. cleanliness helps to prevent odors

B. Guidelines for dressing client (explain procedure and provide privacy)
1. encourage client to be as independent as possible within their capabilities
2. provide client opportunity to make choices regarding what clothing to wear
3. allow client time to make decisions and choices
4. clothing should be appropriate to time of year, temperature of surroundings
5. all of client's clothing should be labeled with name and room number
6. handle client's clothing with care
7. report to supervisor any clothing that needs to be repaired in any way
8. provide client privacy when dressing or undressing
9. report to supervisor or family clothing and shoes that are too big or too small
10. begin dressing on the weak side
11. begin undressing on the strong side
12. dresses that open in the front are easier to put on that ones that open in the back
13. slacks, skirts and pants with elastic waistbands are preferable
14. shoes should have non-skid soles
15. to promote client independence, assistive clothing devices may be required
    a. zipper pull
    b. extended shoe horn
    c. button hole helper
    d. long handled graspers
    e. Velcro openings

C. Observations nurse aide may make when assisting client to dress
1. change in flexibility of joints
2. weakness of one side of body
3. loss of weight if clothing becomes loose
4. gaining weight if clothing becomes tight

D. Safety measures and precautions when assisting client to dress and undress
1. clothing should fit properly
    a. not too long

Objectives	Content Outline
	b. not too tight c. not too loose 2. shoes should have non-skid soles 3. encourage client to sit when putting on socks/stockings and shoes 4. provide sweaters and long-sleeved tops if client complains of feeling cool or cold E. Dress client 1. if client is independent, provide assistance as requested 2. if client needs assistance follow the procedure for "Dresses Client with Affected (weak) Right Arm" in the most current edition of Virginia Nurse Aide Candidate Handbook a. document procedure on Activities of Daily Living form, per facility policy b. report any observations of changes in client's condition or behavior to appropriate supervisor 3. Care of client's personal clothing a. labeled with name and room number b. place in hamper for laundry when soiled or when removed at end of the day c. store clean clothes per facility policy d. report to supervisor and/or family clothing that needs to be mended e. report to supervisor and/or family clothing/shoes that no longer fit VI. Toileting A. Anatomy and Physiology of Urinary System 1. Kidneys a. most people have 2 kidneys, one on each side of the small of the back b. cleanse and filter the blood c. regulate the balance of water, sodium, potassium d. remove toxins and waste products from blood e. assist to regulate blood pressure 2. Urine - fluid created by kidneys from the water and waste products filtered from the blood 3. Ureters - thin tube that carries urine from each kidney to the bladder 4. Bladder - collects urine ~~a. can hold 200 - 400ml of urine~~ 5. Internal urethral sphincter - muscle that holds the neck of bladder closed, keeping the urine in the bladder 6. Urethra - tube that carries urine from bladder to the outside of the body a. about 3- 4 inches long in females b. about 7 – 8 inches long in males
Explain the anatomy and physiology of the urinary system as evidenced by being able to correctly identify each component part and its function.	

Objectives

Define the terms used in the urinary system as evidenced by participation in classroom discussion.

Describe age-related changes seen in the urinary system as evidenced by accurately participating in classroom discussion.

Identify normal characteristics of urine as evidenced by participating in classroom discussion.

Identify abnormal characteristics of urine that the nurse aide should report to the appropriate supervisor.

Content Outline

7. External urethral sphincter - muscle that contracts to preve from exiting the urethra
8. Urethral Meatus - opening to the outside of the body at the end of the urethra

B. Process of passing urine from the body
   a. voiding
   b. micturating
   c. urinating

C. Urinary incontinence
   1. unable to control the internal sphincter
   2. involuntary passing of urine

D. Definitions
   a. Hematuria - blood in the urine
   b. Anuria – no urine
   c. Dysuria – painful urination
   d. Nocturia – urinating at night
   e. Polyuria – excessive urination

E. Age-related changes to the urinary system
1. kidneys do not filter the blood as efficiently
   a. increase in blood pressure
2. urethral sphincter muscle tone decreases
   a. increases risk of urinary incontinence
3. bladder is not able to hold as much urine before the sensation that it needs to empty
   a. more frequent urination
4. bladder does not empty completely
   a. increased risk of urinary tract infection

F. Urine
1. color
   a. pale yellow – normal
   b. dark yellow to amber – dehydrated
   c. can be affected by food, medications and/or illnesses
2. clarity
   a. should be clear
   b. cloudy – sign of infection
3. odor
   a. smells of ammonia
   b. foods can affect smell – asparagus
4. amount
   a. adults produce 1200-1500 ml/24 hours
   b. minimum is 30ml/hour
5. should not contain
   a. blood
   b. pus
   c. mucus
   d. bacteria

Objectives	Content Outline
	e. glucose f. sediment 6. report the following to the appropriate supervisor a. cloudy urine b. dark or rust-colored urine c. strong, offensive smelling urine d. fruity-smelling urine e. blood, pus, mucus in urine f. bacteria or glucose in urine g. sediment h. complaints of pain or burning on urination i. frequent urinary incontinence j. client wakes up frequently during the night to urinate
Explain the guidelines the nurse aide should follow to promote normal urination patterns as evidenced by participation in classroom discussion.	G. Guidelines to promote normal urination 1. provide privacy 2. take to the bathroom, ~~if possible~~ as needed 3. assist male clients to stand to void, if possible 4. if client must use bedpan, raise head of bed to sitting position 5. encourage adequate fluid intake 6. provide fresh water in easy reach of client 7. frequently offer clients fluids to drink 8. encourage activity and exercise 9. teach Kegel exercises to female clients 10. answer call bells promptly 11. take client to bathroom every 2 hours to avoid incontinence
Discuss common disorders of the urinary system, including their signs and symptoms, as evidenced by a minimum grade of 80% on the unit test.	H. Common disorders of the urinary system 1. urinary tract infection (UTI) a. usually a bacterial infection b. causes 1. wiping incorrectly and contaminating urethra with bowel movement 2. not emptying the bladder completely 3. indwelling urinary catheter c. symptoms 1.urgency 2.complaints of pain or burning with urination 3.urinating frequently in small amounts 4.blood in urine 5. lower abdominal pain 6. flank pain 7. change in mental status or behavior 8. nausea d. measures to avoid UTI 1. wipe perineum front to back 2. drink plenty of fluids 3. Vitamin C helps to prevent UTI a. orange juice

Objectives

Content Outline

b. cranberry juice
4. take shower rather than tub bath
b. report to nurse
1. complaints of pain or burning on urination
2. foul-smelling urine
3. dark-colored urine
4. blood in urine
5. client voids frequently in small amounts
6. urine that looks cloudy
7. sediment in urine

I. Urinary retention
a. ~~most commonly seen in men~~ possible causes
1. in men – commonly caused by enlarged prostate - benign prostatic hypertrophy (BPH)
2. in women – may be caused by cystocele (sagging of the bladder) and rectocele (sagging of the lower part of the colon)
b. symptoms
1. unable to empty bladder completely
2. frequent urge to void
3. difficulty starting urine stream
4. weak flow of urine stream
5. dribbling after finished voiding
6. distended lower abdomen
c. report any of the above 6 symptoms to the appropriate supervisor

J. Urinary incontinence
a. involuntary loss of urine from the bladder
b. decreased muscle tone at internal or external sphincter allows urine to "leak"
c. symptoms
1. urine leaks when client coughs, sneezes, laughs
2. client cannot "make it to the bathroom in time"

K. chronic renal failure
a. kidneys do not function correctly
b. unable to filter waste products and toxins from blood
c. unable to regulate water balance and blood pressure
d. life-threatening
e. most frequent causes
1. high blood pressure
2. diabetes mellitus
f. symptoms
1. unexplained weight gain
2. itching
3. fatigue

5. end-stage renal disease (ESRD)

Objectives	Content Outline
	a. kidney stop functioning b. client requires dialysis or kidney transplant 6. dialysis - client's blood flow through a machine that filters out waste products, toxins and extra water a. usually performed 3 times per week b. required to keep client alive
Identify equipment used with the urinary system as evidenced by satisfactory performance in skills lab when performing skills involving the urinary system.	L. Equipment used with the urinary system 1. urinal a. mostly used by male clients but there are female urinals (ask if your facility use them) b. placed between client's leg with penis in the urinal c. can be used standing, sitting or lying down d. do not store on same table used to serve meal tray e. provide privacy for use 2. bedpan (can be used by both male and female) a. used when client is unable to get out of bed b. two types 1. regular - wide, rounded end placed under client's buttocks 2. fracture pan – used when client has had hip surgery. Thin end is placed under client's/ resident's buttocks c. may be very uncomfortable and may damage the client's/resident's skin 3. bedside commode a. chair frame with a toilet seat and collection bucket b. kept at bedside for clients unable to walk into bathroom catheter 4. catheter a. tube inserted through the urinary meatus into the bladder b. drains urine from the bladder c. 3 types 1. straight – temporary – removed as soon as bladder is emptied 2. indwelling – remains in bladder to continuously drain urine into a collection bag 3. condom – fits over the penis and drains urine into a drainage bag 4. Texas catheter is another name 5. urinary drainage bags
Discuss how to provide care to the client/resident with urinary incontinence.	G. Care for client with urinary incontinence 1. can be emotionally traumatic for client and family 2. treat with respect and dignity 3. follow the procedure for "Provides Perineal Care (Peri-Care) for Female" in the most current edition of Virginia Nurse Aide Candidate Handbook

Objectives

Demonstrate how to provide perineal care as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.

Accurately document performance of perineal care on facility ADL form as evidenced by Satisfactory rating on Skills Record

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

q means every

Demonstrate how to provide catheter care as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document performance of catheter care on facility ADL form as evidenced by Satisfactory rating on Skills Record classroom discussion.

Content Outline

4. adaptations of peri-care for male client
   1. if client is not circumcised retract foreskin of penis
   2. hold penis by the shaft
   3. wash in circular motion from tip of penis down toward the body
   4. use clean area of washcloth for each strok
   5. wash scrotum, then the groin
   6. rinse and dry
   7. turn client on side
   8. wash, rinse, dry rectal area
5. document procedure on Activities of Daily Living form, per facility policy
6. report any observations of changes in client's condition or behavior to appropriate supervisor
7. management of urinary incontinence
   a. answer call bell promptly
   b. encourage fluids
   c. encourage client to walk or exercise
      a. toilet client every (q) 2hrs
      b. client wears incontinent pad or brief
      c. check pad or brief q2hr. for dryness and change if wet
      d. keep perineum clean and dry to prevent odor and skin breakdown
      e. change wet clothing immediately
      f. treat client with respect and dignity
      g. anticipate need to toilet
      h. client may need a catheter

H. Care of client with a catheter
1. Guidelines for the indwelling catheter
   a. always wear gloves when emptying catheter drainage bag
   b. do not touch tip of the clamp to any object when draining the bag
   c. do not touch the drainage spout to the graduate
   d. drainage bag should always be lower that the level of the hips or bladder to prevent urine flowing back into the bladder
   e. never hang the drainage bag from the side rail of the bed
   f. hang drainage bag from bed frame
   g. do not have the drainage bag on the floor
   h. catheter tubing should not touch the floor
   i. check catheter tubing frequently to assure it is not kinked
   k. catheter tubing should drape over the thigh, not be under the leg
   l. use catheter strap to position catheter over the thigh
   l. do not place tubing over the side rail

Objectives

Demonstrate how to empty a urinary drainage bag as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document urinary output as evidenced by Satisfactory rating on Skills Record.

Discuss how to collect routine urine specimen as evidenced by participation in classroom discussion.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document specimen collection as evidenced by satisfactory participation in classroom discussion.

m. always clean perineum front to back to prevent infection
n. keep perineum clean and dry to prevent infection
o. do not disconnect drainage tubing from the catheter
p. notify appropriate supervisor immediately if drainage tubing becomes disconnected

2. Care of the client with an indwelling catheter
a. follow the procedure for "Provides Catheter Care for Female" in the most current edition of Virginia Nurse Aide Candidate Handbook
b. document procedure on Activities of Daily Living form, per facility policy
c. report any observations of changes in client's condition or behavior to appropriate licensed nurse

I. Measuring urinary output
1. always wear gloves
2. always measure with a graduate
1. do not use lines on urinal or drainage bag measure urine output
2. place graduate on counter top and bend kı to have urine level at your eye level to measure
3. measure in milliliters (ml)
1. 1ml=1cc (cc= centimeter)
2. 30 ml = 1 ounce (oz)
4. how to empty a drainage bag
1. identify yourself and explain what you wi be doing
2. wash hands and put on gloves
3. provide for privacy
4. obtain graduate
5. place paper towel on floor under graduate
6. open clamp on drainage bag and allow urine to empty into graduate
7. empty entire content of drainage bag
8. close clamp and return to housing on drainage bag
9. measure urine in bathroom by placing graduate on counter top and reading at eye level
10. empty urine into toilet and flush
11. rinse and dry graduate and store per facility policy
12. remove gloves and wash hands
13. document output per facility policy
14. report any observations of changes in client's urine and/or condition or behavior to appropriate supervisor

J. Urinary specimens
1. routine urine specimen
1. not a sterile specimen
2. can be obtained from bedpan, urinal or

Objectives

Discuss how to collect clean-catch urine specimen as evidenced by participation in classroom discussion.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document specimen collection as evidenced by Satisfactory participation in

speci-hat (collector that fits over the porcelain bowl of the toilet and under the seat)

3. equipment needed
   1. specimen container and lid
   2. completed label and lab slip
   3. gloves
   4. means to collect urine
   5. supplies for perineal care
4. procedure
   1. identify yourself and explain what you need the client to do
   2. provide for privacy
   3. wash hands and put on gloves
   4. assist client to toilet with speci-hat, bedside commode (BSC), or provide urinal or bedpan
   5. instruct client to urinate but put toilet paper in trash for disposal
   6. remove gloves and wash hands
   7. assist client to return to comfortable position in room
   8. put on clean gloves
   9. in bathroom, pour urine into specimen cup until cup is half full, keeping outside of cup clean
   10. place lid on cup and label immediately
   11. rinse and dry any equipment used to collect urine
   12. remove gloves and wash hands
   13. place call bell within easy reach of client
   14. document specimen collection per facility policy
   15. report any observations of changes in client's urine and/or condition or behavior to appropriate supervisor

2. Clean-catch urine specimen (Mid-stream specimen)
   a. used to determine the presence of bacteria in the urine
   b. client urinates a small amount to clear the urethra, stops, if possible, then collects sample
   c. procedure for collecting clean-catch specimen
      1. identify yourself and explain what you need the client to do
      2. provide for privacy
      3. wash hands and put on gloves
      4. assist client to bathroom
      5. open specimen kit keeping inside of specimen from touching anything
      6. instruct client to clean perineum prior to obtaining specimen
         1. female – separate labia and clean front to back in 3 separate strokes with a clean towelette or wipe each time
            1. down the left side

Objectives

Content Outline

2. down the right side
3. down the middle

b. male – clean head of penis with circular strokes using clean towelette for each stroke
1. if uncircumcised, pull back foreskin and clean as above
2. return foreskin to unretracted position after urinating

7. ask client to urinate a small amount and then stop, if possible
8. place container and ask client to continue urinating, collecting until cup is about half full
9. instruct client to finish urinating and wipe with toilet paper as usual
10. place lid on specimen cup and clean outside of cup with paper towel
11. apply label and place cup in plastic bag provided
12. remove gloves and wash hands
13. assist client to comfortable position in room
14. place call bell within easy reach of client
15. document specimen collection per facility policy
16. report any observations of changes in client's urine and/or condition or behavior to appropriate supervisor

Explain the anatomy and physiology of the gastrointestinal system as evidenced by being able to correctly identify each component part and its function.

K. Anatomy and Physiology of the Gastrointestinal System (GI) – Digestive System
1. begins at the mouth and ends at the rectum
2. tongue moves food around the mouth
3. salivary glands – secrete saliva which begins the breakdown of food
4. teeth – break up food
5. esophagus – carries food to stomach
6. stomach – contains acid to break down food into chyme (semifluid mass of partly digested food)
7. chyme enters small intestines where it is propelled via peristalsis (wavelike motion that moves contents through small and large intestines)
1. continues to be digested by bile from liver
2. enzymes from pancreas
3. about 90% of absorption of nutrients from food occurs in small intestines

8. large intestines – helps regulate water balance
a. chyme takes 3-10 hours to become feces
b. feces water, sold waste material, bacteria and mucus
c. defecation – eliminating feces from the body

9. functions of the GI system

Objectives

Describe age-related changes seen in the gastrointestinal system as evidenced by accurately participating in classroom discussion.

Identify normal characteristics of stool as evidenced by participation in classroom discussion.

Discuss the importance of identifying abnormal characteristics of stool that the nurse aide should report to the appropriate supervisor.

Explain the guidelines the nurse aide should follow to promote normal bowel elimination patterns as evidenced by participation in classroom discussion.

Demonstrate how to help a client use a bedpan as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.

Content Outline

a. ingestion – taking food/fluid into the body
b. digestion – breakdown of food into nutrients to be absorbed
c. elimination of waste products from the body

L. Age-related changes to the GI system
1. decreased taste (sweet is last taste to remain)
2. loss of teeth affects ability to chew
3. decreased saliva and digestive fluids slow digestion of food
4. medical conditions may cause difficulty swallowing
5. decreased absorption of vitamins and minerals
6. decreased rate of digestion leads to constipation
7. age related changes and behaviors
   a. inactivity
   b. drinking less fluids
   c. some chronic or acute illnesses
   d. medications

M. Bowel elimination
1. called stool, feces, bowel movement (BM)
2. frequency
   a. varies by individual
   b. regularity prevents complications
3. color
   a. brown
   b. foods can cause color to change
   c. iron medication changes color to black
   d. illness
4. consistency
   a. soft, moist, formed
   b. foods can cause change to consistency
   c. illness
5. not normally found in feces
   a. blood
   b. mucus
   c. pus
   d. worms
6. report the following to the appropriate licensed nurse
   a. abnormally colored feces (white, black, bloody)
   b. hard, dry feces
   c. liquid stool (diarrhea)
   d. inability to have bowel movement (constipation)
   e. pain with bowel movement
   f. stool that contains blood, mucus, pus
   g. stool incontinence

N. Guidelines to promote normal bowel elimination
1. encourage adequate fluid intake
2. warm fluids stimulate peristalsis
3. diet with adequate fiber/roughage
4. promote regular exercise

Objectives

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document use of a bedpan and the outcome on facility ADL form as evidenced by Satisfactory rating on Skills Record

Discuss common disorders of the GI system, including their signs and symptoms, as evidenced by participation in classroom discussion.

Content Outline

5. provide good oral care to keep mouth and teeth Healthy
6. provide privacy when using the bathroom
7. allow plenty of time for client to use bathroom
8. follow client's pattern for bowel elimination
9. laxatives may be ~~used~~ ordered to stimulate bowel activity

O. Care of the client needing to use a bedpan
1. used by clients unable to get to the bathroom
2. not comfortable and can cause damage to the skin
3. follow the procedure for "Assists with use of Bedpan" in the most current edition of Virginia Nurse Aide Candidate Handbook
4. document procedure on Activities of Daily Living form, per facility policy
5. report any observations of changes in client's condition, skin changes, and/or behavior behavior to appropriate supervisor

P. Common disorders of the GI system
1. heartburn
a. acid reflux
b. sphincter muscle where esophagus enters stomach has poor muscle tone allowing gastric acid to enter the esophagus
c. causes pain in chest
d. burning in esophagus
e. bitter taste in mouth
f. usually after meals
2. flatulence
a. gas or flatus
b. too much air in GI tract
c. caused by certain foods
1. beans
2. broccoli
3. high fiber
4. dairy products (lactose intolerance)
1. exercise may provide relief
2. lying on left side may be helpful
3. constipation
a. difficult, painful elimination of stool
b. stool is usually hard and dry
c. symptoms
1. abdominal swelling
2. gas
3. irritability
4. straining during bowel movement
d. treatment
1. increase fluid intake
2. increase exercise
3. increase fiber

Objectives	Content Outline
	4. laxative, enema, suppository may be ordered 4. diarrhea a. frequent liquid or semi-liquid stool b. causes 1. infections 2. irritating foods 3. medications 4. stress/anxiety 5. illness or disease process c. treatment 1. BRAT diet (bananas, rice, apples, tea) 2. ~~change~~ diet may be changed 3. ~~change~~ medications may be ordered 4. Probiotics may be ordered 5. fecal incontinence a. involuntary passage or oozing of stool b. causes 1. loss of muscle tone at anal sphincter 2. loss of nerve control at anal sphincter 1. fecal impaction 2. treatment by changing diet and/or medication as ordered 3. bowel training 4. fecal impaction a. hard, dry feces accumulate in rectum and client cannot expel b. symptoms 1. no stool for several days 2. complaints abdominal pain 3. abdominal distension 4. nausea and vomiting 5. oozing liquid stool c. must be manually removed by nurse (RN or LPN) d. prevention 1. encourage adequate fluid intake 2. diet high in fiber 3. adequate exercise 4. regular toileting schedule
Explain the different types of enemas and when a nurse aide is permitted to give an enema as evidenced by participation in classroom discussion.	Q. Enemas ~~and the nurse aide~~ 1. nurse aides may only give enemas that contain no additives 2. know and follow your facility policy regarding nurse aides administering enemas 3. types of enemas a. tap water – 500-1000ml tap water b. soapsuds – 500-1000ml tap water with castile soap added c. saline - 500-1000ml water with salt added

Objectives

Discuss how to collect routine stool specimen as evidenced by participation in classroom discussion.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document specimen collection as evidenced by satisfactory participation in classroom discussion.

Discuss how to perform test for occult blood as evidenced by participation in classroom discussion.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document specimen collection as evidenced by satisfactory participation in classroom discussion.

Explain why a client might have a colostomy
As evidenced by participation in classroom discussion.

d. pre-packaged (Fleets) – 120ml saline or oil

R. Stool specimens
1. Stool specimen
1. purpose
1. identify parasites, microorganisms
2. blood

b. procedure
1. identify yourself and explain what you are going to do
2. wash hands
3. put on gloves or bedpan
4. place speci-hat in toilet, bedpan or bedside commode
5. have client defecate in speci-hat
6. assist with perineal care
7. using 2 tongue blades place stool in specimen cup and close lid
8. attach label immediately
9. dispose of tongue blades per facility policy
10. remove gloves and wash hands
11. position client comfortably in room
12. place call bell within reach of client
13. dispose of tongue blades per facility policy
14. document procedure on Activities of Daily Living form, per facility policy
15. report any observations of changes in client's condition or behavior to appropriate supervisor

2. ~~occult blood – not commonly perform by nurse aides~~
~~a. tests for blood in stool~~
~~b. equipment~~
~~1. stool specimen~~
~~2. Hemoccult kit~~
~~3. tongue blade~~
~~4. paper towel~~
~~5. plastic bag~~
~~6. gloves~~
~~c. procedure~~
~~1. wash hands and put on gloves~~
~~2. open test card~~
~~3. use tongue blade to smear small amount of stool of each window of Hemoccult card~~
~~4. close windows and apply drop of Hemoccult solution to reverse side of window~~
~~5. observe for color to appear in window~~
~~6. dispose of tongue blade and Hemoccult card per facility policy~~
~~7. remove and dispose of gloves and wash hands~~
~~8. document and report results per facility policy~~

S. Ostomies ~~and the nurse aide~~
1. ostomy - opening from an area inside the body to

Objectives

Describe care issues for a client with a colostomy including what observations the nurse aide should make as evidenced by satisfactory participation in classroom discussion.

Discuss the importance of nutrition, hydration, and elimination as it relates to the client/resident.

Describe the six (6) main nutrients in a healthy diet as evidenced by participation in classroom discussion.

the outside of the body
2. colostomy – intestine is brought to outside of abdomen
    1. stoma- opening in abdomen
    2. colostomy bag – appliance that covers the stoma and into which the stool drains
    3. no stool will be eliminated via the rectum
3. some causes
    a. cancer of colon, rectum
    b. trauma – gunshot
    c. diverticulitis
    d. Crohn's disease
4. care for client with ostomy
    a. treat client with respect
    b. be sensitive and supportive
    c. provide privacy for client or nurse to change bag
5. observations nurse aide should report to the appropriate supervisor
    4. color and consistency of stool
    5. unusual odor
    6. blood, pus, mucus in stool in bag
    7. leaking around the seal of the bag
    8. flatus accumulating in the ostomy bag
    9. complaints of pain in abdomen
    10. distended abdomen

T. Eating and hydration
A. Basic nutrition
1. Purposes of GI (gastrointestinal) system
    a. ingestion – take in food
    b. digestion – breakdown food into nutrients the body can absorb and use
    c. elimination – eliminate parts of food not absorbed

2. Types of nutrients
    a. water
        1. most important nutrient
        2. essential for life
        3. ingested as liquid but also as part of foods
        4. 50-60% of body weight
        5. transports waste products out of body
        6. keeps us cool – perspiration
        7. keeps mucous membranes moist
        8. helps joints to move smoothly
    b. carbohydrates
        1. source of glucose – food for the cells of the body
        2. if not used for energy (food) for the body they are stored as fat
        3. 1 gram carbohydrate = 4 calories
        4. grains, cereals, fruit, some vegetables
    c. protein
        1. contain the "building blocks" for the cells

Objectives

Explain how to use My Plate as a guide for a healthy diet as evidenced by satisfactory completion of a diet plan for one week.

Identify various special diets that clients may receive as evidenced by satisfactory participation in classroom discussion.

Content Outline

2. found in fish, meat, nuts, bean, legumes, eggs and dairy products
3. helps body to build new tissue and to rebuild tissue that is damages
4. 1 gram = 4 calories

d. vitamins
1. fat soluble – only dissolve in presence of fat
   a. Vit. D, E, A, K
2. water soluble – dissolve in water
   a. B-vitamins, vit. C
3. essential for the body to function correctly

e. minerals
1. help provide structure to the body
2. Calcium – builds bones and teeth
3. iron – required to transport oxygen throughout the body

f. fat (lipids)
1. found in meat and oils, milk, cheese, nuts
2. make food taste good
3. take long time to breakdown giving the sensation of being "full" longer
4. most be present in the body to use Vitamin D, E, A, K
5. 1 gram = 9 calories

3. USDA My Plate
   a. general guide for types and quantities of foods to eat each day
   b. fruits and vegetables
      1. half of plate
      2. vegetables - fresh, frozen, dried canned, juice
         a) dark green vegetables
         b) red and orange vegetables
         c) dry beans and peas
         d) starchy vegetables
         e) others
      3. fruit – fresh, frozen, dried canned, juice
   c. grains
      1. one quarter of plate
      2. half should be whole grain
   d. protein
      1. one quarter of plate
      2. meat, poultry, seafood, eggs
      3. beans, peas, soy products, nuts, seeds
   e. dairy
      1. 3 cups each day
      2. milk, yogurt, cheese, anything made with milk
      3. skim or 1%
4. Special diets
   a. regular diet -well-balanced diet without restrictions
   b. soft diet
      1. restricts foods hard to chew or swallow

Objectives

Describe the three (3) consistencies of Thicken that may be ordered for clients with swallowing difficulties as evidence by participation in classroom discussion.

Content Outline

2. restricts raw fruits and vegetables
3. restricts high fiber and spicy foods

c. mechanical soft diet
1. foods are chopped or blended to make them easier to chew
2. does not restrict spices, fat or fiber

d. pureed diet
1. consistency of baby food
2. for client with difficulty chewing and/or swallowing

e. clear liquid diet
1. only includes liquids you can see through
2. jello, apple juice, bouillon, water, coffee or tea without cream
3. does not provide enough nutrients to maintain health for prolonged period of time

f. full liquid diet
1. clear liquids and any food that can be poured at room or body temperature
2. puddings, cream soups, yogurt, breakfast drinks

g. bland diet
1. restricts spicy and acidic foods

h. fiber-specific diet
1. may be high or low fiber depending on medical needs of client

i. low sodium diet (low NA diet)
1. restrict amount of salt client may use
2. ordered for client with high blood pressure
3. may be "no added salt: diet (NAS)

j. diabetic diet
1. ordered for clients with diabetes mellitus
2. may restrict caloric intake
3. restricts amount of sugar and carbohydrates

k. fluid restricted diet
1. ordered for client with heart or kidney disease
2. identifies specific quantity of fluid client may have in 24-hour period

l. gluten-free diet
1. may be resident choice or due to intolerance to gluten
2. gluten is a general term for proteins found in wheat
3. clients/residents with celiac disease cannot tolerate gluten

l. NPO
1.nothing by mouth

5. liquid modifications
a. may be required for clients with difficulty swallowing "thin" fluid like water
b. Thicken – works like corn starch to thicken the liquid
c. nectar thick (consistency of thick fruit juice)
d. honey thick (consistency of honey)
e. pudding thick (consistency of pudding)
f. know facility policy and procedures for who can thicken fluids

Objectives

Identify age-related changes that affect eating and nutrition as evidenced by satisfactory participation in classroom discussion.

Identify cultural considerations that affect eating and nutrition as evidenced by satisfactory participation in classroom

Content Outline

B. Age-related changes to eating and nutrition
1. physical changes
    1. dysphagia – difficulty swallowing
    2. loss of teeth – difficulty chewing
    3. decrease saliva – difficulty swallowing
    4. decrease sensations of taste and smell – food is less appealing
    5. decreased ability to see – makes it difficult to feed oneself and food appears less appealing
2. decreased activity level
    1. less appetite
    2. increases risk of constipation
3. special diets
    a. foods not prepared with spices have less flavor
    b. pureed diets not very appealing to the eye
4. psychosocial
    a. decreased income makes it difficult to buy foods that client purchased earlier in life
    b. lack of social interaction may decrease appetite
    c. depression may decrease appetite
5. physical ailments
    a. medical conditions can make eating/cooking difficult
    b. Parkinson's Disease, stroke, certain cancers, Alzheimer's Disease
6. medications
    a. can alter the taste of food
    b. can leave bad taste in the mouth
    c. can decrease appetite
    d. may cause nausea, diarrhea, constipation

C. Cultural considerations for eating and nutrition
1. religious considerations
    1. Jewish religion
        a. ~~will~~ may not eat pork
        b. may require Kosher diet
        c. food specially prepared to religious specifications
    b. Muslim (Islam)
        1. will not eat pork
        2. may require halal diet (foods allowed under Islamic dietary guidelines)
        3 food specially prepared to religious specifications
    c. Hindu (~~will~~ may not eat beef)
    d. Buddhist (many are vegetarian)
    e. Mormon
        1. may not drink caffeine – coffee, tea, cola
        2. may not drink alcohol
2. social considerations

Objectives	Outline Content
	a. vegan 1. ~~will~~ may not eat any animal product 2. restricts eggs, dairy products, meat b. vegetarian (restrict meat, fish and poultry)? c. fasting (voluntarily gives up eating for a period of time) 3. ethnic considerations a. some ethnic groups like food that is cooked with specific spices b. i.e. Asian clients may prefer rice to potatoes
Identify specific observations concerning eating and nutrition that the nurse aide should report to the appropriate supervisor as evidenced by participation in classroom discussion.	D. Observations nurse aide should report concerning eating and nutrition 1. eats less than 70% of meals 2. complains of mouth pain 3. dentures do not fit 4. teeth are loose 5. difficulty chewing or swallowing 6. frequent coughing/choking while eating 7. needs help eating or drinking 8. weight loss – clothes become loose-fitting 9. weight gain – clothes become tight 10. complaints of constipation 11. edema (fluid accumulation) in hands/feet
Explain guidelines for the nurse aide concerning eating and nutrition as evidenced by satisfactory practice in the skills lab.	E. Guidelines for nurse aide concerning eating and nutrition 1. check diet card on client's tray to make sure it is the correct tray for the correct client 2. season food following client's choices 3. assist client to fill out menu 4. if client does not like food on tray try to replace with food of his choice 5. encourage client to eat by making mealtime a pleasant experience 6. assist client/resident to rinse mouth if client/resident receives medication immediately before mealtime 7. assist client/resident with adaptive devices to help him maintain his independence and feed himself 8. accurately record food and fluid intake for each meal 9. follow nursing care plan to assist client/resident to maintain independence at mealtime
Describe actions the nurse aide should take to prepare the client for mealtime as evidenced by satisfactory practice in skills lab and in clinical.	F. Preparing for mealtime 1. encourage client/resident to toilet before going to the dining room 2. assist to wash hands and face, brush teeth 3. encourage client/resident to wear glasses, hearing aides 4. provide pleasant area for eating a. encourage client/resident to eat in dining room with other clients/residents to promote social interaction 5. if eating in his room, clear a clean area for client's tray

Objectives

Demonstrate how to serve client trays as evidenced by satisfactory practice in skills lab and in clinical.

Demonstrate how to feed a client who cannot feed self as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document food and fluid intake as evidenced by Satisfactory rating on Skills Record.

Content Outline

a. remove urinal/bedpan from view
b. position in an upright position
c. if positioned in a wheelchair, lock the wheels

G. Serving the tray
1. wash hands
2. Offer/provide clothing protector or napkin
3. check diet card of tray
   a. correct client/resident
   b. correct diet
3. assist client/resident to prepare food
   a. season food per client/resident choice
   b. if client/resident requests, cut food into bite-sized pieces
   c. open cartons, containers at client/resident's request
4. provide client/resident with appropriate assistive devices to promote client/resident independence
   a. plate guard
   b. silverware with built-up handles
   c. sippy cup
5. decrease distractions by lowering TV/radio volume
6. allow client/resident sufficient time to eat, do not rush
7. talk with client/resident respectfully
8. for a visually impaired client/resident identify the location foods on the plate using the numbers on a clock-face

H. Guidelines for feeding client/resident
1. assist client/resident to wash hands
2. place a clothing protector over the client's chest
3. sit at the same level as client/resident, facing the client
4. identify foods for the client/resident
5. ask client/resident in what order he/she would like to have his/her food
6. do not mix foods unless requested by client/resident
7. offer liquids between bites of food
8. do not touch food to test for hotness, place hand above food
9. do not force client/resident to eat
10. provide client/resident ample time to chew and swallow food before offering another bite
11. do not rush client/resident

I. Feed a client/resident who cannot feed himself
   1. follow the procedure for "Feed Client who Cannot Feed Self" in the most current edition of Virginia Nurse Aide Candidate Handbook
   2. document procedure on Activities of Daily Living form, per facility policy
   3. report any observations of changes in client's/ resident's condition or behavior to appropriate licensed nurse

J. Calculate food intake

Objectives

Describe actions to help prevent aspiration as evidenced by satisfactory practice in skills lab and in clinical.

Define hydration, including actual amount of fluid required per day, as evidenced by a minimum grade of 80% on unit test.

Describe signs and symptoms of dehydration as evidenced by satisfactory participation in classroom discussion.

Content Outline

1. know facility procedure for calculating food intake
2. some facilities use a percentage eaten of the entire plate of food
3. some facilities calculate percentage based on type of food eaten, for example:
   a. all of protein eaten = 30%
   b. all of carbohydrates eaten = 50%
   c. all of vegetable eaten = 20%
4. document and report food intake and fluid intake per facility policy

K. Guidelines to help prevent aspiration

1. aspiration – taking food/liquid into the lungs
2. client should be in up-right position (90°) to eat
3. feed client slowly
4. reduce distractions
5. use Thicken in liquids per nursing care plan
6. cut food into small bites
7. alternate liquids and solid food
8. if client has paralysis, place food in non-paralyzed (non-affected) side of mouth
9. provide mouth care after client has finished eating
10. have client remain in up-right position about 30 minutes after finishes meal
11. report choking or gagging during meal to appropriate supervisor

L. Supplemental nutrition

1. used to increase caloric intake
   a. Ensure
   b. Sustacal
   c. Instant Breakfast
2. served between meals, or as ordered by health care provider
3. include in daily intake and output

M. Hydration

1. man cannot live without water
2. recommend 8-8oz glasses (2000-2500 ml) of fluid every day, unless restricted by health care provider
3. dehydration
   a. lack of sufficient fluid intake
   b. may cause
      1.constipation
      2. UTI
      3. change in level of consciousness
   c. most common fluid and electrolyte problem in the elderly

N. Signs of dehydration the nurse aide should report to the appropriate supervisor

1. drinking less that 6-8oz glasses (1400ml) of fluid/day
2. complaints of thirst
3. dry, cracked lips

Objectives	Content Outline
	4. dry mucous membranes 5. sunken eyes 6. decrease urine output 7. urine is dark and strong smelling 8. complaints of constipation 9. loss of weight 10. weak, dizzy, light-headed 11. low blood pressure 12. complaints of headache 13. irritable 14. confusion 15. weak, rapid heartbeat
Accurately describe actions of the nurse aide to prevent client dehydration as evidenced by successful participation in classroom discussion.	O. Actions the nurse aide can take to prevent dehydration 1. provide clients with fresh water every shift and place pitcher where client can easily reach it 2. frequently ask client if they would like something to drink 3. offer fluids that client likes to drink 4. provide fluids at temperature client prefers 5. provide client with assistive devices if needed 6. keep accurate I/O records 7. follow nursing care plan and specific fluid 8. report to appropriate supervisor any signs of dehydration
Identify signs and symptoms of fluid overload to report to the appropriate supervisor.	P. Signs of too much fluid (fluid overload) that the nurse aide should report to the appropriate supervisor 1. edema a. body retains fluid b. hands and feet swell c. rings and shoes become tight 2. weight gain 3. moist cough 4. shortness of breath on exertion 5. increased heart rate 6. skin on legs and feet becomes tight and shiny
Explain the anatomy and physiology of the skin as evidenced by being able to correctly identify each component part and its function.	e. Care of the Skin (Integumentary System) A. Anatomy and Physiology of the Skin 1. layers of the skin a. epidermis 1. outer layer 2. made up of dead cells 3. has no blood vessels 4. contains melanin – pigment that gives color to the skin b. dermis 1. inner layer 2. contains oil glands, sweat glands, hair follicles, blood vessels c. protects internal organs from injury

Objectives	Content Outline
	d. produces Vitamin D when exposed to the sun 2. subcutaneous tissue a. layer of fat under the dermis b. blood vessels and nerve of the skin originate here c. nerves provide sense of touch 3. glands in the dermis a. oil glands (sebaceous glands) 1. secretes oily substance to prevent skin from drying and from harmful bacteria b. sweat glands 1. produce sweat 2. excrete waste products 3. help to cool the body 4. hair - helps to keep body warm 5. nails - protects the ends of fingers and toes
Describe age-related changes seen in the skin as evidenced by accurately participating in classroom discussion. Objectives	B. Age-related changes of the skin that may occur in geriatric clients/residents 1. decrease in fat in subcutaneous layer a. wrinkles b. sagging skin c. client feels cooler 2. decrease in amount of melatonin a. gray hair b. age spots 3. decreased production of oil and sweat a. skin becomes drier b. becomes thinner c. becomes fragile d. more prone to infections and tearing 4. nails thicken and may become yellow C. Factors promoting health skin 1. good nutrition 2. adequate hydration 3. adequate sleep 4. adequate exercise
Discuss common disorders of the skin, including their signs and symptoms, as evidenced by participating in classroom discussion.	D. Common disorders of the skin 1. Burns a. first degree 1. involves epidermis 2. redness and pain b. second degree 1. involves dermis 2. red, painful, swelling, blistering c. third degree 1. dermis and underlying tissue 2. scarring 3. muscle and bone may be involved 4. pain, swelling, peeling d. causes

Objectives

Content Outline

1. hot liquid
2. electrical equipment
3. hair dryer
4. heating pad
5. chemicals

e. never put oil, lotion or butter on a burn
f. cool and cover loosely
g. notify supervisor immediately

2. Shingles
a. related to chicken pox reactivation
b. viral infection that follow path of a nerve
c. blistery rash that appears as a single line on one side of the body
d. very painful
e. contagious for someone who has never had chicken pox
f. keep rash covered
g. wash hands frequently

3. wounds
a. two types
1. open wound
a. abrasion
b. puncture wound
c. gunshot wound
d. laceration
2. closed would
a. bruise
b. hematoma

b. symptoms
1. pain
2. damage to the skin
3. discoloration of the skin
4. bleeding
5. fever, chills
6. difficulty breathing

c. report any wounds to the appropriate supervisor immediately

E. Pressure Sores (decubitus ulcers)
1. pressure points
a. bony prominences
b. heels
c. shoulder blades
d. elbows
e. sacrum
f. areas with very little fat between bone and skin

2. pressure sores
a. breakdown of skin over a bony prominence
b. harder to cure than to prevent
c. caused by
1. immobility – lying, or sitting on same area for a prolonged period of time

Objectives

Identify risk factors for developing pressure sores as evidenced by participating in classroom discussion.

Describe the staging of pressure sores as evidenced by participating in classroom discussion.

*For Information Only:
Staging of pressure sores is within the scope of practice of an RN or LPN, not a nurse aide.

Content Outline

2. weight of body prevents blood flow to tissue and body tissue begins to die after 2 – 3 hours
3. lying on wrinkled linen
4. lying on an object in the bed
5. sitting on bedpan for prolonged time
6. wearing splint or brace that does not fit properly

d. risk factors for developing pressure sores
1. aging – skin becomes more fragile
2. poor nutrition and hydration
3. skin that has prolonged contact with water or moisture – causes epidermis to breakdown
4. cardiovascular and respiratory problems – decreases amount of oxygen reaching cells
5. skin exposed to friction and shearing - during turning and positioning

e. signs of developing pressure sore
1. skin becomes whitish or reddened
2. skin is dry, cracked and/or torn
3. blisters, bruises

*f. staging of pressure sores
1. Stage 1
a. skin intact, but red, blue or grey non-blanchable
b. relieving pressure for 15-30 minutes does not return skin to normal coloration
c. can be reversed if treated early
2. Stage 2
a. involves both epidermis and dermis
b. looks like clear fluid filled blister or shallow crater
c. epidermis cracks or peels away
d. open area is portal of microorganism to enter
e. no dead tissue yet
3. Stage 3
a. both epidermis and dermis are gone
b. looks like a deep crater
c. drainage is present
d. necrotic (dead) tissue may be visible but doesn't obscure depth of tissue loss
e. takes weeks or months to completely heal
4. Stage 4
a. crater of damaged tissue extends down to the muscle or bone
b. often becomes seriously infected
c. takes months to heal
d. may require skin graft
5.Deep Tissue Injury (DTI)
a. purple or discolored area with intact skin
b. firm, mushy, boggy, or warmer or cooler than adjacent tissue

6.Unstageable
a. unable to see wound bed
b. eschar or slough in wound

Objectives

Describe actions the nurse aide can take to prevent pressure sores as evidenced by satisfactory participation in skills lab role-play and clinical practice.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Content Outline

c. can be yellow, tan, brown, black
d. can be firm, soft, or draining

3. Actions to prevent pressure sores
   a. prevention is easier than treating and healing
   b. perform skin care and skin checks on regular basis
      1. during routine personal care
      2. throughout the day as needed
      3. use moisturizer on unbroken skin
   c. keep skin clean and dry
      1. where skin comes in contact with skin
         a. under pendulous breasts
         b. between scrotum and legs
         c. between abdominal folds
      2. clean and dry immediately after urinary or bowel incontinence
         a. replace soiled linen protectors and clothing with clean, dry linen and clothing
         b. assist client to wipe well, drying perineum
         c. toilet q2hrs. to avoid incontinence
         d. keep linen clean, dry and free of wrinkles (if client eats in bed remove any crumbs from linen)
   e. turn and reposition immobile clients at least q2hours
   f. encourage mobile clients to change position frequently
   g. during transfer and repositioning client
      1. avoid dragging client across the linen by using draw sheet to turn and reposition client
      2. use mechanical lift to transfer from bed to chair
      3. use transfer board to transfer bedridden client from bed to stretcher
      4. avoid bumping client against side rails or wheelchair leg rests
   h. use positioning devices to keep pressure off areas at risk
      1. foot boards
      2. bed cradles
      3. heel/elbow protectors
      4. sheepskin pads to protect the back
   i. perform range of motion exercises on regular basis
   j. massage healthy skin to increase circulation (do not massage skin that is white, red, purplish)
   k. encourage healthy diet and adequate hydration

4. Observations to report to the appropriate supervisor
   a. change in skin coloration over a bony prominence or in a skin fold (whitish, red, grey, purplish)
   b. dry, cracked, flaking skin, particularly on heels or elbows
   c. torn skin
   d. blisters, bruises, cuts
   e. client itches or scratches skin frequently

Objectives

Demonstrate how to perform a back massage as evidenced by satisfactory practice in skills lab and clinical.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Identify the structure and function of the skeletal system as evidenced by participating in classroom discussion.

Content Outline

f. broken skin anywhere on the body, including between the toes
g. any change in an existing pressure sore
    1. drainage
    2. odor
    3. peeling skin
    4. change in color of skin
    5. change in size of crater

F. Back Massage (back rub)
1. relaxes tired, tense muscles
2. improves circulation
3. check nursing care plan for instructions on when to perform
4. procedure for performing back rub
    a. identify yourself and explain what you are going to do
    b. wash hands
    c. put on gloves if there is an area of broken skin
    d. provide for privacy
    e. adjust bed to waist-height and lock bed wheels
    f. lower side rail closest to you
    g. position client on his side or back, if tolerated
    h. pour lotion on hands and rub hands together
    i. using full palm of your hand, start at base of spine and with firm, even stroke gently massage upward toward the shoulders
    j. at shoulders, circle hands outward and stroke along outside of back, down toward base of spine
    k. repeat circular motion for 3-5 minutes
    l. using circular motion, gently massage bony prominences
    m. if bony prominences are red, massage around them, not over them
    n. if there is extra lotion, remove it
    o. redress and reposition client
    p. raise side rail, if appropriate
    q. return bed to low position
    r. place call bell in easy reach of client
    s. store lotion per facility policy and client request
    t. wash hands
    u. report to appropriate supervisor any changes in client or skin that you observed

f. Transfer, positioning and turning

A. Anatomy and Physiology of Musculoskeletal System
    1. Skeleton
        a. long bones (arms and legs)
        b. short bones (wrists and ankles)
        c. flat bones
            1. thin and often curved
            2. skull and ribs
        d. irregular bones

Objectives	Content Outline
	1. oddly shaped 2. spine and face e. joints (where 2 bones join together) f. cartilage 1. fibers that permit limited movement between bones 2. acts as shock absorber between bones g. ligaments 1. strong fibrous bands attaching one bone to another 2. stabilize joint h. purpose of skeletal system 1. support the body 2. protect the body
Identify the structure and function of the muscular system as evidenced by participating in classroom discussion.	2. Muscles a. skeletal muscles 1. attach to bones 2. allow for movement 3. client controls these muscles b. smooth muscles 1. line walls of blood vessels, stomach, bladder and hollow organs 2. controlled involuntarily c. cardiac muscle 1. forms the heart 2. cause heart to contract and relax 3. controlled involuntarily d. purpose of muscles 1. enables body to move, internally and externally
Describe age-related changes seen in the musculo-skeletal system as evidenced by accurately participating in classroom discussion.	B. Age-related changes to musculoskeletal system 1. bones lose calcium a. become weak b. break easily c. osteoporosis 2. muscles weaken a. lose tone b. cannot support the body or move bones 3. lose muscle mass a. causes weight loss 4. joints become less flexible a. decreases range of motion b. slows body movements 5. lose height a. space between vertebrae decreases
Discuss common disorders of the musculoskeletal system, including their signs and symptoms and guidelines for the nurse aide, as evidenced by participating in classroom discussion.	C. Common Disorders of musculoskeletal system 1. Osteoporosis a. bones break easily due to loss of bone tissue b. caused by 1. lack of calcium in diet 2. loss of estrogen 3. reduced mobility

Objectives

Content Outline

c. bones most commonly affected
1. vertebrae
2. pelvic bones
3. arm and leg bones

d. signs and symptoms
1. low back pain
2. loss of height
3. stooped posture

e. treatment
1. medication
2. exercise

f. considerations for the nurse aide providing care
1. allow time for client to move
2. turn and reposition very carefully
3. follow special dietary orders
4. encourage and assist with mobility
5. report to appropriate supervisor any changes in client's ability to be active or to move

2. Arthritis

a. painful inflammation of joints
1. stiff, swollen joints
2. decreases mobility of joints

b. two types of arthritis
1. osteoarthritis
a. DJD – degenerative joint disease
b. cartilage between joints decreases
c. causes pain when bones rub together
2. rheumatoid
2 considered an auto-immune disease
3 causes deformity which can be disabling

c. signs and symptoms
1. swollen and stiff joints
2. joints deformed

d. treatment
1. rest
2. range of motion exercises
3. anti-inflammatory medications
4. weight loss
5. heat
6. total joint replacement surgery

e. considerations for the nurse aide providing care
1. encourage activity per nursing care plan
2. range of motion exercises as ordered
3. assist with ADLs
4. encourage use of assistive devices to promote client independence
5. report the following to the appropriate supervisor
a. unusual stiffness of joints

Objectives	Content Outline
	b. swelling of joints c. client complaint of pain in joints d. decreased ability to perform range of motion exercises e. decreased ability of client to perform daily activities
Identify complications of immobility as evidenced by participating in classroom discussion.	D. Complications of immobility 1. physical discomfort 2. pressure sores 3. contractures 4. bones become brittle due to loss of calcium 5. pneumonia 6. blood clots, especially in the legs
Demonstrate the various positions for the client in bed as evidenced by satisfactory practice in skills lab.	E. Proper body alignment 1. positioned so spine is straight and not twisted 2. promotes comfort and good health 3. supine a. flat on back b. support head and shoulders with a pillow c. support arms and hands with pillow or rolled washcloth d. place pillow under calves so heels are elevated off bed to prevent pressure sores e. use footboard to keep ankles flexed to promote anatomical position of feet and ankles 4. lateral a. lying on side b. pillow to support the head and neck c. pillow to the back to maintain side-lying position d. flex top knee and place pillow under the knee and lower leg for support e. pillow under bottom foot to keep toes from touch the bed 5. prone a. lying on the abdomen b. many clients do not like this position c. head turned to the side and placed on small pillow d. place pillow under abdomen to allow room for breasts and to allow chest to expand during inhalation e. do not leave client prone for a long period of time 6. Fowler's a. client on back with head of bed (HOB) elevated 45 - 60° b. semi-Fowler's – HOB elevated 30 - 45° c. high Fowler's – HOB elevated 60 - 90° d. raise knee gatch or place pillow under knees to help prevent client from sliding down the mattress 7. Sims' a. extreme side-lying position, almost prone b. head turned to side and supported with pillow c. lower arm positioned behind the back

Objectives

Demonstrate how to raise a client's head and shoulders as evidenced by satisfactory practice in skills lab and clinical.

Demonstrate how to move a client up in bed as evidenced by satisfactory practice in skills lab and clinical.

Demonstrate how to move a client up in bed using a draw sheet as evidenced by satisfactory practice in skills lab and clinical.

Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.

Accurately document moving client up in bed on facility ADL form as evidenced by Satisfactory rating on Skills Record.

Objectives

Demonstrate how to position client on side as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical.

Content Outline

d. upper knee is flexed and supported with pillow
e. pillow under each foot to prevent toes from touching bed

8. Trendelenburg
   a. head is lower than the rest of the body
   b. used to increase blood flow to the brain if client is in shock
9. reverse Trendelenburg
   a. mattress placed at an angle with the head higher than the foot of the mattress
   b. used for clients with digestive disorders
10. logrolling
   a. turning client onto side while keeping spine straight
   b. use a draw sheet and a helper

G. Repositioning client

1. raising client's head and shoulders
   a. use good body mechanics
   b. raise bed to waist-height and lower side rail
   c. place closest hand and arm under client back to the far shoulder
   d. place other hand and arm under client's closest shoulder
   e. gently raise head and shoulders on the count of three
   f. re-fluff, turn, and replace pillow
   g. make client comfortable, provide with call bell
   h. lower bed and replace side rail, as appropriate
   i. document procedure and report any client changes to appropriate supervisor
2. assisting client to move up in bed
   a. practice good body mechanics
   b. raise bed to waist-height and lower side rail and head of bed
   c. place 1 arm under client's shoulders
   d. place other arm under client's knees and turn your feet toward the HOB
   e. have client bend knees
   f. on count of 3, have client push with feet while you lift body up in bed
   g. make client comfortable, raise HOB, return
   h. document procedure and report any client changes to appropriate supervisor
3. assisting client to move up in bed with a draw sheet
   a. practice good body mechanics
   b. raise bed to waist-height and lower side rail and head of bed
   c. have one nurse aide on each side of bed turned slightly toward HOB
   d. with 1 hand at the shoulder and 1 hand at the hips roll draw sheet toward client
   e. grasp roll of draw sheet with palms up

Objectives	Content Outline
Accurately document positioning client on side on facility ADL form as evidenced by Satisfactory rating on Skills Record.	f. on count of 3 both nurse aides lift the draw sheet and client toward the HOB g. unroll draw sheet and tuck edges under mattress h. make client comfortable, raise HOB, return bed to low position i. place call bell in client's reach j. wash hands k. document procedure and report any client changes to appropriate supervisor 4. position client on side a. follow the procedure for "Position Client on Side" in the most current edition of Virginia Nurse Aide Candidate Handbook b. document procedure on Activities of Daily Living form, per facility policy c. report any observations of changes in client's condition or behavior to appropriate supervisor
Demonstrate how to transfer client from bed to wheelchair using a transfer belt as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	G. Transferring Client 1. assisting client to move from one location to another 2. weight-bearing a. client's ability to stand on one or both legs 3. gait belt or transfer belt a. device nurse aide uses to assist unsteady or weak client to transfer or ambulate 4. transfer client from bed to wheelchair using transfer belt a. follow the procedure for "Transfer Client from Bed to Wheelchair Using Transfer Belt" in the most current edition of Virginia Nurse Aide Candidate Handbook b. document procedure on Activities of Daily Living form, per facility policy c. report any observations of changes in client's condition or behavior to appropriate supervisor.
Demonstrate how to transfer client from bed to wheelchair using a mechanical lift as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	5. mechanical lifts a. equipment used to lift and move clients b. Fair Labor Standards Act, Hazardous Occupation Order Number 7 1. prohibits minors under 18 from operating or assisting in the operation of most power-driven hoists, including those designed to lift and move patients c. should only be used by nurse aides 18 years of age and older d. nurse aide should receive training to use the specific lift in the facility e. at least 2 nurse aides should be present when a mechanical lift is used to move a client f. practice good body mechanics g. raise bed to waist-height and lower side rail and head of bed h. position wheelchair next to bed with footrests

Objectives	Content Outline
	removed and wheels locked i. lower side rail on side nearest nurse aide j. assist client to turn on side and place lift pad under client k. assist client to turn to opposite side and position lift pad under client without wrinkles l. roll mechanical lift to bedside with base at its widest point, the wheels locked and the overhead bar directly over the client m. with client on his back attach the straps to each side of the lift pad and the overhead bar n. fold client arms over chest to protect arms and elbows o. raise client about 2 inches off bed p. with assistance of 2nd nurse aide guide client to the wheelchair q. slowly lower client into chair, taking care with arms and legs and making sure the client's hips are against the back of the wheelchair r. replace footrests and support client's feet on wheelchair footrests s. remove straps from overhead bar and lift pad t. make sure client is comfortable and is wearing non-skid footwear u. cover client's lap and legs with blanket or robe v. place call bell in client's reach w. wash hands x. document procedure and report any client changes to appropriate supervisor
Identify complaints and concerns the nurse aide should report to the appropriate supervisor related to ambulation as evidenced by participation in skills lab role play.	H. Ambulating a Client 1. walking a client 2. assistive devices a. transfer or gait belt b. walker c. cane d. crutches 3. report to the appropriate supervisor a. complaints of dizziness b. shortness of breath c. chest pain d. rapid heart beat e. sudden complaints of head pain f. unusual pain on weight bearing g. changes in client's strength or ability to walk h. change in client attitude toward walking i. assistive equipment that is broken or not working correctly 4. assist client to ambulate using transfer belt a. follow the procedure for "Assist to Ambulate Using Transfer Belt" in the most current edition of Virginia Nurse Aide Candidate Handbook
Demonstrate how to ambulate client using Transfer/gait belt as evidenced by Satisfactory rating on Skills Record for skills lab and for clinical. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. Accurately document ambulating client on facility ADL form as evidenced by Satisfactory rating on Skills Record.	

Content Outline

b. document procedure on Activities of Daily Living form, per facility policy

c. report any observations of changes in client's condition or behavior to appropriate supervisor.

Unit IX – Individual Client's Needs, including Mental Health and Social Service Needs
(18VAC90-26-40.A.4.a, c, d, e, f, g)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Identify basic needs of clients, including physical and psychosocial needs.
2. Demonstrate guidelines for the nurse aide to assist the client to meet his psychosocial needs.
3. Demonstrate way the nurse aide can modify his behavior in response to the behavior of clients.
4. Demonstrate principles of behavior management by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated.
5. Demonstrate skills supporting age-appropriate behavior by allowing the client to make personal choices and by providing and reinforcing other behavior consistent with the client's dignity.
6. Demonstrate appropriate responses to client behavior, including aggressive behavior, anger, combative behavior, inappropriate language, confusion, and inappropriate sexual behavior.
7. Utilize the client's family/concerned others as a source of emotional support.
8. Demonstrate strategies to provide appropriate clinical care to the aged and the disabled.

Objectives	**Content Outline**
Identify basic physical needs of the client as evidenced by participation in classroom discussion. Identify basic psychosocial needs of the client as evidenced by participation in classroom discussion.	I. Basic psychosocial needs A. Physical needs 1. food and water 2. protection 3. activity 4. rest and sleep 5. safety 6. comfort B. Psychosocial needs 1. recognition as a unique individual 2. love and affection 3. supportive environment 4. acceptance by others 5. independence 6. social interaction 7. security 8. success and self-esteem 9. spiritual expression 10. sexual expression C. Problems meeting these needs 1. physical loss of body functions and/or body parts 2. social losses a. spouse b. relatives c. friends 3. economic losses a. retirement b. health costs

Objectives	Content Outline
	4. loss of personal control over decision making a. loss of driver's license b. loss of personal dwelling when enter a long-term care facility
Demonstrate guidelines for the nurse aide to assist the client to meet his psychosocial needs as evidenced by satisfactory rating on Skills Checklist in skills lab and in clinical.	D. Guidelines for the nurse aide to assist client in meeting psychosocial needs 1. demonstrate caring, personal feeling for each client 2. communicate a caring, personal feeling for each client 3. promote client independence and personal control as much as possible a. allow to follow habits and make personal choices b. adjust client care to permit continuation of lifestyle as much as possible c. encourage use of personal belongings d. encourage self-care as appropriate e. encourage client to continue religious practices f. provide personal time for sexual expression 4. provide client with explanations when providing care a. promote right to dignity b. respect right to refuse care E. Common reactions when client is unable to meet psychosocial needs 1. anxiety 2. depression 3. anger or aggression 4. confusion or disorientation
	II. Mental health A. client able to make adjustments to maintain state of emotional balance 1. stress a. anxiety, burden, pressure, worry b. causes 1. loss of independence 2. loss of significant other/s 3. loss of economic resources 4. loss of body part/function 5. many causes
Identify defense mechanisms as evidenced by participating in classroom discussion.	2. defense mechanisms a. compensation - substituting for the loss b. conversion – may have physical symptoms that cannot be explained medically

Objectives	Content Outline
	1. may use physical problem to avoid participating in an activity 2. "changes" the real reason into something else c. denial 1. refuses to believe d. displacement 1. shifting an emotion from one person to another less threatening person e. projection 1. blaming someone else for own actions or feelings f. rationalization 1. creating acceptable reasons for behavior or action g. regression 1. demonstrate behaviors from an earlier time in life h. repression 1. refusing to remember frightening or unpleasant memory
Describe the signs and symptoms of anxiety as evidenced by participating in classroom discussion.	III. Mental Illness A. Anxiety 1. feeling of uneasiness, dread, worry 2. can be helpful response unless it persists and effects ability to cope with everyday life 3. signs and symptoms a. rapid pulse b. dry mouth c. sweating d. nausea e. difficulty sleeping f. loss of appetite g. restless h. irritable
Identify the behaviors associated with obsessive-compulsive disorder as evidenced by participating in classroom discussion.	B. Obsessive-Compulsive Disorder (OCD) 1. obsession a. recurring unwanted thoughts 2. compulsion a. rituals that client cannot control b. hand-washing c. repeatedly checking door to make certain it is locked, for example 3. prohibiting the ritual increases the level of anxiety C. Phobias 1. excessive, abnormal fear a. fear of heights b. fear of water

Objectives	Content Outline
	c. fear of flying d. fear of dogs e. fear of closed in spaces
Identify the signs and symptoms of depression as evidenced by participating in classroom discussion.	2. can be very debilitating D. Depression 1. overwhelming sadness prohibits client from functioning 2. signs and symptoms a. lack of interest b. frequent crying c. fatigue d. weight loss e. sleep disturbances f. irritability g. frequent physical complaints h. feelings of worthlessness i. feelings of hopelessness
Describe the behavior associated with bipolar disorder as evidenced by participating in classroom discussion.	E. Bipolar Disorder 1. severe mood swings a. manic phase 1. everything is wonderful 2. hyperactive b. depression phase 1. excessive sadness 2. not enough energy to participate in ADLs 2. caused by chemical imbalance in brain
Describe the signs and symptoms associated with schizophrenia as evidenced by participating in classroom discussion.	F. Schizophrenia 1. loss of contact with reality 2. signs and symptoms a. delusions 1. false ideas of who or what is around client 2. delusions of grandeur 3. delusions of persecution 4. paranoia b. hallucinations 1. false sensations that are real to client 2. hearing voices 3. seeing things that are not really there 4. may involve any of the 5 senses c. disorganized speech 1. flight of ideas d. catatonic behavior - may stop in mid-sentence an
Demonstrate ways the nurse aide can modify his behavior in response to the behavior of the client as evidenced by satisfactory participation in skills lab and classroom role-play.	IV. Guidelines to modify the nurse aide's behavior in response to the behavior of clients A. Know the client 1. Greet client when entering the room 2. encourage self-care as appropriate 3. encourage independence with ADLs and activities 4. allow client to make choices

Objectives	Content Outline
	5. offer to come back at a later time 6. remember the aide is not the cause of the client's behavior 7. do not take client's actions and behavior personally 8. stop when client resists what you are doing B. Be aware of your actions 1. monitor your body language 2. stay calm 3. do not yell at or argue with client 4. use silence appropriately 5. treat client like an adult, not a child 6. use appropriate eye contact 7. be respectful of client 8. provide privacy, if appropriate for client 9. review reality with client 10. answer questions about time, place, people honestly
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	C. report unusual behavior to appropriate supervisor 1. change in ability to perform ADLs 2. change in mood 3. behavior that is extreme, dangerous or frightening to other clients 4. hallucinations or delusions 5. comments about suicide 6. client not taking medications or hiding medications 7. any activity that causes a change in client's behavior
Demonstrate principles of behavior management by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated as evidenced by satisfactory participation in classroom and skills lab role-play.	V. Behavior management techniques A. Principles of behavior management 1. ABCs a. Antecedent – what precedes the behavior b. Behavior – an action, activity, or process which can be observed and measured ~~c.~~ Consequence – ~~what is the consequence of the behavior~~ how people in the environment react to the behavior d. to change the behavior, change either the antecedent or the consequence 2. speak with the 3 s's a. slowly b. softly c. simply – avoid medical terminology 3. cueing – graduated guidance a. provide guidance to perform a skill and then gradually let client perform task on his own 4. mirroring - modeling a. have client mirror or copy what you are doing

Objectives	Content Outline
	5. directing a. instructing the client to do a specific behavior 6. redirecting a. change client focus from one behavior to another more appropriate behavior 7. schedule care when client is least agitated B. Reward steps that lead to final desired behavior 1. plan what behavior is to be addressed 2. behavior is broken down into small steps 3. each step completed is rewarded C. Three (3) types of rewards 1. primary rewards a. food 2. social rewards a. smile b. words of praise 3. physical rewards a. touch b. hug c. pat on the arm 4. rewards must be given in a way that would normally occur in the environment 5. rewards should suit the preferences of the client receiving the reward
Demonstrate strategies to reinforce appropriate behavior as evidenced by satisfactory participation in class and skills lab role-play.	D. Strategies to reinforce appropriate behavior 1. remain calm 2. maintain client's routine 3. maintain client's toileting schedule 4. encourage independence 5. provide privacy 6. encourage socialization 7. respond positively to appropriate behavior
Demonstrate strategies to reduce inappropriate behavior as evidenced by satisfactory participation in class and skills lab role-play.	E. Strategies to reduce client's inappropriate behavior 1. ignore behavior if it is safe to do so 2. remove behavior triggers 3. focus on the familiar 4. avoid caffeine 5. allow to pace in a safe place 6. **do not** argue with client 7. try distraction – redirect behavior 8. do not take behavior personally 9. continue to reinforce appropriate behavior
Identify age-appropriate strategies to reinforce client dignity as evidenced by participating in classroom discussion.	IV. Supporting age-appropriate behavior A. Age-appropriate strategies 1. participate in planning own care 2. encourage to make independent choices 3. maintain privacy 4. maintain confidentiality

Objectives	Content Outline
	5. encourage client to have own possessions 6. encourage participation in social activities 7. encourage participation in recreational activities 8. respect client's decisions and choices
Identify guidelines for nurse aide to reinforce client dignity as evidenced by satisfactory role-play in class and skills lab.	B. Guidelines for nurse aide to reinforce client dignity 1. address client in a dignified manner 2. take time to listen to what client has to say 3. converse with client as with an adult 4. do not ignore or humor client 5. respect client's privacy 6. explain what you are going to do 7. treat client as you would want to be treated 8. encourage client to make choices 9. client has right to refuse treatment, medications, activities
	VI. Responding appropriately to client's behavior A. Aggressive behavior 1. common causes a. pain b. lack of sleep c. fear d. medication side effects e. too hot or too cold f. hunger g. unable to communicate h. forgetting i. infection and/or illness j. being approached by unknown clients and/or staff
Identify warning signs that frequently precede aggressive behavior as evidenced by participating in classroom discussion.	2. Warning signs preceding aggressive behavior a. fear b. restlessness c. pacing d. clenching fists e. clenching jaw f. yelling g. trying to leave facility h. throwing things
Demonstrate strategies to respond to aggressive behavior as evidenced by participating in classroom discussion.	3. Strategies to respond to aggressive behavior a. stay calm b. avoid touching client c. try to identify the trigger for the behavior d. take threats seriously e. get help f. do not argue with client g. protect yourself and others from harm h. report observations to appropriate supervisor

Objectives	Content Outline
Identify warning signs that frequently precede angry behavior as evidenced by satisfactory participation in classroom discussion.	B. Angry behavior 1.common causes a. disease b. fear c. pain d grief e. loneliness f. loss of independence g. change in daily routine 2. warning signs preceding angry behavior a. yelling b. throwing things c. threatening d. sarcasm e. pacing f. narrowed eyes g. clenched, raised fists h. withdrawal i. silent, sulking
Demonstrate strategies to respond to Angry behavior as evidenced by satisfactory Participation in classroom discussion.	3. strategies to respond to angry behavior a. be pleasant and supportive b. try to find cause of anger c. listen to client d. observe body language e. think before speaking f. do not argue with client g. speak in a normal tone of voice h. treat client with respect i. respond promptly to requests j. report behavior to supervisor 4. strategies if anger escalates a. stay a safe distance away from client b. provide for safety of other clients c. leave client alone if it is safe to do so d. summon help
Identify signs of combative behavior as evidenced by satisfactory participation in classroom discussion.	C. Combative behavior 1. common causes a. disease affecting the brain b. escalating anger or frustration c. medication side effects
Demonstrate strategies to respond to combative behavior as evidenced by satisfactory participation in classroom discussion.	2. combative behavior a. hitting b. shoving c. kicking d. throwing things e. insulting others 3. strategies to respond to combative behavior a. immediately call for help b. keep yourself and others at a safe distance from the client c. stay calm

Objectives	Content Outline
	d. be reassuring, speak calmly e. try to find the trigger for the behavior f. do not respond to insults g. do not hit back h. follow the direction of the supervisor i. when behavior is under control sit with client to provide comfort, if instructed by supervisor j. report behavior to supervisor D. Inappropriate language 1. examples a. cursing b. name calling c. yelling d. sexually suggestive language
Demonstrate strategies to respond to inappropriate language as evidenced by satisfactory participation in role-play in class and in skills lab.	2. strategies to respond to inappropriate language a. remain calm b. do not take the language personally c. do not argue with the client d. **politely** tell client that language is inappropriate e. do not respond emotionally to the language f. if appropriate, permit client to have private time g. tell client you will return when he has had opportunity to calm down h. report behavior to supervisor E. Confused/disoriented behavior 1. inability to think clearly
Identify common causes of confusion and/or disorientation as evidenced by participating in classroom discussion.	a. disoriented to time, place and/or person b. unable to focus on a task c. temporary or permanent 2. common causes a. low blood sugar b. stroke c. head trauma/injury d. dehydration e. nutritional problems f. fever g. sudden drop in body temperature h. lack of oxygen i. medication side effects j. infection k. illness l. loss of sleep m. seizure n. constipation o. difficulty hearing

Objectives	Content Outline
Demonstrate strategies to respond to confused and/or disoriented behavior as evidenced by satisfactory participation in role-play in class and in skills lab.	3. strategies to respond to confusion/disorientation a. do not leave client alone b. stay calm c. provide quiet environment c. speak slowly, softly, simply d. introduce yourself every time you encounter client e. reality orientation f. repeat directions as needed g. break ADL tasks into simple steps h. do not rush client to complete tasks i. keep client's routine j. observe client's body language as well as listen to what client is saying k. tell client when you are leaving room l. encourage use of glasses and hearing aides m. allow client to make choices n. encourage independence as appropriate o. report observations to the appropriate supervisor F. Inappropriate sexual behavior 1. examples a. sexual advances or comments b. inappropriate touching of staff c. inappropriate touching of themselves d. removing clothing in public e. masturbation in public 2. common causes a. illness b. dementia c. confusion d. medication side effects
Demonstrate strategies to respond to inappropriate sexual behavior as evidenced by participating in classroom discussion.	3. strategies to respond to inappropriate sexual behavior a. do not over-react b. be matter-of-fact c. distract the client d. do not judge behavior e. if client wants to talk, listen f. client has right to express sexuality, provide privacy g. report inappropriate behavior to supervisor
Identify the role of family/concerned others as a source of emotional support for the client as evidenced by satisfactory participation in classroom discussion.	VII. Family/concerned others as source of emotional support A. Role of family/concerned others on the health care team 1. provide love, support, self-esteem for client 2. lessen loneliness of client

Objectives	Content Outline
	3. participate in care planning, if desired by client 4. participate in care decisions on behalf of client 5. provide vital information to assist staff in planning appropriate behavior management plan as needed
Demonstrate strategies to meet the emotional needs of the client and the family/concerned others as evidenced by satisfactory participation in classroom discussion and role-play in class and skills lab.	B. Strategies to meet emotional needs of client and families/concerned others 1. be kind and respectful 2. ask appropriate questions 3. answer questions from client and family/concerned promptly and appropriately 4. listen 5. provide competent care to gain confidence of family/concerned others and client 6. create permanent assignments so client and family/concerned others can develop relationship with caregiver 7. allow client to contact family/concerned others as desired
Demonstrate strategies to encourage Family/concerned others to provide Emotional support to the client as Evidenced by satisfactory participation In classroom discussion.	C. Strategies to encourage family/concerned others to provide emotional support to client 1. invite family to care conferences as appropriate 2. send newsletters informing of up-coming events and special occasions 3. make space for families/concerned to celebrate private events (birthday, anniversary, etc.) 4. be friendly and respectful to visiting family/concerned others 5. keep facility welcoming, clean and odor-free
Demonstrate appropriate clinical care of the aged as evidenced by satisfactory ratings in the skills lab and in the clinical setting.	VIII. Providing appropriate clinical care to the aged and disabled A. Clinical care for the aged 1. respect client rights at all times 2. provide for privacy 3. maintain confidentiality 4. know each client as an individual 5. provide care within the nurse aide scope of practice, as assigned 6. promote client independence 7. keep client free from pain and discomfort 8. follow nursing care plan 9. observe and report physical and/or behavioral changes to appropriate supervisor B. Developmental disabilities 1. definition a. present from birth b. restricts physical and/or mental ability c. client has difficulty with language, mobility and/or learning

Objectives	Content Outline
Describe the effects developmental disabilities may have on the client as evidenced by satisfactory participation in classroom discussion.	2. examples a. cerebral palsy – caused by oxygen deficit at birth b. autism c. mental retardation 3. functions limited by developmental disabilities a. affect b. self-care c. learning d. mobility e. self-direction f. expressing language g. expressing understanding
Identify various physical disabilities the nurse aide may find in a long-term care facility as evidenced by satisfactory participation in classroom discussion.	C. Physical disabilities 1. examples a. visual impairment b. hearing impairment c. amputee d. cerebral vascular accident (CVA/stroke) 2. functions limited by physical disability a. depends on part of the body affected
Demonstrate appropriate clinical care of the disabled as evidenced by satisfactory ratings in the skills lab and in the clinical setting.	D. Guidelines for clinical care for the disabled 1. treat as adults regardless of behavior 2. praise and encourage 3. be patient 4. maintain privacy 5. maintain confidentiality 6. keep free from pain and discomfort 7. encourage client independence 8. encourage client to make personal choices 9. help teach ADLs as appropriate 10. repeat words and directions as needed 11. allow time to process what you have said 12. encourage participation in restorative care 13. follow nursing care plan 14. observe and report any physical and/or behavioral changes to appropriate supervisor

Unit X – Special Needs Clients
(18VAC90-26-40.A.5.a, b, c, d)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Describe age-related changes of the nervous system.
2. Discuss common disorders of the nervous system, including the care of the client.
3. Describe age-related changes to the eye.
4. Discuss common disorders of the eye, including the care of the client.
5. Demonstrate understanding of behavior of the visually impaired client, including how to respond to this behavior.
6. Describe age-related changes of the ear.
7. Discuss common disorders of the ear, including care of the client.
8. Demonstrate understanding of behavior of the hearing-impaired client, including how to respond to this behavior.
9. Demonstrate understanding of behavior of the cognitively impaired client, including how to respond to this behavior.
10. Demonstrate how to communicate with the cognitively impaired client.
11. Demonstrate techniques for addressing the unique needs and behaviors of cognitively impaired clients.
12. Demonstrate methods to reduce the effects of cognitive impairment.
13. Describe complications of diabetes mellitus, include care of the client.
14. Describe care of the client experiencing hypoglycemia and hyperglycemia.
15. Describe care of the client experiencing hypothyroidism and hyperthyroidism

Objectives	**Content Outline**
Explain the anatomy and physiology of the nervous system as evidenced by being able to correctly identify each component part and its function.	I. Nervous System A. Anatomy and Physiology 1. Neuron a. cell that sends and receives information b. dendrite – short extension from the neuron cell body that receives information c. axon – long extension from the cell body that sends information d. synapse – space between axon of one neuron and the dendrite of the next e. myelin – covering of some of the axons 2. 2 divisions of the nervous system a. central nervous system (CNS) - brain and spinal cord b. peripheral nervous system (PNS) - nerves outside of brain and spinal cord 3. Central nervous system a. brain 1. cerebrum – largest part of brain a. controls voluntary movement of muscles b. processes information received from sensory organs c. allows us to speak, remember, think and feel emotions 2. cerebellum a. helps coordinate brain's commands to muscles

Objectives	Content Outline
	b. assists with balance 3. brain stem a. connects spinal cord to brain b. regulates body temperature, blood pressure, respirations and heartbeat b. spinal cord 1. extends from base of brain to about the level of the naval 2. surrounded and protected by the vertebrae 3. carries messages from the brain to and from the body 4. Peripheral nervous system a. sensory nerves - carry information from the internal organs and the outside world to the spinal cord and into the brain b. motor nerves - carry commands from brain down spinal cord and to the muscles and organs of the body 5. function of the nervous system a. regulates what goes on inside the body in response to external stimuli b. allows body to interact with the world around us 1. senses – touch, hearing, sight, smell, taste
Describe age-related changes seen in the nervous system as evidenced by accurately participating in classroom discussion.	B. Effect of aging on the nervous system 1. slower conduction time a. slower reflexes b. increased risk of falling c. short-term memory loss d. decreased sense of touch e. some hearing loss f. decreased vision, sense of smell and sense of taste
Discuss common disorders of the nervous system, including their signs and symptoms, as evidenced by participating in classroom discussion.	C. Common disorders of the nervous system 1. cerebrovascular accident (CVA, stroke) a. caused by blocked blood vessel or a ruptured blood vessel in the brain b. signs and symptoms 1. dizziness 2. confusion 3. loss of consciousness 4. seizure 5. facial droop on one side 6. drooping of one eyelid 7. blurred vision 8. sudden, intense headache 9. loss of bowel and/or bladder control 10. numbness, tingling on one side of the body

Objectives	Content Outlines
	11. weakness and/or paralysis on one side of the body 12. inability to speak 13. elevated blood pressure c. guidelines for caring for client recovering from a CVA 1. encourage independence by using assistive devices as appropriate 2. promote self-esteem 3. allow client time to respond by providing ample time for tasks 4. assist with range of motion to maintain muscle tone and joint mobility 5. be aware of changes in or loss of sensation when providing or assisting with personal care 6. assist with nutrition and fluid intake as appropriate to maintain weight and avoid constipation 7. do not refer to a "bad" body part 8. place food in the strong or unaffected side of the mouth when feeding client 9. keep communication simple and use a communication board if appropriate 10. if client forgets about paralyzed body part, gently remind him when transferring or repositioning client 11. reposition client q2hrs to prevent pressure sores and contractures 12. be aware client emotions can suddenly change 13. encourage client progress 14. encourage client to socialize and participate in activities d. notify appropriate supervisor of the following 1. change in level of consciousness 2. change in ability to use a body part 3. change in degree of sensation 4. signs of dehydration 5. weight loss 6. signs of depression 2. Parkinson's Disease a. client progressively deteriorates b. signs and symptoms 1. uncontrollable tremors 2. mask-like facial expression 3. drooling 4. pill-rolling 5. rigid muscles 6. shuffling gait 7. stooped posture

Objectives	Content Outline
	c. guidelines for caring for client with Parkinson's Disease 1. assist with ambulation to prevent falls 2. when ambulating encourage client to stand as straight as possible and to pick up his feet 3. allow client ample time to complete simple tasks 4. assist with ADLs as appropriate 5. provide assistive devices to help with eating 6. encourage socialization and participation in activities to prevent depression d. notify the appropriate supervisor of the following 1. severe trembling 2. severe muscle rigidity 3. mood swings 4. sudden incontinence 5. dehydration 6. signs of depression
https://www.epilepsy.com/learn/seizure-first-aid-and-safety/a first-aid-plans	3. Seizures a. caused by short-circuit in brain's electrical pathways 1. head trauma 2. tumor in the brain 3. high fever 4. alcohol and/or drug abuse 5. deficiency of oxygen to the brain at birth b. signs and symptoms 1. change in level of consciousness 2. tonic-clonic muscle movements 3. staring c. guidelines for care of the client having a seizure 1. lower client to floor and protect the head from injury 2. watch breathing, turn client/resident on his/her side to help keep airway open if need 3. allow the rest of the body to move 4. do not attempt to put anything in client's mouth 5. when seizure is finished position client on side in the recovery position 6. when client recovers assist into clean, dry clothes if appropriate 7. be ~~matter-of-fact and~~ supportive of client to promote self-esteem 8. notify supervisor immediately a. report time seizure began b. how long it lasted c. describe seizure

Objectives

Content Outline

4. multiple sclerosis (MS)
    a. progressive disorder that effects the nervous system's ability to communicate with muscles and control movement
    b. occurs in young adults most often
    c. signs and symptoms
        1. numbness and tingling
        2. muscle weakness
        3. extreme fatigue
        4. tremors
        5. decreased sensation in extremities
        6. blurred or double vision
        7. poor balance
        8. difficulty walking because the feet drag
        9. bowel and/or bladder incontinence
        10. paralysis in late stages of disease
    d. guidelines for caring for the client with MS
        1. assist with ambulation to prevent falls
        2. allow client ample time to complete tasks and ADLs
        3. offer frequent rest periods during tasks and ADLs
        4. turn, reposition, and provide skin care q2hrs to prevent pressure sores
        5. assist with range of motion to maintain muscle tone and joint mobility
        6. encourage socialization and participation in activities to prevent depression
    e. notify the appropriate supervisor of the following
        1. skin that is red, pale or looks like the beginning of a pressure sore
        2. joints that do not move as easily as they did
        3. complaints of burning on urination, frequenc of urination, urine that is concentrated or foul smelling
        4. change in level of consciousness
        5. signs of depression
5. head and spinal cord injuries
    a. causes
        1. concussion – banging injury to the brain
        2. accidents
    b. sign and symptoms
        1. headache
        2. unequal pupils
        3. drowsy
        4. seizure
        5. change in level of consciousness
    c. guidelines for care of the client with head or spinal cord injury

Objectives	Content Outline
	1. turn, reposition and give skin care q2hrs to maintain skin, preventing pressure sores and contractures 2. perform range of motion exercises on a regular basis 3. encourage as much independence with ADLs as is appropriate 4. encourage hydration 5. provide assistive devices as necessary to promote independence and self-esteem 6. follow bowel and bladder schedule 7. encourage client to socialize and participate in activities to prevent depression d. report to the appropriate supervisor the following 1. skin that looks as though a pressure sore is forming 2. joints that do not move as easily as they did 3. complaints of burning on urination, frequency of urination, urine that is concentrated or foul smelling 4. change in level of consciousness 5. signs of depression
Explain the anatomy and physiology of the eye as evidenced by being able to correctly identify each component part and its function.	B. The Eye 1. organ of sight a. sclera – white of the eye b. cornea – clear part of sclera that allows light to enter into the eyeball c. lens – clear structure that refracts (bends) the light to focus on the retina b. retina – inner-most part of the eyeball 1. contains receptors (rods and cones) that convert light into nerve impulses that travel to the brain where the impulses are processed
Describe age-related changes seen in the eye as evidenced by accurately participating in classroom discussion.	2. effects of aging on the eye a. decreased number of receptors in the retina b. lens becomes cloudy and opaque c. lens becomes less flexible, unable to properly focus the light on the retina d. decrease in tear production
Demonstrate an understanding of the visually impaired client as evidenced by satisfactory role-play in the skills lab and satisfactory performance in the clinical setting.	3. common disorders of the eye a. conjunctivitis (pink eye) 1. infection and inflammation of the eyelid 2. signs and symptoms a. eye is red, itchy b. eye tears a lot c. white or yellow discharge from the eye 3. guidelines for caring for the client with pink eye

Objectives	Content Outline
	a. wash hands before and after caring for the client b. keep your hands away from your face and eyes c. encourage client to avoid touching or rubbing his eyes and to use a tissue if he/she must 4. report the following to the appropriate supervisor a. discharge for eyes b. complaint of burning or itching in the eyes b. cataracts 1. lens becomes cloudy preventing light from entering into the eye and decreasing vision 2. treated by surgery to remove the lens and replace it with an artificial lens 3. guidelines for caring for the client with a cataract a. provide extra light in room or when performing tasks such as reading b. sit facing a bright window, turn and sit with back toward window c. encourage to be as independent as possible d. assist with ADLs as appropriate c. glaucoma 1. increased pressure inside the eye a. can lead to blindness if not treated 2.signs and symptoms a. decreased vision b. nausea/vomiting c. seeing “halo” around lights d. blurred vision d. age-related macular degeneration (AMD) 1. receptors in center of retina are destroyed a. client can only see the periphery of the field of sight e. guidelines for caring for the client with vision impairment 1. encourage use of their glasses 2. check glasses daily to assure they are clean 3. wash glasses with warm water and dry with soft towel. Never dry with a paper towel 4. knock before entering client’s room 5. identify yourself whenever enter client’s room 6. announce to client when you are leaving client’s room 7. leave furniture where client knows where it is 8. use numbers of a clock to tell client where an item
Respond appropriately to the behavior of the visually impaired client as evidenced by satisfactory role-play in skills lab and satisfactory performance in the clinical setting.	

Objectives	Content Outline
	an item or food is located on the plate 9. when assisting client to ambulate, walk slightly ahead of client and allow client to hold your arm or elbow f. report to appropriate supervisor ~~the following~~ ~~1.~~ glasses that are in need of repair
	C. The Ear 1. Anatomy and Physiology of the Ear a. outer ear 1. tympanic membrane – ear drum 2. cerumen – ear wax b. middle ear 1. equalizes air pressure 2. 3 small bones – malleus, incus and stapes c. inner ear 1.cochlea – contains receptors for hearing 2. vestibule 3. semicircular canals – help keep our balance 2. function of the ear a. hearing b. balance 3. effects of aging on the ear a. tympanic membrane becomes stiff b. 3 small bones don't vibrate as easily c. sensory receptors in cochlea decrease d. decreased hearing 4. common disorders of the ear a. otitis media 1. infection of the middle 2. signs and symptoms a. ear pain b. fever c. discharge from the ear d. difficulty hearing 3. report to appropriate supervisor the following a. discharge from the ear b. complaints of ear pain c. complaints of difficulty hearing d. fever b. Meniere's Disease 1. disease of the inner ear 2. signs and symptoms a. dizzy b. tinnitus – ringing in the ears c. temporary hearing loss d. nausea/vomiting e. guidelines for care of client with Meniere's Disease
Explain the anatomy and physiology of the ear as evidenced by being able to correctly identify each component part and its function.	
Describe age-related changes seen in the ear as evidenced by accurately participating in classroom discussion.	
Demonstrate an understanding of the hearing impaired client as evidenced by satisfactory role-play in the skills lab and satisfactory performance in the clinical setting.	

Objectives	Content Outline
	1. lie down 2. keep eyes from moving 3. allow client ample time to complete ADLs c. deafness 1. conductive hearing loss - sound waves prevented from reaching receptors in cochlea 2. sensorineural hearing loss - receptors unable to transmit nerve impulses or to receive stimuli 3.hearing aids a. battery operated device to amplify sound b. very expensive, handle with care c. guidelines for caring for hearing aide 1. treat with care 2.turn off when not in use 3. store in labeled container in a cool, dry place 4. check batteries frequently to ensure they are in working order 5. do not get batteries wet 6. remove hearing aid before bathing, showering or shampooing hair d. report to supervisor dead batteries, hearing aid that needs repair d. guidelines for caring for the client with hearing impairment 1. reduce or eliminate background noise 2. encourage client to wear hearing aid and verify that hearing aid is turned on 3. check that batteries for hearing aid are functional 4. face client when speaking 5. use note pad to write important directions 6. consider learning sign language
Respond appropriately to the behavior of the hearing impaired client as evidenced by satisfactory role-play in skills lab and satisfactory performance in the clinical setting.	
	II. Cognitive Impairment – **Memory Care** A. introduction 1. inability to think, to remember or to reason 2. causes a. delirium – temporary confusion b. depression c. dementia
Define the terms used with cognitive impairment as evidenced by participation in classroom discussion.	

Objectives

~~Describe how an unmet need might cause behavior changes~~
~~Describe basic unmet human needs that will most likely Cause behavior problems in:~~
~~An alert, oriented resident~~
~~A confused resident~~
~~Psychosis, dementia, and combative residents~~
~~State the steps of behavioral management~~
~~Discuss how the nurse aide functions with the Health care team for behavior management~~
~~Describe 1 step for increasing appropriate behavior and 1 step for reducing inappropriate behavior~~

Discuss the various types of dementia

Discuss the three stages of Alzheimer's Disease as evidenced by participating in classroom discussion.

Content Outline

3. dementia in long-term care
   a. brain atrophies, nerve fibers become tangled and covered with a sticky protein
   b. progressive
   c. not reversible
   d. there is no cure
   e. many causes
      1. brain injury
      2. AIDS
      3. prolonged substance abuse
      4. CVA
      5. Parkinson's Disease
      6. Alzheimer's Disease (AD)

   f. types of dementia
      1. over 100 different types
         a. vascular dementia – may occur after a stroke due to cut off blood supply. Symptoms of impaired judgment and problems planning, concentrating and thinking.
         b. dementia with Lewy bodies – less common. Symptoms of memory loss, thinking problems, visual hallucinations, muscle rigidity.
      2. Alzheimer's Disease -most common type

B. Alzheimer's Disease (AD)
1. three (3) stages
   a. stage 1- early/mild
      1. short-term memory loss
      2. disorientated to time
      3. loses interest in work and hobbies
      4. unable to concentrate
      5. decreased attention span
      6. mood swings
      7. rude behavior
      8. tends to blame others
      9. poor judgment
      10. poor personal hygiene and safety awareness
   b. stage 2 - middle/moderate
      1. increased disorientation
      2. increased memory loss – may forget family and friends
      3. slurred speech
      4. difficulty finding the right words
      5. difficulty following directions
      6. loses ability to read, write or do math
      7. unable to perform own ADLs without assistance

Objectives	Content Outline
	8. unable to recognize common items like comb or eating utensils 9. becomes incontinent 10. restless, wanders, paces, sundown syndrome 11. difficulty sleeping 12. poor impulse control – inappropriate language, sexually aggressive 13. hallucinations (experiences sensations that are not real) and/or delusions (false ideas about who one is or what is going on around them) c. stage 3 – late/severe 1. total disorientation to time, place and persor 2. total dependence on others for care 3. completely incontinent 4. verbally unresponsive 5. confined to bed unable to walk 6. unable to recognize family or self 7. difficulty swallowing and eating 8. seizures 9. coma 10. death
Demonstrate an understanding of the behavior of the cognitively impaired client as evidenced by satisfactory role-play in the skills lab and satisfactory performance in the clinical setting.	C. Behaviors associated with dementia 1. wandering or pacing a. causes 1. over-stimulating environment 2. feeling scared or lost 3. looking for someone or something 4. need to go to the bathroom 5. hunger 6. forgetting how or where to sit
Respond appropriately to the behavior of the cognitively impaired client as evidenced by satisfactory role-play in skills lab and satisfactory performance in the clinical setting.	b. appropriate responses to wandering or pacing 1. provide safe place for wandering/pacing 2. maintain toileting schedule 3. offer snacks 4. redirect to other activities 5. redirect to other exercise 6. for nighttime wandering, minimize daytime napping 7. provide reassurance 2. agitation a. causes 1. frustration 2. insecurity 3. new people or new places 4. changes in routine 5. over-stimulating environment b. appropriate responses to agitation 1. eliminate triggering behavior 2. keep calm 3. speak slowly and simply

Objectives	Content Outline
	4. reduce noise and stimulation in environment 5. redirect to a familiar activity 6. reassure client that he is safe 3. hallucinations and delusions a. hallucinations – hearing/seeing things that are not there b. delusions – false ideas about who one is or what is going on around one d. appropriate responses to hallucinations/delusion 1. if they are harmless, ignore them 2. do not argue because they are real to the client 3. redirect client to other activities 4. report behavior to appropriate supervisor 4. violent behavior a. hitting, attacking, threatening to self and/or others b. causes 1. frustration 2. over-stimulation 3. change in routine c. appropriate responses to violent behavior 1. notify supervisor immediately 2. decrease environmental stimulation 3. step out of reach and remain calm 4. protect yourself and others 5. never hit back 6. speak slowly and simply 5. catastrophic reactions a. unreasonable, exaggerated reaction 1. may be inappropriate language b. causes 1. fatigue 2. change of routine 3. over-stimulation in environment 4. pain or discomfort 5. hunger or need to toilet c. appropriate responses to catastrophic reactions 1. remove triggers 2. use calming techniques 3. do not leave the client alone 4. block blows 5. never hit back 6. stay out of reach 7. protect yourself and others 8. call for help 9. notify supervisor immediately 6. pillaging, rummaging and/or hoarding a. pillaging – taking items that belong to someone else b. rummaging – going through drawers, closets, personal items that belong to oneself or to others

Objectives	Content Outline
	c. hoarding – collecting more items than one needs and never throwing anything away d. appropriate responses to pillaging, rummaging and/or hoarding 1. do not judge client- these behaviors are out of their control 2. label all of client belongings 3. check hiding places periodically 4. notify family so they are aware of behavior 5. set aside special drawer for rummaging or hoarding 7. sundown syndrome a. client becomes restless and agitated in late afternoon, evening or night b. causes 1. hunger 2. fatigue 3. change in routine 4. new situation c. appropriate responses to sundowning 1. provide adequate lighting before it gets dark 2. avoid stressful situations in afternoon or evening 3. discourage daytime naps 4. follow a bedtime routine 5. plan calming activity just before bedtime 6. eliminate caffeine from diet 7. give soothing back rub 8. redirect behavior to a calm activity 9. maintain daily exercise routine 10. notify supervisor of behavior 8. perseveration a. repeat words, phrases or questions over and over again b. may repeat same activity over and over again c. appropriate responses to perseveration 1. remember that client is unaware of behavior 2. respond each time to a question 3. remain calm 4. do not attempt to silence or stop client 5. redirect client to another activity 9. inappropriate social behavior a. cursing, yelling b. banging on furniture, slamming doors, etc. c. causes 1. pain 2. constipation 3. frustration 4. desire for attention d. appropriate responses to inappropriate social behavior

Objectives	Content Outline
	1. remain calm 2. speak slowly, simply, softly 3. try to determine cause of the behavior 3. report behavior to supervisor 10. inappropriate sexual behavior a. removing clothing, inappropriate touching of self or others b. causes 1. client is hot 2. need to toilet 3. attempting to remove soiled clothing 4. pleasant sensation c. appropriate responses to inappropriate sexual behavior 1. stay calm and professional 2. try to find reason for behavior 3. direct client to private area 4. distract client 5. report behavior to supervisor
Demonstrate strategies for communicating with the cognitively impaired client as evidenced by satisfactory role-play in skills lab and satisfactory performance in the clinical setting.	D. Strategies for communicating with the cognitively impaired client 1. always introduce yourself to client 2. be careful with touching client, as this may frighten or upset client 3. maintain eye contact when speaking with client 4. allow client ample time to respond 5. speak slowly, simply, softly 6. reduce environmental noise 7. give directions one at a time, not a list of directions 8. repeat directions and answers as often as needed 9. if client does not seem to understand what you are saying, try using different words 10. watch for body-language clues that indicate what client needs or is trying to say 11. always describe what you are doing 12. break tasks into simple steps 13. use pictures or a communication board 14. post reminders such as calendars, signs, activity boards, pictures 15. frequently offer praise 16. if language is offensive, ignore it or gently try to redirect client to another activity 17. do not talk to or about client as though he is a child 18. use validation therapy a. acknowledge the client's reality b. do not argue with client c. attempt to distract client and redirect attention to another, more appropriate activity
Demonstrate techniques for addressing the unique needs and behaviors of client's with cognitive impairment as evidenced by satisfactory role-play in skills lab and satisfactory performance in the clinical setting.	E. Techniques to address unique needs of the

Objectives	Content Outline
	cognitively impaired client 1. bathing a. schedule bathing when client is least agitated b. adhere to the schedule c. gather all supplies before beginning procedure d. use sponge bath if client becomes upset with tub bath or shower e. have bathroom warm and well-lit f. make sure water is warm g. provide for privacy and safety h. encourage independence by giving client washcloth i. explain everything you are doing j. be calm and reassuring throughout procedure 2. grooming and dressing a. assist with grooming to maintain self-esteem and dignity b. use clothing that opens in the front, has elastic waistbands, Velcro instead of buttons c. choices may agitate client therefore do not give client too many choices when selecting clothes. May be best to offer only one outfit to wear 3. toileting a. establish toileting schedule and adhere to it b. toilet q2hrs or more often if necessary c. toilet before meals and before bedtime c. place sign on bathroom door so client will recognize it d. keep bathroom lit e. assist client to clean self after toileting f. change client's clothing if they become soiled g. keep skin clean and dry h. document bowel movements i. reassure family and friends if they are upset by client's incontinence j. encourage fluid intake to avoid dehydration 3. eating a. establish a meal schedule and adhere to it b. encourage independence at mealtime with the use of assistive devices c. dining area should be well-lit, pleasant, with a minimum of background noise (turn off TV) d. seat client with others to promote socialization e. food should look pleasant and appealing f. food and drink should not be too hot or too cold g. keep table setting simple 1. no patterns on the tablecloth or plates 2. do not put unnecessary plates, glasses or silverware on the table h. finger foods are acceptable i. offer plenty of fluids j. give simple directions

Objectives	Content Outline
Demonstrate methods to reduce the effects of cognitive impairment as evidenced by satisfactory role-play in skills lab and satisfactory performance in the clinical setting.	k. use cueing to give client idea of how to feed self l. allow ample time for client to feed self m. give client smaller meals at more frequent intervals if wandering interferes with meals n. report to appropriate supervisor 1. choking or difficulty swallow 2. changes in intake and/or output 4. general health issues a. assist to wash hands at frequent intervals b. be alert to risk for falls and reduce risks for client c. be diligent with skin care d. observe for non-verbal cues regarding pain or discomfort and report to appropriate supervisor e. promote self-esteem by encouraging independence in activities where possible f. provide daily/weekly calendar g. encourage participation in activities and socialization h. reward behavior with smiles, hugs and praise 5. therapies used with cognitively impaired clients a. reality orientation 1. calendars 2. clocks 3. signs 4. lists b. validation therapy 1. acknowledge client's reality 2. do not argue 3. redirect activity to more appropriate behavior c. reminiscence therapy 1. reminds client of past experiences and people d. re-motivation therapy 1. promote self-esteem, socialization 2. groups to focus on specific topic
Identify strategies the nurse aide can use to keep a positive, empathetic attitude when caring for clients with cognitive impairment as evidenced by participation in classroom discussion.	A. Care for the caregiver 1. do not take behavior personally 2. consider what client is feeling 3. work with client as they are today 4. work as a team making sure everyone follows the nursing care plan 5. work with and support family members 6. take care of yourself
Describe age-related changes seen in the endocrine system as evidenced by accurately participating in classroom discussion.	III. Diabetes Mellitus A. The endocrine system 1. regulates many body functions 2. made up of glands that secrete hormones directly into the blood stream

Objectives	Content Outline
	3. glands a. pituitary gland – 7 hormones including growth-stimulating hormone b. thyroid –controls metabolism c. parathryoids – regulates body's use of calcium d. thymus – regulates immune system e. adrenals – regulates BP and fight vs flight f. pancreas – produces insulin to regulate blood sugar g. ovaries – female sex hormones h. testes – male sex hormones 4. age-related changes in the endocrine system a. levels of hormones decrease 1. menopause in women a. levels of insulin decrease b. body handles stress less efficiently 5. common disorders of the endocrine system a. diabetes mellitus b. hypothyroidism
Discuss common disorders of the endocrine system, including their signs and symptoms, as evidenced by participating in classroom discussion.	
Describe the difference between Type 1 and Type 2 diabetes mellitus as evidenced by Participating in classroom discussion.	B. Diabetes mellitus (DM) 1. insulin a. the key that opens the door to allow glucose to enter the cell b. cells use glucose for energy/food c. without glucose, cells will die d. without insulin, glucose stays in the blood and cannot get into the cells 2. type 1 – insulin dependent diabetes mellitus (IDDM) a. pancreas produces little or no insulin b. must have outside source of insulin (injection) 3. type 2 – non-insulin dependent diabetes mellitus (NIDDM) a. pancreas produces insulin but the body has become resistant to its own insulin b. may take oral hypoglycemic tablet c. may be treated with diet and exercise d. may require injection of insulin
Identify signs and symptoms of diabetes mellitus as evidenced by participating in classroom discussion.	4. signs and symptoms of DM a. increased thirst b. increased urination c. increased hunger d. fatigue e. elevated blood sugar f. blurred vision g. slow-healing cuts or sores h. numbness/tingling in hands/feet i. increased number of infections
Discuss hypoglycemia, including the signs and symptoms and the care of the client experiencing hypoglycemia as evidenced by satisfactory participation in classroom discussion.	5. complications of DM a. hypoglycemia 1. signs a. change in level of consciousness b. skin cool and clammy

Objectives	Content Outline
Discuss hyperglycemia, including the signs and symptoms and the care of the client experiencing hyperglycemia as evidenced by satisfactory participation in classroom discussion.	c. complaint of headache d. shaky e. nauseated 2. causes a. skipped a meal b. too much exercise c. received too much insulin 3. notify supervisor immediately 4. if conscious, give orange juice or peanut butter crackers or follow facility policy
Describe long-term complications of diabetes mellitus as evidenced by participating in classroom discussion.	b. hyperglycemia 1. signs a. skin warm and flushed b. breath has fruity smell c. blood sugar is elevated 2. causes a. over-eating b. not enough exercise c. did not receive enough insulin 3. notify supervisor immediately
Discuss guidelines for the nurse aide caring for the client with diabetes mellitus as evidenced by satisfactory role-play in class and satisfactory performance in the clinical setting.	c. damage to blood vessels 1. damage to blood vessels in the retina leads to blindness 2. damage to blood vessels in the kidneys leads to kidney failure and dialysis 3. damage to blood vessels in the feet and legs leads to amputation d. damage to nerves 1. numbness and tingling in hands and feet 2. loss of sensation in fingers and toes 6. guidelines for the care of the client with DM a. maintain meal schedule b. encourage client to follow diet and not eat concentrated sweets c. monitor blood sugar per facility policy d. inspect client's feet and toes every day for blisters, reddened areas e. client should always wear well-fitting shoes when ambulating f. if client has loss of sensation in hands assist them with activities such as eating, writing or holding objects g. if client has loss of sensation in feet assist with ambulation h. never cut client's toenails, only a podiatrist i. always dry between client's toes after washing feet
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	7. what to report to the appropriate supervisor a. a missed meal b. complaints of increased thirst c. complaints of increased urination, particularly at night

Objectives	Content Outline
Identify signs and symptoms of hypothyroidism as evidenced by participating in classroom discussion.	d. complaints of blurred vision e. change in level of consciousness f. skin that is cool and clammy g. skin that is warm and flushed h. observing client eating concentrated sweets between meals i. cuts, bruises, sores that do not seem to be healing j. blisters, sores, redness, cracks on toes or feet k. increased incidence of infections C. hypothyroidism 1. description a. lack of thyroid hormone b. causes body metabolism to slow down 2. signs and symptoms a. fatigue b. weakness c. weight gain d. constipation e. intolerant of the cold f. dry skin g. hair thins and/or begins to fall out h. brittle hair and fingernails i. pulse slows j. blood pressure decreases k. temperature is lower l. goiter (enlarged thyroid) m. voice becomes hoarse n. depression 3. guidelines for care of the client with hypothyroidism a. offer sweater, blanket to keep client comfortable when complains of being cold b. set room thermostat a little higher to provide warmth c. be extra careful when grooming hair and nails d. provide frequent rest periods, as necessary, during ADLs e. encourage fluid intake 4. report the following to the appropriate supervisor a. unusual complaints of coldness b. unusual complaints of fatigue c. hair that breaks or appears to be falling out d. complaints of constipation e. changes in voice f. neck becoming larger g. decrease in vital signs from baseline h. increase in weight
Discuss guidelines for the nurse aide caring for the client with hypothyroidism as evidenced by participating in classroom discussion.	
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. .	
Identify signs and symptoms of hyperthyroidism as evidenced by participating in classroom discussion.	D. hyperthyroidism 1. thyroid gland produces too much thyroid hormone 2. body processes speed up 3.

Objectives	Content Outline
	4. body metabolism increases 5. signs and symptoms a. nervousness b. restlessness c. fatigue d. bulging or protruding eyes e. tremors of the hands f. intolerance to heat g. excessive perspiration h. rapid pulse i. high BP j. increased appetite with weight loss k. enlarged neck (goiter) 6. guidelines for care of the client with hyperthyroidism a. assist to dress in cooler clothing b. lower thermostat in room c. assist at mealtime if appropriate 7. what to report to appropriate supervisor a. unusual complaints of being warm/hot b. nervousness c. unusual tremors of hands d. eyes that appear to be bulging e. excessive perspiration f. increase in vital signs g. weight loss h. change in appetite i. change in size of neck

Unit XI – Basic Restorative Services
(18VAC90-26-40.A.6.a, b, c, d, e, f)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Discuss the role of the nurse aide in rehabilitation and restorative care.
2. Describe ways to teach, with supervision, a client to participate in self-care.
3. Demonstrate the use of assistive devices when transferring client from bed to chair or bed to stretcher.
4. Discuss the assistive devices the client may use when ambulating.
5. Identify assistive devices the client may have to help with eating.
6. Identify assistive devices the client may have to help with dressing.
7. Demonstrate passive range of motion for the knee and ankle.
8. Demonstrate passive range of motion for the shoulder.
9. Discuss observations the nurse aide should report to the supervisor when performing passive range of motion exercises.
10. Identify positioning devices the nurse aide may use when turning and positioning a client.
11. Demonstrate positioning a client on his side in bed.
12. Demonstrate positioning a client in the chair.
13. Describe caring for and using prosthetic devices.
14. Describe caring for and using orthotic devices.
15. Demonstrate how to put elastic stockings on the client.
16. Describe the role of the nurse aide in bladder training.
17. Describe the role of the nurse aide in bowel training.

Objectives	**Content Outline**
	I. Definitions A. Disability 1. impaired function a. physical b. emotional c. both at the same time 2. may be permanent or temporary 3. goal of care a. assist client to learn to manage disability b. gain as much independence as possible
Describe the purpose of rehabilitation as evidenced by participation in classroom discussion.	B. Rehabilitation 1. occurs after accident, illness or injury 2. assist client with disability to achieve highest possible level of functioning a. physical b. emotional c. economic 3. holistic care a. treating the entire person b. physical and psychological
Identify members of the rehabilitation team as evidenced by participating in classroom discussion.	C. Members of the rehabilitation team 1. physiatrist – physician specializing in rehabilitation 2. other physicians

Objectives	Content Outline
	3. therapists a. speech therapy b. physical therapy c. occupational therapy 4. social workers 5. discharge planners 6. nurses 7. nurse aides 8. client 9. client's family D. Goals of rehabilitation team 1. assist client to maintain and/or regain ability to perform ADLs 2. promote client independence 3. assist client adaptation to disability 4. prevent complications of disability
Describe restorative care as evidenced by participation in classroom discussion.	E. Restorative Care 1. actions of health care workers 2. goals a. assist client maintain health, strength, function b. increase independence 3. includes a. treatment b. education c. prevention of complications
Discuss the role of the nurse aide in rehabilitation and restorative care as evidenced by participating in classroom discussion.	II. Guidelines of Rehabilitation and Restorative Care A. Understand diagnosis and disability 1. be aware of client limitations 2. know client abilities 3. follow nursing care plan B. Display patience with client and significant others 1. small improvements may be significant 2. respond appropriately and offer praise C. Display positive attitude 1. staff sets the tone for the day D. Listen to client's thoughts and feelings 1. emotional needs are important E. Provide for client privacy 1. avoids distractions 2. allows client to practice new skills without an audience F. Promote client independence 1. accomplishing a task by himself improves client self-esteem G. Promote personal choice 1. supports self-esteem H. Encourage physical activity 1. helps prevent complications of disability 2. encourages social interaction

Objectives	Content Outline
	I. Be aware client may have setbacks J. Report the following to appropriate supervisor 1. lack of motivation 2. signs of withdrawal or depression 3. change in ability, both increased or decreased 4. decrease in client strength 5. change in ability to perform range of motion
	III. Methods to teach client to participate in self-care program A. Nurse aide project positive attitude 1. be enthusiastic 2. nurse aide's attitude will encourage client
Describe ways to teach, with supervision, a client to participate in self-care as evidenced by satisfactory participation in role-play in classroom and skills lab.	B. Establish reasonable goals with client's participation 1. what does client want to achieve 2. how will client work toward goal 3. how will client know when goal has been achieved 4. begin at client's current level of function 5. use cueing, mirroring, behavior reinforcement
Describe reasons why client may not want to participate in self-care as evidenced by satisfactory participation in classroom discussion.	C. Reasons for client to refuse 1. fear of hurting themselves 2. fear of failure 3. feeling of hopelessness 4. not understanding why self-care is helpful 5. not understanding why self-care is necessary
	IV. Assistive devices A. definition 1. devices to make specific tasks easier 2. promote independence
Identify assistive devices the nurse aide may use for transferring clients, including bed to chair and bed to stretcher, as evidenced by Satisfactory rating on Skills Record in skills lab and in the clinical setting.	B. Transferring client 1. transfer belt (gait belt) for ambulation and transfer bed to wheelchair 2. slide board to transfer client from bed to stretcher 3. mechanical lift to transfer client from bed to chair
Identify assistive devices the nurse aide may use to assist the client to ambulate as evidenced by Satisfactory rating on Skills Record in skills lab and in the clinical setting.	4. U.S. Department of Labor Fair Labor Standards Act (FLSA) Hazardous Occupation Order No. 7 a. prohibits minors under 18 from operating or assisting in the operation of most power-driven hoists, including those designed to lift and move clients b. www.dol.gov/whd/regs/compliance /whc i. US Department of Labor Wage and Hour division website ii. page 2

Objectives	Content Outline
Demonstrate how to assist the client to ambulate with assistive devices as evidenced by Satisfactory rating on Skills Record in skills lab and in the clinical setting.	C. Ambulating client 1. transfer belt (gait belt) 2. cane a. C-cane: handle in shape of a "C" b. Quad cane: has 4 rubber-tipped feet 3. walker- provides more support than cane 4. crutches - used when client has limited weight bearing on one leg D. Guidelines for canes, walkers, and crutches 1. check assistive device for any defect or damage prior to use 2. client should always wear non-skid shoes that fit correctly when ambulating 3. clothing should fit properly, not be too long or too loose fitting 4. promptly clean spills and clutter from floors where client will be walking 5. encourage client to stand as straight as possible when walking 6. do not rush client 7. do not use walker to hang items 8. client should use cane in strong hand 9. when assisting client to walk, stay near client on the weak side 10. have chair available for client to use if he experiences pain or discomfort while ambulating 11. after walking, return client to chair or bed, in the low position, with call bell ~~in easy~~ within reach
Identify assistive devices the nurse aide may use to assist the client to eat as evidenced by satisfactory role-play in skills lab.	E. Assistive devices for eating 1. plate guard 2. utensils with built-up handles 3. utensils with curved handles 4. utensils that have a Velcro strap to hold utensil in client's hand 5. sippy cup 6. cup holders
Identify assistive devices the nurse aide may use to assist the client to dress as evidenced by satisfactory role-play in skills lab.	F. Assistive devices for dressing/grooming 1. zipper pulls 2. Velcro fasteners instead of buttons 3. long-handles shoe horn 4. long-handled graspers 5. button hole hooks 6. elastic shoelaces 7. denture brush 8. long handled bathing sponge

Objectives	Content Outlines
Define terms associated with range of motion as evidenced by participating in classroom discussion.	V. Range of Motion Exercises A. Definitions 1. Abduction - move away from the body's midline 2. Adduction - move toward the body's midline 3. extension - straighten the body part 4. flexion - bend the body part 5. dorsiflexion - bend body part backward 6. pronation - turn body part downward 7. rotation - turn the joint 8. supination - turn body part upward 9. contraction a. joint remains in permanently bent position b. caused by lack of movement c. prevented by 1. proper positioning 2. range of motion exercise to joint
Describe benefits of exercise as evidenced by Participating in classroom discussion.	B. Benefits of exercise 1. increase muscle strength 2. maintain joint mobility 3. prevent contractures 4. improve coordination to help prevent falls 5. improve self-image to prevent depression 6. maintain/reduce weight 7. improve circulation to prevent leg ulcers
	C. Range of motion exercises 1. active range of motion exercise (AROM) - client exercises own joints without assistance 2. passive range of motion exercise (PROM) – staff exercises client's joints without assistance from the client 3. promotes self-care and client independence
	D. Perform passive range of motion (PROM) for lower Extremity - follow the procedure for "Performs Modified Passive Range of Motion (PROM) for One Knee and One Ankle" in the most current edition of Virginia Nurse Aide Candidate Handbook
Demonstrate passive ROM to lower extremity as evidenced by Satisfactory rating on Skills Record in skills lab and in the clinical setting.	E. Perform passive range of motion (PROM) for upper Extremity - follow the procedure for "Performs Modified Passive Range of Motion (PROM) for One Shoulder" in the most current edition of Virginia Nurse Aide Candidate Handbook
	F. Signs to stop or withhold range of motion exercises 1. pain in the joint 2. red, swollen joint
Demonstrate passive ROM to upper extremity as evidenced by Satisfactory rating on Skills Record in skills lab and in the clinical setting.	G. Ways to maintain range of motion 1. therapeutic positioning to maintain good body alignment 2. use of positioning devices 3. range of motion exercises on a regular schedule

Objectives	Content Outlines
Discuss the guidelines for range of motion exercises as evidenced by satisfactory participation in classroom discussion.	H. Guidelines for range of motion exercises 1. follow client's nursing care plan 2. use proper body mechanics when performing range of motion exercises to protect your body 3. provide range of motion exercises to both sides of client's body beginning at the head and working down the body a. head and neck are usually not exercised unless specifically ordered 4. support the extremity above and below the joint during range of motion 5. do not exercise joint that is bandaged or has dressing, cast, IV tubing 6. never exercise a joint that is red, bruised, has open sore, draining fluid 7. provide for privacy when doing range of motion exercises 8. do not exercise joint to point of discomfort a. hyperextension can cause damage to joint 9. maintain client in good body alignment 10. talk with client while performing range of motion
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	I. Report the following to the appropriate supervisor 1. joint that is red, swollen, painful, draining 2. complaints of pain during range of motion exercise 3. lack of motivation 4. signs of withdrawal or depression 5. change in ability, both increased or decreased 6. decrease in client strength 7. change in ability to perform range of motion
Identify positioning devices the nurse aide may use when turning and position clients In bed and in the chair as evidenced by Satisfactory rating on Skills Record in skills lab and in clinical.	VI. Turning and positioning in bed and chair A. Positioning devices 1. backrests a. pillow b. special wedge-shaped foam pillows c. provide support, comfort d. maintain proper body alignment 2. bed cradles/foot cradles a. keep sheets/blankets from pushing down on the client's toes and feet 3. footboards a. padded boards or device placed against client's feet to keep ankles and foot in proper alignment b. prevent foot drop 4. heel/elbow protectors a. padded protectors wrapped around foot and ankle (heel) or elbow and arm (elbow) b. prevents rubbing, irritation and pressure on

Objectives	Content Outlines
	the heel or elbow c. heel protector maintains proper body alignment for ankle d. heel protector prevents foot drop 5. abduction wedges - keep hips in proper position after hip surgery 6. trochanter roll a. rolled blanket or towel placed on outside of leg b. prevent hip and leg from turning outward 7. handroll a. rolled washcloths placed in palm of hand b. keep hand and/or fingers in proper alignment c. prevents contractures of finger, hand or wrist B. Turning client in bed 1. protects against problems of immobility a. blood clots in the legs b. pneumonia c. contractures d. depression e. urinary tract infection 2. prevents pressure sores - turn and reposition every 2 hours around the clock 3. comfort 4. position client on side - follow the procedure for "Positions on Side" in the most current edition of Virginia Nurse Aide Candidate Handbook 5. use positioning devices for proper body alignment and comfort
	C. Position client in chair 1. feet on floor or wheelchair footrests 2. hips touching back of chair 3. use positioning devices to maintain body alignment and comfort 4. place call bell within client's reach
	VII. Prosthetic and Orthotic Devices A. Prosthetic devices 1. definition a. artificial replacement for legs, feet, arms or other body part 2. examples a. artificial arm or leg b. artificial eye 3. caring for and using prosthetic devices a. handle with extreme care – they are very expensive b. follow instructions when applying and removing prosthesis c. assist client as needed to apply prosthesis d. follow nursing care plan and manufacturer's
Demonstrate positioning client on his side as evidenced by satisfactory rating on Skills Record in skills lab and in the clinical setting.	
Demonstrate positioning client in a chair as evidenced by satisfactory rating on Skills Record in skills lab and in the clinical setting.	

Objectives	Content Outlines
	instructions e. make sure skin is always clean and dry under prosthesis f. use special stockings under an artificial leg or arm g. if client experiences phantom pain, be supportive h. do not react negatively to sight of anatomical stump or prosthesis
Describe caring for and using prosthetic devices as evidenced by participating in classroom discussion.	4. report the following to the appropriate supervisor a. redness, swelling of stump or extremity b. drainage, bleeding or sores of any kind on the stump or extremity c. phantom pain, phantom sensation, stump pain d. decreased ability to move extremity e. cyanosis of any part of the extremity f. any difficulty applying or using prosthesis
	B. Orthotic devices 1. definition a. device applied over a body part for support and protection b. keep joint in correct alignment c. improve function of body part d. prevent contractures of body part e. splints and braces
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	2. examples a. splints b. shoe inserts c. knee/leg braces d. surgical shoes e. elastic stockings
	3. caring for and using orthotic devices a. do not immerse in water b. do not use hot water to clean c. clean with warm, damp cloth d. check braces and splints for wear and tear e. after removal wash elastic stocking in warm, soapy water every day f. gradually increase wearing time of device g. if device causes pain remove and notify supervisor h. observe area around, under device
Describe caring for and using orthotic devices as evidenced by participating in classroom discussion.	4. report the following to the appropriate supervisor a redness, swelling of body part b. drainage, bleeding or sores of any kind on the body part c. complaints of pain d. decreased ability to move body part e. cyanosis of the body part f. any difficulty applying or using orthotic device

Objectives	Content Outlines
	g. orthotic device that needs repair C. Anti-embolic (elastic) stockings 1. purpose a. cause smooth, even compression of the leg b. allows blood to move through the arteries and veins c. improves blood circulation in lower extremities d. prevent swelling of legs and feet e. reduce fluid retention f. reduce blood clots in legs
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	1. require a physician's order 2. sized to fit client a. measure length of leg b. measure girth of leg 3. apply elastic stocking a. follow the procedure for "Applies one knee-high elastic stocking" in the most current edition of Virginia Nurse Aide Candidate Handbook
Describe the purpose of elastic stockings as evidenced participating in classroom discussion.	4. daily observations a. use open area at toes to observe client's toes b. look for cyanosis, bluing of toes/nailbeds c. document application of stocking and observations per facility policy 5. risks of elastic stocking a. turning down the top of the stocking may impede circulation b. stockings should be applied first thing in the morning when legs are smallest c. apply stockings while legs are elevated, before client gets out of bed
Demonstrate correct application of elastic stockings as evidenced by Satisfactory rating on Skills Record in skills lab and in the clinical setting.	d. make sure there are no wrinkles or twist in stocking after it is applied 6. report the following to the appropriate supervisor a. toes or feet that are bluish and/or cool to touch b. complaints of pain or discomfort in the feet or legs c. red areas on heels, toes, calf of the leg
	VIII. Bladder and Bowel Training A. Goal 1. relearn control of urinary elimination pattern 2. control involuntary urination (incontinence)
	B. Guidelines for bladder training 1. identify pattern of elimination 2. establish schedule for use of bathroom, at least every 2 hours 3. explain training schedule to client 4. follow schedule consistently

Objectives	**Content Outlines**
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	5. keep accurate record of elimination to help establish a routine 6. toilet client before beginning long procedures and after procedure is completed 7. toilet client before meals and before bedtime 8. answer call bell promptly 9. provide privacy when client emptying bladder 10. do not rush client 11. assist client to maintain good perineal hygiene 12. encourage or increase fluid intake, if permitted 13. toilet about 30 minutes after fluid intake 14. if client has difficulty urinating try running water in the sink, leaning forward slightly to place additional pressure on the bladder 15. assist with change of clothing if accident occurs 16. be positive with success and understanding with accidents
Describe the process for bladder training as evidenced by satisfactory participation in classroom discussion.	
	C. Guidelines for bowel training 1. identify pattern of elimination 2. establish schedule for use of bathroom 3. explain training schedule to client 4. follow schedule consistently 5. provide diet that stimulates the bowels a. high in fiber b. plenty fresh fruits and vegetables c. adequate hydration 6. provide exercise as tolerated 7. provide privacy when in the bathroom provide encouragement 8. answer call bell promptly 9. do not rush client 10. assist with change of clothing if accident occurs 11. be positive with success and understanding with accidents
Describe the process for bowel training as evidenced by satisfactory participation in classroom discussion.	

Unit XII – Respiratory System, Cardiovascular System, HIV/AIDS, Cancer, and Care of the Client When Death is Imminent
(18VAC90-26-40.A.2.g)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Discuss care of client with a common respiratory disorder, including what the nurse aide would report to the appropriate supervisor.
2. Describe care of the client receiving oxygen therapy.
3. Discuss care of client with a common circulatory disorder, including what the nurse aide would report to the appropriate supervisor.
4. Discuss HIV/AIDS, including signs and symptoms and nursing care.
5. Identify the American Cancer Society signs of cancer.
6. Discuss cancer, including nursing care for the client with a diagnosis of cancer.
7. Discuss how attitudes about death may affect the nurse aide providing care to the dying client.
8. Identify the stages of grief.
9. List the physical changes that occur when death is imminent.
10. Discuss care measures, including physical and psychosocial measures, for the client when death is imminent.
11. Discuss care measure for the family when death is imminent.
12. Demonstrate postmortem care.

Objectives	**Content Outline**
Explain the anatomy and physiology of the respiratory system as evidenced by being able to correctly identify each component part and its function.	I. Respiratory System A. Anatomy 1. airway a. mouth b. nasal cavities c. throat – pharynx d. voice box – larynx 1. epiglottis – flap that closes off opening to trachea when client swallows e. trachea – windpipe f. bronchi – 2 branches of the trachea 1. one to right lung, one to left lung 2. lungs a. where respiration occurs b. exchanges carbon dioxide from the body for oxygen from the environment c. bronchioles d. alveoli – where gas exchange actually occurs e. inhalation – breathe air and oxygen into the lungs f. exhale – breathe out carbon dioxide B. Ventilation 1. diaphragm a. muscle separating chest from abdomen b. during inhalation diaphragm contracts making room for lungs to expand and negative pressure to pull air from environment into the lungs

Objectives	Content Outline
	c. during exhalation diaphragm relaxes and causes positive pressure in the lungs to push the air out of the lungs 2. respiratory rate a. controlled by central nervous system b. medulla oblongata of the brain has control C. Function of respiratory system 1. cleanse inhaled air 2. supply oxygen to body cells 3. remove carbon dioxide from cells 4. produce sound associated with speech D. Effects of aging on the respiratory system 1. less efficient ventilation a. lung strength decreases (do not expand and contract as easily) b. alveoli become less elastic (do not empty on exhalation) c. alveoli decrease in number d. diaphragm becomes weaker e. airways become less elastic 2. lung capacity decreases 3. muscles of the rib cage become weaker making it harder to expand the chest during inhalation 4. cough reflex becomes less effective making the cough weaker 5. decrease in effectiveness of ventilation causes less oxygen in the blood 6. decreased lung capacity cause voice to weaken E. Common disorders of the respiratory system 1. chronic obstructed pulmonary disease (COPD) a. client becomes progressively worse with time b. no cure c. acute bronchitis – inflammation of lining of bronchi 1. cause – infection 2. symptoms a. production of yellow or green sputum and b. difficulty breathing 3. last a short time d. chronic bronchitis 1. cause – inflammation of bronchial lining a. cigarette smoking b. environmental air pollution 2. symptoms a. chronic cough producing thick, whitish sputum 3. restricts air flow 4. scars lungs e. emphysema 1. alveoli become over-stretched 2. carbon dioxide remains trapped in the Alveoli
Describe age-related changes seen in the respiratory system as evidenced by accurately participating in classroom discussion.	
Discuss common disorders of the respiratory system, including their signs and symptoms, as evidenced by participating in classroom discussion.	

Objectives	Content Outlines
	3. causes a. cigarette smoking b. chronic bronchitis 4.symptoms a. short of breath b. coughing c. difficulty breathing f. signs and symptoms of COPD 1. coughing/wheezing 2. difficulty breathing (dyspnea) 3. short of breath especially during exercise 4. cyanosis 5. complaints of chest tightness or pain 6. confusion 7. weakness 8. loss of appetite and weight 9. fear and anxiety g. guidelines for COPD 1. use pillows to assist client to sit up and lean slightly forward to facilitate breathing 2. plan periods of rest during ADLs to prevent client from getting overly tired 3. practice good hand washing to protect client from infections 4 encourage a healthy diet 5.provide plenty of fluids to help keep client well hydrated 6.be supportive and calm if client is anxious and fearful 7.provide waste can close to client to help with appropriate disposal of used tissues 8.if client is receiving oxygen, follow instructions on use of oxygen h. report the following to the appropriate supervisor 1. signs and symptoms of colds or the flu a. fever b. chills c. complaints of feeling achy
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	2.confusion 3.change in breathing patterns 4.shortness of breath on exertion 5.change in color or consistency of sputum 6.complaints of chest pain or tightness 7.insomnia due to anxiety or fear 2. asthma a. chronic b. causes 1. allergens, including cigarette smoke 2. infection 3. cold air c. signs and symptoms 1. wheezing

Objectives	Content Outlines
	2. coughing 3. complaints of tightness in the chest 4. difficulty breathing d. report the following to the appropriate supervisor 1. changes in respirations and/or pulse 2. wheezing 3. shortness of breath 4. cyanosis 5. complaints of chest pain or chest tightness 6. refusal to use inhaler when needed 3. pneumonia a. acute inflammation of lungs b. cause 1. infection – viral, bacterial or fungal 2. chemical irritant c. signs and symptoms 1. high fever 2. chest pain during inhalation 3. coughing 4. difficulty breathing 5. shortness of breath 6. chills 7. increased pulse 8. thick, colored sputum d. report the following to the appropriate supervisor 1. changes in vital signs 2. complaints of difficulty breathing 3. complaints of chest pain or discomfort 4. unusual sputum production 5. sputum that has a distinct color
Describe the use of various types of oxygen therapy equipment as evidenced by satisfactory participation in classroom discussion.	F. Oxygen therapy 1. administration of oxygen to improve oxygen levels in the body a. normal blood oxygen level is 95-100% b. clients with certain disease processes have different optimal blood oxygen levels 2. methods of delivery a. oxygen 1. compressed air – green oxygen tank or in wall unit 2. air condenser – connects to electrical outlet and pulls oxygen out of room air b. appliance 1. nasal cannula – 2 nasal prongs and tubing that goes around the ears and cinches under the chin. Tubing is attached to oxygen source 2. mask – mask fits over nose and mouth and attaches to tubing attached to oxygen source c. medication 1. oxygen is medication 2. requires physician's order

Objectives	Content Outlines
	3. ordered in liters/minute 4. nurse aide may only monitor administration of oxygen
iscuss the guidelines for caring for the client receiving oxygen therapy is evidenced by satisfactory role-play in skills lab and classroom.	3. guidelines for oxygen delivery a. no smoking can take place in same room as oxygen administration b. post No Smoking signs outside of room and in client's room c. any spark can cause a fire in presence of oxygen, including static electricity from wool, and from dry air in winter d. perform frequent skin care to areas in contact with oxygen equipment (under the nose, behind the ears) e. observe these areas for redness and drainage f. use water-based lubricant to keep nostrils and lips moist and to prevent skin cracking g. monitor oxygen delivery device frequently to assure client is receiving correct amount of oxygen h. encourage activity as tolerated by client i. provide emotional support to client j. know where fire alarms and extinguishers are located
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	4. report the following to the appropriate supervisor a. sores or crusty areas on or under client's nose b. dry, red areas on skin in contact with oxygen tubing c. shortness of breath d. changes in respirations and/or pulse e. changes in respiratory patterns f. changes in character or color of sputum g. cyanosis h. complaints of chest pain or tightness
Explain the anatomy and physiology of the circulatory system as evidenced by being able to correctly identify each component part and its function.	II. Cardiovascular System A. Anatomy 1. blood a. red blood cells 1. carry oxygen to the individual cells and carbon dioxide to the lungs b. white blood cells 1. part of immune system 2. attack invading micro-organisms (infection) c. platelets - assist the blood to clot d. plasma- fluid portion of blood 2. heart a. pump that circulates blood throughout the body b. has 4 chambers 1. right atrium – blood from the body enter heart through right atrium and flows into the right ventricle 2. right ventricle – blood goes from right ventricle

Objectives	Content Outline
	to the lungs where carbon dioxide leaves the blood and is replaced with oxygen 3. left atrium – blood returns to the heart from the lungs and enters the left atrium 4. left ventricle – blood flows from the left atrium into left ventricle which pumps oxygen-rich blood to the body 3. arteries a. arteries carry oxygen-rich blood to the cells b. exception are pulmonary arteries which carry deoxygenated blood from right ventricle to lungs 4. veins - carry deoxygenated blood from the cells back to the heart (right atrium) 5. capillaries a. connect arteries to veins at the cellular level b. where actual exchange of oxygen from the arteries to the cells and pick-up of carbon dioxide to return to the heart B. Functions of the circulatory system 1. blood a. carry oxygen, nutrients and chemicals to cells b. remove carbon dioxide and waste products from cells c. controls acidity of body d. control body temperature e. fight infection and foreign bodies within the body 2. heart a. pump blood to every cell in the body C. Effects of aging on the circulatory system 1. heart muscle weakens and pumps less effectively 2. blood vessels become clogged with cholesterol and clots and become less efficient at circulating blood 3. blood vessels become less elastic 4. blood flow decreases D. Common disorders of the circulatory system 1. hypertension – high blood pressure a. BP greater than 140/90 b. causes 1. arteries become less elastic (hardening of the arteries) 2. arteries become more narrow 3. kidney disease 4. stress and/or pain 5. side effect of medication
Describe age-related changes seen in the circulatory system as evidenced by accurately participating in classroom discussion.	
Discuss common disorders of the circulatory system, including their signs and symptoms, as evidenced by participating in classroom discussion.	c. signs and symptoms 1. headache 2. blurred vision 3. dizziness d. if untreated 1. may cause kidney damage 2. may cause rupture of blood vessel in the brain (cerebrovascular accident – CVA– stroke)

Objectives	Content Outlines
	e. treatment 1. medication 2. diet with controlled sodium (salt) and/or fat intake 2. coronary artery disease (CAD) a. arteries that provide blood to heart muscle become blocked with fatty deposits or blood clots and the heart muscle does not receive enough oxygen b. heart muscle deprived of oxygen causes chest pain – angina 1. may occur with activity or at rest 2. described a. pressure/tightness in chest b. pain radiating down left arm c. pain in back, neck, jaw, shoulder 3. symptoms a. sweaty b. trouble breathing c. complexion pales d. cyanosis of lips, nail beds e. complaints of dizziness 4. guidelines for client experiencing angina a. have client lie down and rest b. notify supervisor immediately c. reduce stressors d. encourage rest periods during ADLs e. avoid large meals close to bedtime f. avoid exposure to weather extremes g. report to supervisor 1. complaints of chest pain, 2. shortness of breath that occurs with activity or at rest c. when muscle cells begin to die – myocardial infarction (MI or heart attack) 1. area of the heart is permanently damaged 2. signs and symptoms a. same as angina 3. guidelines for client having an MI a. a medical emergency b. notify supervisor immediately c. have client lie down d. remain calm and stay with client e. remove constrictive clothing f. if client becomes unresponsive, begin CPR g. report to supervisor 1. complaints of chest pain, 2. shortness of breath that occurs with activity or at rest 3. peripheral vascular disease (PVD) a. decreased blood supply to extremities (arms, hands, legs, feet) b. causes
Discuss the guidelines for caring for the client experiencing angina as evidenced by satisfactory participating in classroom discussion.	
Discuss the guidelines for caring for the client experiencing an MI as evidenced by participating in classroom dicussion.	

Objectives	Content Outlines
	1. narrowed blood vessels 2. blood vessels less elastic 3. blockages in blood vessels 4.decreased amount of blood being pumped by heart 5. inflammation of veins in legs c. signs and symptoms 1. pain in legs when walking or during activity 2. pain in legs that remains after activity is stopped 3. cyanosis in hands and/or feet 4. cyanotic nail beds 5. extremities that are cool to touch 6. swelling of the hands and/or feet 7. sores on arms, hands, legs, feet that do not heal in expected time frame d. report the following to the appropriate supervisor 1. complaints of pain or discomfort in extremities with activity or at rest 2. change in skin color of extremities 3. change in warmth of extremities 4. change in pulse or blood pressure 5. edema in feet and/or hands 6. increase in weight 7. output that is significantly less that intake 8. complaints of headache 9. complaints of blurred vision 10. complaints of chest pain 11. change in level of consciousness
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	4. congestive heart failure (CHF) a. when one or both sides of heart pumps ineffectively and blood begins to back up in the heart and in the arteries and veins b. signs and symptoms 1. fatigue 2. swelling (edema) in hands and feet 3. difficulty breathing 4. shortness of breath not relieved by rest 5. persistent cough 6. decreased activity tolerance 7. increased pulse 8. irregular pulse 9. chest pain 10. dizziness 11.change in level of consciousness 12. weight gain 13. increased urination 14. swelling of the abdomen c. guidelines for caring for the client with CHF 1. include rest periods during ADLs 2. daily weights 3. record intake and output daily 4. follow care plan for diet and fluid intake

Objectives	Content Outlines
	5. use elastic stockings as ordered 6. position client so breathing is comfortable d. report the following to the appropriate supervisor 1. change in level of consciousness 2. change in activity tolerance 3. change in vital signs 4. shortness of breath with activity or at rest 5. coughing and/or wheezing 6. weight gain 7. increase in urination 8. unusual swelling in hands, feet, legs
Discuss the guidelines for caring for the client experiencing CHF as evidenced by participating in classroom discussion.	
	III. Client with AIDS (Acquired Immune Deficiency Syndrome) A. description 1. human immunodeficiency virus (HIV) attacks immune system 2. damages or destroys cells of immune system 3. weakens and disables immune system
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	
	B. causes - exposure to HIV infected blood and/or body fluids
	C. signs and symptoms 1. flu-like symptoms 2. swollen glands 3. headache 4. fever 5. weight loss 6. night sweats 7. difficulty breathing 8. cold sores 9. frequent infections of skin, respiratory system and mouth 10. change in mental status
Discuss HIV/AIDS, including signs and symptoms and guidelines for care, as evidenced by participating in classroom discussion.	D. guidelines for care of client with HIV/AIDS 1. practice Standard Precautions and encourage client and significant others to practice Standard Precautions 2. disinfect surfaces in client's room and bathroom on a regular basis 3. discourage visitors who have infections or colds from visiting 4. observe client's skin on regular basis 5. keep skin clean and dry 6. turn and reposition every 2hrs (q2hr). 7. provide rest periods during ADLs 8. provide mouth care at frequent intervals 9. monitor VS 10. measure and record weight, intake and output 11. follow nursing care plan 12. encourage independence as much as possible

Objectives	Content Outlines
Discuss the guidelines for caring for the client with HIV/AIDS as evidenced by participating in classroom discussion.	13. provide emotional support 14. provide private time with families and visitors E. report the following to the appropriate supervisor 1. change in appetite 2. weight loss 3. mouth sores 4. difficulty swallowing 5. changes in the skin 6. changes in VS 7. bleeding from any opening on the body 8. unusual behavior – anxiety, depression, mood swings, suicidal thoughts IV. The Client with Cancer A. Definitions 1. Tumor - abnormal growth of tissue 2. Benign - slowly growing tumor that is easily treated 3. malignant a. abnormal cells that do not function properly b. divide rapidly c. invade nearby tissue 4. cancer - abnormal cells growing in an uncontrolled manner 5. metastasis - cancer cells spread from their original locati to a new location 6. biopsy - removal of a sample of tissue to test for cancer B. Risk factors for cancer 1. inheritance a. race b. gender c. family history 2. environmental factors a. history of smoking b. alcohol use c. exposure to chemical and food additives 3. lifestyle factors a. diet/obesity b. lack of exercise c. exposure to sun C. American Cancer Society signs of cancer 1. fever 2. fatigue 3. unexplained weight loss 4. pain 5. skin changes 6. new mole or change in existing mole/wart 7. change in bowel/bladder function 8. sore that does not heal/unusual bleeding/discharge 9. thickening in breast, scrotum 10. indigestion, difficulty swallowing 11. nagging cough or hoarseness
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	
Discuss cancer, including signs and symptoms and guidelines for care, as evidenced by participating in classroom discussion.	

Objectives	Content Outlines
	D. Guidelines for care of client with cancer 1. manage pain a. reposition at frequent intervals b. offer back rubs c. provide rest periods during ADLS d. report pain to supervisor for medication 2. skin care a. observe skin on regular basis b. keep skin clean and dry c. turn and reposition q2hr. 3. oral care a. provide mouth care at regular intervals b. use soft toothbrush or swabs 4. schedule rest periods 5. provide small, frequent meals 6. encourage fluid intake 7. weigh client on regular basis 8. provide nutritional supplements as ordered 9. monitor vital signs 10. provide emotional support for changes in self-image 11. encourage participation in activities to promote socialization 12. encourage participation in support groups
Identify the American Cancer Society signs of cancer as evidenced by participating in classroom discussion.	
Discuss the guidelines for caring for the client with cancer as evidenced by participating in classroom discussion.	
	E. Report the following to the appropriate supervisor 1. pain or increase in pain 2. changes in vital signs 3. any changes to the skin a. new lesions b. rashes c. red areas 4. odors 5. changes in ability to ambulate 6. chest pain 7. difficulty breathing 8. change in appetite or weight loss 9. sores or pain in mouth 10. bleeding from any opening in the body 11. nausea or vomiting 12. change in bowel or bowel patterns 13. change in urine or urinary patterns 14. change in level of consciousness
	V. Care of the client when death is imminent A. Feelings about death and dying 1. cultural a. fear of unknown b. anticipation of what has been promised 2. religious a. anticipate after-life b. no after-life c. reincarnation
Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	

Objectives	Content Outlines
	d. punishment 3. personal experience B. Stages of grief 1. Denial - refuse to accept diagnosis 2. anger a. occurs when realize they are going to die b. may be expressed at self, family, staff 3. bargaining - bargain with God or a higher power 4. depression 5. acceptance - may appear detached from situation 6. not everyone passes through all the stages of grief before they die 7. nurse aide must remember not to take client's behavior personally
Identify an understanding of the student's own feelings about death and dying as evidenced by participation in classroom discussion.	C. Rights of the dying client 1. to have visitors 2. to privacy 3. to be free of pain 4. to honest, accurate information 5. to refuse treatment
Describe the stages of grief as evidenced by participating in classroom discussion.	D. Physical changes of the dying client 1. changes in vital signs a. increased pulse b. shallow, irregular respirations c. gurgling, rattling sound to respirations d. decreased BP 2. changes in skin a. bluish b. mottled c. sweaty d. becomes cool to touch 3. urine production decreases 4. incontinent of urine and/or stool 5. client may not want to eat or drink 6. difficulty swallowing 7. decreased muscle tone 8. decreased vision 9. change in level of consciousness 10. hallucinations 11. hearing is the last sense
List physical changes that occur when death is imminent as evidenced by satisfactory participation in classroom discussion.	E. Guidelines for meeting the physical needs of the dying client 1. care of the skin a. turn and reposition q2hrs. b. keep skin clean and dry c. change soiled clothing and linen immediately 2. care of mucous membranes a. oral care q2hrs if needed

Objectives	Content Outlines
	b. moisten lips and mucous membranes as needed c. using warm, wet washcloth gently clean eyes of any accumulated crust d. apply water-based lubricant to nostrils if client is receiving oxygen therapy 3. positioning a. use positioning devices to assure proper body alignment b. turn and reposition q2hr. c. notify supervisor of pain d. elevate head of bed if client having difficulty breathing 4. comfort measures a. back rub b. soft music c. keep room well ventilated d. use soft lighting, adequate to see but not glaring e. remove soiled linens and bedpans immediately f. encourage and assist family/significant others to visit g. do not leave client alone h. remember that dying client may still have intact sense of hearing
Discuss care measures for the client when death is imminent as evidenced by participation in role-play in skills lab and classroom discussion.	
Discuss psychosocial and spiritual care measures for the client when death is imminent as evidenced by participation in classroom discussion.	F. Guidelines for meeting the psychosocial and spiritual needs of the dying client 1. do not isolate or avoid the dying client 2. provide opportunity for dying client to talk 3. be non-judgmental about client and anything he tells you 4. allow client to express his views on death and dying 5. respect client's wishes for visits from spiritual leaders 6. provide privacy for client and family/friends 7. maintain confidentially regarding anything client and/or family shares 8. provide care with compassion, understanding, patience, empathy
Discuss care measures for the family when death of the client is imminent as evidenced by participation in classroom discussion.	G. Care for the family of the dying client 1. communicate what is happening to the client 2. provide space for family members to be by themselves 3. provide time for family members to be with the client 4. permit family members to care for dying client, if they so desire 5. allow family members to verbalize feelings in a non-judgmental environment 6. permit family to follow religious rituals of their choice 7. do not be afraid to show your own emotions

Objectives

Demonstrate proper procedure for postmortem care as evidenced by Satisfactory rating on Skills Record in skills lab and in clinical setting.

Content Outlines

H. Postmortem care
1. provide for privacy
2. explain procedure to family and request they leave the room
3. remove any tubes, drains, catheters
4. gently close the eyes
5. bathe body and comb hair
6. place in clean gown or pajamas
7. place in proper body alignment
8. elevate head slightly
9. make client's room neat and tidy for the family
10. turn lights down for family
11. provide privacy and time for family to grieve
12. prepare body for funeral home to transport
13. follow facility policy for handling and removal of personal items
14. Have a witness for any personal items that is given to a family member
15. document procedure following facility policy

Unit XIII – Admission, Transfer and Discharge
(18VAC90-26-40.A.7.e.)
(18VAC90-26-40.A.2.d.)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Describe preparation of the client room prior to admission.
2. Identify areas of orientation that must be provided to the client during the admission process.
3. Describe how to care for client's personal belongings.
4. Discuss the observations that the nurse aide should make during the admission process.
5. Document the admissions process, including care of client's personal belongings, observations and vital signs.
6. Demonstrate preparing client for transfer.
7. Identify responsibilities of nurse aide during the discharge of the client.
8. Demonstrate discharge of the client, including care of personal belongings and assisting to transport to the pick-up area

Objectives	**Content Outline**
Describe preparation of client room prior to admission as evidenced by satisfactory participation in classroom discussion.	I. Admission to long-term care facility A. prepare the room 1. admission pack a. wash basin b. bedpan/urinal c. toiletry items d. water pitcher/cup 2. assemble vital sign equipment a. stethoscope b. BP cuff c. thermometer 3. open curtains/blinds 4. adjust room temperature 5. bed in low position with wheels locked
Identify areas of orientation that must be provided to the client during admission as evidenced by satisfactory participation in classroom discussion.	B. orientation to facility 1. introduce yourself, including your title 2. identify how you will work with client providing care 3. introduce roommate, if there is one 4. be friendly, polite 5. include family and significant others 6. review client rights 7. review facility rules a. meal times b. smoking policy c. visitation policy d. how to complete menu 8. tour facility a. dining area b. bathing area c. activity room and schedule d. chapel

Objectives	Content Outline
	C. orientation to client's room a. how to use the bed b. call bell c. bathroom/emergency light d. lights e. TV f. how to use telephone
Describe how to care for client's personal belongings as evidenced by satisfactory participation in classroom discussion.	D. care of personal belongings 1. complete client inventory sheet - describe all belongings completely and accurately 2. assist to label all personal items, including clothing 3. assist to unpack personal items
	E. admission process 1. wash hands 2. explain to client what you will be doing 3. provide for privacy 4. if appropriate, ask family to wait outside the room 5. obtain baseline vital signs, height, weight 6. observe a. condition of skin b. mobility c. behavior d. ability to communicate
Discuss the observations that the nurse aide should make during the admission process as evidenced by satisfactory role-play in class and skills lab.	
Document the admissions process, including care of client's personal belongings, observations and vital signs as evidenced by satisfactory participation in role-play in class and skills lab.	7. fill water pitcher with fresh water 8. have family return to room 9. make client comfortable 10. place call bell within reach and demonstrate how to use it 11. wash hands 12. document vital signs, height, weight
Discuss the importance of reporting abnormal observations or findings to the appropriate supervisor.	13. report any abnormal findings to appropriate supervisor
	II. Transfer of client A. prepare client 1. inform client of transfer as soon as you know 2. assist client to prepare for moving belongings 3. accompany client to new unit 4. provide report to new unit personal a. vital signs b. condition of skin c. mobility d. ability to communicate
Discuss important factors in preparing client for transfer from his room and/or facility as evidenced by satisfactory participation in classroom discussion.	
Demonstrate preparing client for transfer as evidenced by satisfactory participation in skills lab role-play.	4. introduce client to new unit staff 5. assist client to unpack belongings on new unit 6. make client comfortable 7. have call bell in easy reach 8. wash hands

Objectives	Content Outline
	9. document procedure 10. report any changes in the client to the appropriate supervisor
Discuss care of the client room after transfer has occurred as evidenced by satisfactory participation in classroom discussion.	B. care of room after transfer 1. strip bed 2. place all linen, used and unused in laundry hamper 3. inform housekeeping service that room is empty and ready for terminal cleaning
Identify responsibilities of nurse aide during the discharge of the client as evidenced by satisfactory participation in classroom discussion.	III. Discharge A. responsibilities of nurse aide 1. explain what you will be doing to client 2. provide for privacy 3. compare admission client inventory sheet to items being packed for discharge 4. carefully assist client/family to pack belongings 5. assist client to dress in personal clothing 6. assist client to say “Good-byes” to staff 7. using wheelchair, take client to area where family vehicle is waiting 8. lock wheels on wheelchair 9. assist client into vehicle, engage seatbelt and close door 10. return to unit with wheelchair 11. wash hands 12. document procedure
Demonstrate discharge of the client, including care of personal belongings and assisting to transport to the pick-up area as evidenced by satisfactory participation in skills lab role-play.	B. care of room after discharge 1. strip bed 2. place all linen, used and unused in laundry hamper 3. inform housekeeping service that room is empty and ready for terminal cleaning

Unit XIV – Legal and Regulatory Aspects of Practice for the Certified Nurse Aide
(18VAC90-26-40.A.8)
(18VAC90-26-40.A.10)
(18VAC90-26-40.A.7.f)

Unit Objectives:

At the end of this unit, as evidenced by a minimum grade of 80% on the unit test, the student will be able to:

1. Discuss professional behaviors of the nurse aide.
2. Review methods of conflict management.
3. Discuss the role of the Virginia Board of Nursing.
4. Discuss the OBRA requirements.
5. Discuss the different types of abuse, including the signs of abuse.
6. Discuss inappropriate nurse aide behavior, including abuse, neglect and misappropriation of client property.
7. Describe strategies the nurse aide may use to avoid inappropriate behavior.
8. Discuss the role of the mandated reporter as described in the Code of Virginia.
9. List reasons for the Virginia Board of Nursing to begin disciplinary proceedings for a certified nurse aide as identified in Regulation 18VAC90-25-100.
10. Identify the consequences of abuse, neglect and/or misappropriation of client property for a nurse aide
11. Discuss the consequences of using social media, cell phones, and/or texting that involves the client's/resident's image or likeness
12. Discuss responsibilities of the certified nurse aide to the Virginia Board of Nursing.
13. Discuss responsibilities of employers of certified nurse aides to the Virginia Board of Nursing.
14. Describe the application process for the NNAAP exam.
15. Describe what the nurse aide graduate is required to bring to the NNAAP test site the day of the test.

Objectives	**Content Outline**
Discuss professional behaviors of the nurse aide as evidenced by satisfactory participation in classroom discussion and role-play.	I. Professional behaviors of a nurse aide A. positive attitude B. maintain confidentiality and privacy 1. client information 2. staff information C. be polite and cheerful D. listen to clients E. perform assigned duties 1. in timely manner 2. to the best of your ability F. do not give or accept gifts from clients G. follow facility policies and procedures H. take directions and constructive criticism I. practice good personal hygiene J. dress neatly and appropriately K. be punctual to work L. be respectful 1. to clients 2. to staff 3. to visitors M. be dependable 1. report to work on assigned shifts 2. call in following facility policy if you will be late or are sick

Objectives	Content Outline
	3. complete assignments without having to be prompted 4. if you volunteer to perform a task, do it N. be dedicated to your position - take pride in your work O. treat clients the way you would want to be treated 1. regardless of diagnosis 2. regardless of race 3. regardless of gender 4. regardless of ethnicity P. always use appropriate language 1. do not curse 2. do not use slang 3. do not use medical terminology that client does not understand
Discuss a Code of Ethics for the nurse aide as evidenced by satisfactory participation in classroom discussion.	II. Nurse Aide Code of Ethics A. preserve life, ease suffering and work to restore client's health B. consider client's physical, mental, emotional and spiritual needs C. loyalty to employer, clients and co-workers D. provide quality care regardless of client's religious beliefs E. demonstrate equal courtesy and respect to everyone F. respect client confidentiality and dignity G. perform only those procedures that you have been trained to perform H. be willing to learn new skills and keep old skills current I. care for client as you were taught J. always be clean and professional in appearance
Review methods of conflict management as evidenced by satisfactory participation in classroom discussion.	III. Conflict management A. report conflicts to appropriate supervisor 1. conflicts between clients 2. conflicts between client and staff 3. conflicts among staff B. respect client's rights 1. right to complain without fear for their safety or care 2. right to have assistance in resolving grievances and disputes 3. right to contact the Ombudsman C. resolve conflict in professional manner 1. remain calm 2. do not be aggressive or argumentative 3. do not use inappropriate language 4. do not take client's behavior personally 5. do not act inappropriately

Objectives	Content Outline
List two (2) regulatory agencies that are involved with nurse aides as evidenced by participation in classroom discussion.	IV. Regulatory agencies for nurse aides A. Nurse Aide Training and Competency Evaluation Program (NATCEP) 1. makes rules for training and testing 2. Federal Government Omnibus Budget Reconciliation Act (OBRA) 1987 3. individual state programs assure federal rules are followed in facilities receiving Medicare/Medicaid funds 4. establishes registry to track nurse aides working in that individual state
Discuss the role of the Virginia Board of Nursing as evidenced by participation in classroom discussion.	B. Virginia Board of Nursing 1. member agency of Department of Health Professions 2. protects the welfare of the public 3. enforces the Virginia Nurse Practice Act 4. establishes and enforces Regulations for Nurse Aide Education Programs (18VAC90-26-10 et seq.) a. approves nurse aide education programs b. establishes curriculum requirements for nurse aide education programs 5. establishes and enforces Regulations Governing Certified Nurse Aides in Virginia (18VAC90-25-10 et seq.) a. establishes certification process for nurse aides b. establishes nurse aide competency standards c. maintains the Nurse Aide Registry d. denies, revokes, suspends or reinstates certification for nurse aides e. otherwise discipline nurse aide certificate holders in Virginia
Describe abuse, including the signs of abuse that the nurse aide might observe, as evidenced by satisfactory participation in classroom discussion.	V. Inappropriate behavior for the nurse aide A. abuse 1. causing physical, mental or emotional pain to client 2. failure to provide food, water, care and/or medications 3. involuntary confinement or seclusion 4. withholding Social Security checks and/or other sources of income 5. intentional mismanagement of client's money 6. intentional or unintentional posting pictures of residents on any type of social media or texting pictures of residents 7. types of abuse a. verbal b. financial c. assault – threatening to harm client d. battery – touching client without their permissior

Objectives	Content Outline
	e. domestic abuse – within the family f. sexual abuse 8. signs of abuse a. bruising, swelling, pain or other injuries b. fear and anxiety c. sudden changes in client's personality or behavior
Give examples of inappropriate nurse aide behavior, including neglect and misappropriation of client property, as evidenced by satisfactory participation in classroom discussion.	B. neglect 1. harming client physically, mentally, emotionally by failing to provide care C. misappropriation of client's property 1. deliberate misplacement, exploitation, or wrongful use of client's belongings or money without the client's consent 2. may be temporary or permanent
Describe strategies the nurse aide can use to avoid inappropriate behavior as evidenced by satisfactory participation in classroom discussion.	D. how to avoid inappropriate behavior 1. remain calm 2. do not take client's behavior personally 3. always remember there is no excuse for abusing a client 4. if you are feeling overwhelmed with assigned duties or a certain client a. discuss it with supervisor b. get help from co-workers c. make arrangements to take a break and compose yourself 5. if you see a co-worker who is feeling overwhelmed a. offer support and assistance b. encourage co-worker to report situation c. report situation to supervisor
Discuss the role of the mandated reporter as described in the Code of Virginia, including who is a mandated reporter, what must be reported, to whom it must be reported, and the penalty for not reporting as evidenced by participation in classroom discussion.	VI. Mandated reporter Authority (§63.2-1606 of Virginia Code) A. who is a mandated reporter? 1. any person licensed, certified, or registered by health regulatory boards listed in § 54.1-2503, except persons licensed by the Board of Veterinary Medicine 2. Any mental health services provider as defined in §54.1-2400.1 3. any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5 4. any guardian or conservator of an adult 5. any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity

Objectives	Content Outline
	6. any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to companion, chore, homemaker and personal care workers 7. any law-enforcement officer B. What to report 1. required to report <u>suspected</u> abuse, neglect, or exploitation of adults 60 years or older or incapacitated adults 18 years or older 2. name, age, address or location of the person Suspected being abused and as much about the suspected situation as possible 3. to be reported immediately C. where to report 1. report suspected finding to supervisor 2. local departments of social services in the city or county where the adult resides or the Virginia Department of Social Services APS hotline at 1 (888) 832-3858 D. rights of mandated reporters 1. A person who makes a report is immune from civil and criminal liability unless the reporter acted in bad faith or with a malicious purpose. 2. A person who reports has a right to have his/her identity kept confidential unless consent to reveal his/her identity is given or unless the court orders that the identity of the reporter be revealed. 3. A person who reports has a right to hear from the investigating local department of social services confirming that the report was investigated. E. failure to report suspected abuse 1. punishable by a civil money penalty of not more than $500 for the first failure and not less than $100 nor more than $1,000 for subsequent failures 2. failure to report may also subject a mandated reporter to administrative action by the appropriate licensing authority 3. not obligated to report if mandated reporter has actual knowledge the same matter has been already reported to APS hotline
	VII. Disciplinary proceedings against a Certified Nurse Aide A. regulation 18VAC90-25-100 1. disciplinary provisions for nurse aides 2. examples of allegations investigated by Virginia Board of Nursing a. unprofessional conduct 1. abuse 2. neglect 3. abandoning client
List reasons why the Virginia Board of Nursing would begin disciplinary proceedings for a Certified Nurse Aide as evidenced by participation in classroom discussion.	

Objectives	Content Outline
	4. falsifying documentation 5. obtaining money or property of a client by fraud, misrepresentation or duress 6. entering into an unprofessional relationship with a client 7. violating privacy of client information 8. taking supplies or equipment or drugs for personal or other unauthorized use 9. b. performing acts outside the scope of practice for a nurse aide in Virginia c. providing false information during a Virginia Board of Nursing investigation B. consequences of abuse (including texting or posting pictures to social media), neglect, exploitation conviction 1. permanent bar to employment in health care 2. revocation of certification 3. possible imprisonment
Identify the consequences of abuse, neglect, and exploitation conviction as evidenced by participation in classroom discussion.	VIII. Responsibilities of certified nurse aide to the Virginia Board of Nursing (BON) (18VAC90-25 -10 et seq) A. Requirements of approved nurse aide education program B. notify BON of name change C. notify BON of address change D. renew certification every year E. Disciplinary provisions
Discuss responsibilities and requirements of certified nurse aides per Virginia Board of Nursing regulations as evidenced by participation in classroom discussion.	IX. Responsibilities of employers of certified nurse aides to the ~~Virginia~~ BON A. notify BON of unprofessional/unethical conduct by the nurse aide B. notify BON of disciplinary actions taken against a certified nurse aide
Discuss responsibilities of employers of nurse aides to the Virginia Board of Nursing as evidenced by participation in classroom discussion.	X. Obtaining Certification A. Academic requirements 1. Successfully complete nurse aide education program approved by ~~Virginia~~ BON 2. enrolled in Registered Nurse or Practical Nursing education program and have completed at least one (1) clinical course with a minimum of 40 clinical hours providing direct client care 3. completion of Registered Nurse or Practical Nursing education program 4. previously certified nurse aide in Virginia who allowed certificate to expire
Describe the process of applying for the NNAAP examination as evidenced by successfully completing the NNAAP application.	

Objectives	Content Outline
DID THIS PROCESS CHANGE? Describe what the nurse aide graduate is required to bring to the testing site the day of the NNAAP exam as evidenced by satisfactory participation in classroom discussion.	B. Required accompanying documentation 1. copy of certificate of completion from nurse aide education program 2. letter (on official educational program letterhead) from the program director documenting attendance in nursing education program C. Complete Examination Application 1. receive from nurse aide education program 2. download from Pearson VUE a. www.pearsonvue.com 3. call PearsonVUE a. 800-758-6028 4. completed application valid for twelve (12) months from the date of approval or the original receipt date 5. failure to accurately answer questions on application is considered falsification of an application and grounds for denial of certification or disciplinary action by the BON even after successful completion of the NNAAP exam. D. Submit in one package 1. application 2. required accompanying documentation 3. fee E. Exam scheduling 1. PearsonVUE will schedule the test date 2. you will receive, in the mail, Authorization to Test Notice F. Day of the NNAAP exam 1. arrive 30 minutes early 2. provide proper identification a. one (1) current picture identification b. one additional current identification c. both identifications must have a signature d. name on both identifications must be identical to name on NNAAP application 3. also bring a. three (3) no. 2 pencils b. eraser c. watch with a second hand

Adult Protective Services (APS)
http://dss.virginia.gov/files/division/dfs/as/aps/intro_page/learn_more/abuse/Stop_Adult_Abuse_2017.pdf

Aging Related Sites

Age in Action Newsletter http://www.sahp.vcu.edu/departments/vcoa/newsletter/
Age in Action is a 20-page quarterly published jointly by the Virginia Center on Aging and the Virginia Department for the Aging. Its target audience includes professionals in the field of aging, gerontologists, geriatricians, health professionals and administrators, adult home and community professionals, and others interested in aging-related education and research in the Commonwealth of Virginia

Virginia Division for the Aging http://www.vda.virginia.gov/

CNA Educational Sites

Abdominal Thrusts https://youtu.be/A80wU5UgS-A
4CNAs The Online Magazine for Certified Nursing Assistants
CNA Articles

- Alzheimers Disease / Dementia
- CNA Education
- CNA Stress / Burnout
- CNA Test and Exam
- CNA Tips
- Disease / Illnesses
- Elder Abuse
- Fall Prevention
- Hospice / Palliative Care
- Home Health Aide
- Heart Disease
- New CNA
- Night Shift CNAs
- Patient Care
- Restorative Nursing Assistant

CNA Practice Tests All States http://www.4cnas.com/CNA-Practice-Tests.html
CNA Practice Test Virginia NNAAP https://www.asisvcs.com/publications/pdf/069912.pdf
CNA Skills Videos (please review for accuracy and appropriateness)
http://www.4cnas.com/CNAskillvideos.html
Pearson Vue, Virginia Nurse Aides http://www.pearsonvue.com/va/nurseaides/
VBON On-Site Visit PACKAGE SUBMISSION CHECKLIST

On-Site Visit Report Form for Nurse Aide Education Programs

CNA Association and Organizations

National Association of Health Care Assistants https://nahcacareforce.org/
The mission of the **National Association of Health Care Assistants** (NAHCA) is to elevate the professional standing and performance of caregivers through recognition, advocacy, education and empowerment while building a strong alliance with health care providers to maximize success and quality patient care

National Network of Career Nursing Assistants National Network of Career Nursing Assistants http://cna-network.org/
Mission promoting recognition, education, research, advocacy and peer support development for nursing assistants in nursing homes and other long-term care settings.
NATIONAL HONOR SOCIETY (TWENTY YEAR CLUB) National Honor Society Application

1. To recognize and validate the nursing assistants who provide consistency and predictability to the people in their care.
2. To identify and address career growth, training and safety needs and other issues relating to experienced nursing assistants.
3. To foster community understanding of the role, responsibilities, and value of experienced nursing assistants in long-term care services.
4. To provide a peer connection by, for and with, career nursing assistants across the country

Just for Nursing Assistants http://www.justfornursingassistants.com/index.php
Just for Nursing Assistants was established by Linda Leekley, a registered nurse. Linda has devoted the last two decades of her career to the educational needs of certified nursing assistants

Dementia Care Tips

Alzheimer's Association http://www.alz.org/

An Interdisciplinary Dementia Approach in Long-Term Care
https://www.crisisprevention.com/Blog/November-2010/An-Interdisciplinary-Dementia-Approach-in-Long-Ter

Helping People with Alzheimer's Disease Stay Physically Active
Helping People with Alzheimer's Disease Stay Physically Active - Go4Life Tip Sheet (PDF, 850K)
HealthCare Interactive Dementia Care Training
http://www.hcinteractive.com/ProfessionalCARES?GroupID=3

National Council of Certified Dementia Practitioners http://www.nccdp.org/train.htm

Infection Control

Association for Professionals in Infection Control and Epidemiology
https://apic.org/For-Media/News-Releases/Article?id=063cdb1f-1ac9-477d-a768-1428e6e1c5ee
The Association for Professionals in Infection Control and Epidemiology (APIC) is the leading professional association for infection preventionists (IPs) with more than 15,000 members. Their mission is to create a safer world through the prevention of infection.

INFECTION CONTROL GUIDELINES FOR LONG TERM CARE FACILITIES

Tracking Infections in Long-term Care Facilities
https://www.cdc.gov/nhsn/ltc/index.html

Long-Term Care Issues and Resources
National Care Planning Council (NCPC) https://www.longtermcarelink.net/a13information.htm
Long Term Care Resources for seniors, caregivers, and providers

National Consumer Voice for Quality Long-Term Care http://theconsumervoice.org/home
National Consumer Voice was formed as NCCNHR (National Citizens' Coalition for Nursing Home Reform) in 1975 because of public concern about substandard care in nursing homes.
Below, is information on important long-term care topics:

- Deemed Status
- Direct Care Workforce Issues
- Elder Abuse
- Financial Exploitation
- Infection Prevention
- LGBT Elders
- Long-Term Care Provisions in the Affordable Care Act
- Nursing Home Transtions
- Protecting Long-Term Care Consumers from the Dangers of Bed Rails
- Residents' Rights
- Transfer, Discharge & Transitions

Workforce Resources
National Clearinghouse on the Direct Care Workforce https://phinational.org/
The National Clearinghouse on the Direct Care Workforce is a national online library for people in search of solutions to the direct-care staffing crisis in long-term care. A project of PHI, the Clearinghouse includes government and research reports, news, issue briefs, fact sheets, and other information on topics such as recruitment, career advancement supervision, workplace culture, and caregiving practices
OIG Nurse Aide Training Recommendations https://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf
Safety Data Sheets (SDS) https://www.osha.gov/Publications/OSHA3514.html

Virginia Adult Care Education http://vacetraining.com/
***Virginia Adult Care Education**, LLC* is committed to providing quality education and training programs for persons who care for the elderly. Programs are current, well-researched and presented by health-care professionals who are specialists in their field of practice. This company is well- respected throughout the Commonwealth for commitment to improving the care of the elderly by providing high quality, relevant training

Here are some more articles, videos & websites:

Pioneer Network
https://www.pioneernetwork.net/

The Green House Project
http://www.thegreenhouseproject.org/

The Green House Project Youtube
https://www.youtube.com/results?search_query=The+Green+House+project

Action Pact (The Household Model)
http://actionpact.com/household/household_model

The Household Model Youtube
https://www.youtube.com/playlist?list=PLD0EE15E8B9E4EC54

The Eden Alternative
http://www.edenalt.org/about-the-eden-alternative/

https://www.nhqualitycampaign.org/goalDetail.aspx?g=pcc

Leading Age Article: "Building a Person-Centered Culture for Dementia Care"
Http://www.leadingage.org/Building_a_Person-Centered_Culture_for_Dementia_Care_V3N5.aspx

Scripps Gerontology Center, Video-Changing Minds: An Introduction to Person-Centered Care
http://miamioh.edu/cas/academics/centers/scripps/research/tra

Abuse and Neglect of Nursing Home Residents

MANDATED REPORTS GUIDE
http://www.dss.virginia.gov/files/division/dfs/mandated_reporters/aps/resources_guidance/about_mr.pdf

LIST OF MANDATED REPORTERS

http://www.dss.virginia.gov/files/division/dfs/mandated_reporters/aps/resources_guidance/mandated_reporters.pdf

Signs of Nursing Home Abuse and Neglect

Nearly two million Americans live in long-term care facilities, and abuse and neglect against the elderly are national concerns. Federal nursing home regulations state that "the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." These regulations define nursing home abuse and neglect as:

- **Abuse**: an intentional infliction of injury, unreasonable confinement, intimidation, care/service deprivation or punishment that results in physical harm, pain or mental anguish
- **Neglect**: a failure, intentional or not, to provide a person with the care and services necessary to ensure freedom from harm or pain; a failure to react to a potentially dangerous situation resulting in resident harm or anxiety

Types of Abuse and Neglect

- Assault and battery (including kicking, slapping, pinching, pushing, shaking, beating, threats and verbal or emotional abuse)
- Lack of care for existing medical problems
- Prolonged or continual deprivation of food or water
- Rape or other forms of sexual assault or battery
- Unreasonable physical restraint or seclusion
- Use of a physical or chemical restraint or psychotropic medication for any purpose not consistent with that authorized by a physician

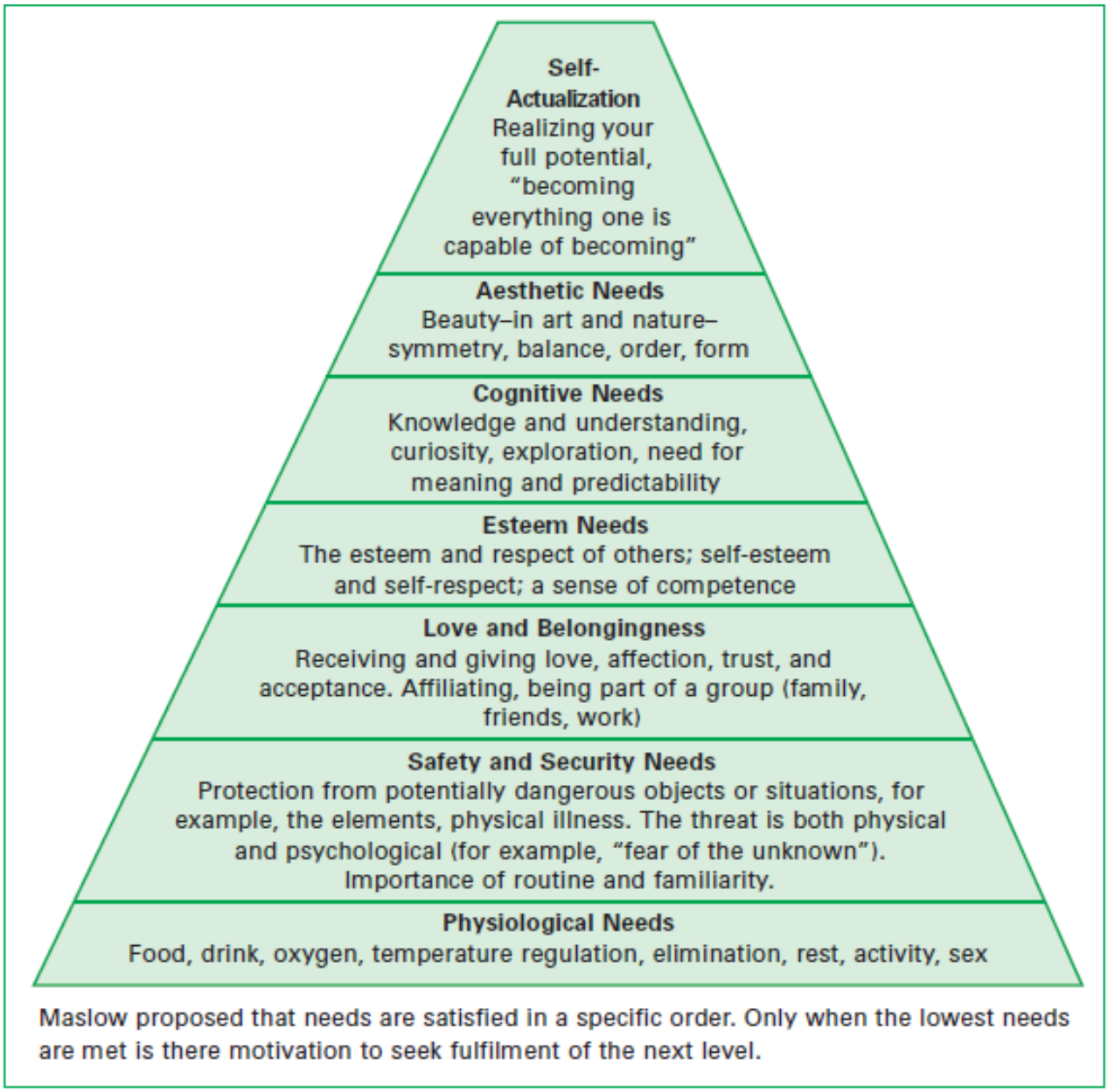
Common Signs of Physical or Verbal Abuse and Neglect

- Bed injuries/asphyxiation
- Dehydration
- Emotionally upset or agitated, extremely withdrawn and non-communicative
- Falls, fractures or head injuries
- Infections
- Instances of wandering/elopement
- Malnutrition
- Pressure ulcers (bed sores)
- Rapid weight loss or weight gain; signs of malnutrition
- Reluctance to speak in staff members' presence
- Unexplained or unexpected death of the resident
- Unexplained injuries such as wounds, cuts, bruises or welts in various stages of healing
- Unsanitary and unclean conditions
- Unusual or sudden changes in behavior (fear of being touched, sucking, biting, rocking)
- Wanting to be isolated from others

Other Warning Signs of Physical or Verbal Abuse and Neglect

- Injuries requiring emergency treatment or hospitalization
- Any incident involving broken bones, especially a fractured hip

- Any injury or death occurring during or shortly after an episode of wandering (including outside the facility)
- Heavy medication or sedation
- One resident injures another resident
- Resident is frequently ill, and the illnesses are not promptly reported to the physician and family



Maslow proposed that needs are satisfied in a specific order. Only when the lowest needs are met is there motivation to seek fulfilment of the next level.

ABBREVIATIONS AND TERMINOLOGY

Infection Control Definitions

1. **MDRO** (multidrug-resistant organism) – microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents

2. **MRSA –** Methicillin-Resistant Staphylococcus Aureus

3. **VRE –** Vancomycin-Resistant Enterococcus

4. **MDR-GNB –** Multidrug Resistant Gram Negative Bacilli

5. **MDRSP –** Multidrug-Resistant Streptococcus Pneumoniae

6. **Contact Precautions -** are a set of practices used to prevent transmission of infectious agents that are spread by direct or indirect contact with the resident or the resident's environment.

7. **Asepsis –** free from germs

8. **Infection –** Invasion of a bodily part by disease causing microorganisms (pathogens)

9. **Infectious Disease –** disease caused by some parasitic organism and transmitted from one person to another by transfer of the organism

10. **Contagious Disease –** disease readily transmitted by direct or indirect contact

11. **HAI – (hospital acquired infection)** any infection acquired while in the hospital or a facility

12. **CAI – (community acquired infection) –** any infection acquired in the community

13. **Isolation –** the act of separating or setting residents\patients apart from others. It is now know as **Precautions**

14. **Microorganisms –** small living body not visible to the naked eye

15. **Contamination –** to make something unclean or unsterile

16. **Disinfection –** destroying ***MOST*** disease-carrying organisms

FREQUENTLY USED ABBREVIATIONS

A.C.	Before Meals
ABD	Abdomen
AD LIB	As desired
ADL's	Activities of daily living
AMB	Ambulate (To walk)
AROM	Active range of motion
B&B	Bowel and bladder
BID	Twice a day
BM	Bowel movement
BP	Blood Pressure
BRP	Bathroom Privilege
c	With
cc	Cubic Centimeters
C/O	Complains Of
CVA	Cerebral Vascular Accident (Stroke)
DC	Discontinue
DNR	Do Not Resuscitate
DOB	Date of Birth
Dx	Diagnosis
F.F	Force Fluids
Fx	Fracture
HS	Hours of Sleep (bedtime)
HOB	Raise Head of Bed
I & O	Intake and Output
IV	Intravenous
N & V	Nausea and Vomiting
NPO	Nothing by Mouth
P.O.	By Mouth

O2	Oxygen
OOB	Out of Bed
P.C.	After Meals
Prn	When Needed
PROM	Passive Range of Motion
PT	Physical Therapy
qd	Every Day
qid	Four Times a Day
qod	Every Other Day
qh	Every Hour
q2h	Every Two Hours
Rx	Prescription
S	Without
SBA	Standby Assist
SOB	Shortness of Breath
STAT	Immediately
TID	Three Times a Day
UA	Urinalysis
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection
VS	Vital Signs
W/C	Wheelchair
Wt	Weight

Stop and Watch Interact Early Warning Tool for CNAs to observe and report status changes in geriatric clients/residents. This is being implemented in many nursing home facilities. The tool is endorsed by the Centers for Medicare and Medicaid Services (CMS). It is one of the tools I will be using in my doctoral project.

Stop and Watch
Early Warning Tool

INTERACT
Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

Source: Ouslander JG, Shutes J. INTERACT [website]. [cited 2016 Feb 10]. Boca Raton (FL): Florida Atlantic University. Available from Internet: http://interact2.net/index.aspx

SKILLS LISTING FOR THE 2018 NNAAP® for Nurse Aide Candidates Studying for the NNAAP®
Skills Evaluation The NNAAP® Skills List for 2018 is a list of skills that a nurse aide candidate may be asked to demonstrate during the Skills Evaluation. Within each skill is a list of the steps that should be performed in order to demonstrate that skill. Many skills have steps highlighted in bold type—these are Critical Element Steps. If a nurse aide candidate leaves out a Critical Element Step or does not perform a Critical Element Step properly, the candidate will not pass the skill. Also, a candidate who performs only the Critical Element Step correctly in a skill does not automatically pass that skill. A pre-determined number of steps must be correctly demonstrated to meet the passing standard (or cut score) for each skill.

SKILL 1 — HAND HYGIENE (HAND WASHING)

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

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

SKILL 3 — ASSISTS TO AMBULATE USING TRANSFER BELT
1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2 Privacy is provided with a curtain, screen, or door
3 Before assisting to stand, client is wearing non-skid shoes/footwear
4 Before assisting to stand, bed is at a safe level
5 Before assisting to stand, checks and/or locks bed wheels
6 Before assisting to stand, client is assisted to sitting position with feet flat on the floor
7 Before assisting to stand, applies transfer belt securely at the waist over clothing/gown

8 Before assisting to stand, provides instructions to enable client to assist in standing including prearranged signal to alert client to begin standing
9 Stands facing client positioning self to ensure safety of candidate and client during transfer. Counts to three (or says other prearranged signal) to alert client to begin standing
10 On signal, gradually assists client to stand by grasping transfer belt on both sides with an upward grasp (candidate's hands are in upward position), and maintaining stability of client's legs by standing knee to knee, or toe to toe with client
11 Walks slightly behind and to one side of client for a distance of ten (10) feet, while holding onto the belt
12 Assists client to bed and removes transfer belt
13 Signaling device is within reach and bed is in low position
14 After completing skill, wash hands

SKILL 4 — ASSISTS WITH USE OF BEDPAN
1 Explains procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2 Privacy is provided with a curtain, screen, or door
3 Before placing bedpan, lowers head of bed
4 Puts on clean gloves before placing bedpan under client
5 Places bedpan correctly under client's buttocks
6 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
7 After positioning client on bedpan and removing gloves, raises head of bed
8 Toilet tissue is within reach
9 Hand wipe is within reach and client is instructed to clean hands with hand wipe when finished
10 Signaling device within reach and client is asked to signal when finished
11 Puts on clean gloves before removing bedpan
12 Head of bed is lowered before bedpan is removed
13 Ensures client is covered except when placing and removing bedpan
14 Empties and rinses bedpan and pours rinse into toilet
15 Places bedpan in designated dirty supply area
16 Removes and disposes of gloves (without contaminating self) into waste container and washes hands
17 Signaling device is within reach and bed is in low position

SKILL 5 — CLEANS UPPER OR LOWER DENTURE
1 Puts on clean gloves before handling denture
2 Bottom of sink is lined and/or sink is partially filled with water before denture is held over sink
3 Rinses denture in moderate temperature running water before brushing them
4 Applies denture toothpaste to toothbrush
5 Brushes all surfaces of denture
6 Rinses all surfaces of denture under moderate temperature running water
7 Rinses denture cup and lid
8 Places denture in denture cup with moderate temperature water/solution and places lid on cup
9 Rinses toothbrush and places in designated toothbrush basin/container
10 Maintains clean technique with placement of toothbrush and denture
11 Sink liner is removed and disposed of appropriately and/or sink is drained
12 Removes and disposes of gloves (without contaminating self) into waste container and washes hands

SKILL 6 — COUNTS AND RECORDS RADIAL PULSE
1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2 Places fingertips on thumb side of client's wrist to locate radial pulse

3 Count beats for one full minute
4 Signaling device is within reach
5 Before recording, washes hands
6 Records pulse rate within plus or minus 4 beats of evaluator's reading

SKILL 7 — COUNTS AND RECORDS RESPIRATIONS
1 Explains procedure (for testing purposes), speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2 Counts respirations for one full minute
3 Signaling device is within reach
4 Before recording, washes hands
5 Records respiration rate within plus or minus 2 breaths of evaluator's reading

SKILL 8 — DONNING AND REMOVING PPE (GOWN AND GLOVES)
1 Picks up gown and unfolds
2 Facing the back opening of the gown places arms through each sleeve
3 Fastens the neck opening
4 Secures gown at waist making sure that back of clothing is covered by gown (as much as possible)
5 Puts on gloves
6 Cuffs of gloves overlap cuffs of gown
7 Before removing gown, with one gloved hand, grasps the other glove at the palm, remove glove
8 Slips fingers from ungloved hand underneath cuff of remaining glove at wrist, and removes glove turning it inside out as it is removed
9 Disposes of gloves into designated waste container without contaminating self
10 After removing gloves, unfastens gown at waist and neck
11 After removing gloves, removes gown without touching outside of gown
12 While removing gown, holds gown away from body without touching the floor, turns gown inward and keeps it inside out
13 Disposes of gown in designated container without contaminating self
14 After completing skill, washes hands

SKILL 9 — DRESSES CLIENT WITH AFFECTED (WEAK) RIGHT ARM 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Asks which shirt he/she would like to wear and dresses him/her in shirt of choice 4 Avoids overexposure of client by ensuring client's chest is covered
5 Removes gown from the left (unaffected) side first, then removes gown from the right (affected/weak) side 6 Before dressing client, disposes of gown into soiled linen container 7 Assists to put the right (affected/weak) arm through the right sleeve of the shirt before placing garment on left (unaffected) arm 8 While putting on shirt, moves body gently and naturally, avoiding force and overextension of limbs and joints 9 Finishes with clothing in place 10 Signaling device is within reach and bed is in low position 11 After completing skill, washes hands

SKILL 10 — FEEDS CLIENT WHO CANNOT FEED SELF 1 Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Before feeding, looks at name card on tray and asks client to state name 3 Before feeding client, client is in an upright sitting position (75-90 degrees) 4 Places tray where the food can be easily seen by client 5 Candidate cleans client's hands before beginning feeding 6 Candidate sits in a chair facing client during feeding 7 Tells client what foods and beverage are on tray 8 Asks client what he/she would like to eat first 9 Using spoon, offers client one bite of each type of food on tray, telling client the content of each spoonful 10 Offers beverage at least once during meal 11

Candidate asks client if they are ready for next bite of food or sip of beverage 12 At end of meal, candidate cleans client's mouth and hands 13 Removes food tray 14 Leaves client in upright sitting position (75-90 degrees) with signaling device within client's reach 15 After completing skill, washes hands

SKILL 11 — GIVES MODIFIED BED BATH (FACE AND ONE ARM, HAND AND UNDERARM) 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Removes gown and places directly in soiled linen container while ensuring client's chest and lower body is covered 4 Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water 5 Puts on clean gloves before washing client. 6 Beginning with eyes, washes eyes with wet washcloth (no soap), using a different area of the washcloth for each stroke, washing inner aspect to outer aspect then proceeds to wash face
7 Dries face with dry cloth towel/washcloth 8 Exposes one arm and places cloth towel underneath arm 9 Applies soap to wet washcloth 10 Washes fingers (including fingernails), hand, arm, and underarm keeping rest of body covered 11 Rinses and dries fingers, hand, arm, and underarm 12 Moves body gently and naturally, avoiding force and over-extension of limbs and joints 13 Puts clean gown on client 14 Empties, rinses, and dries basin 15 Places basin in designated dirty supply area 16 Disposes of linen into soiled linen container 17 Avoids contact between candidate clothing and used linens 18 Removes and disposes of gloves (without contaminating self) into waste container and washes hands 19 Signaling device is within reach and bed is in low position

SKILL 12* — MEASURES AND RECORDS ELECTRONIC BLOOD PRESSURE *STATE SPECIFIC (EVALUATOR: DO NOT SUBSTITUTE THIS SKILL FOR SKILL 23 'MANUAL BLOOD PRESSURE')
~~1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible~~
~~2 Privacy is provided with a curtain, screen, or door~~
~~3 Has client assume a comfortable lying or sitting position~~
~~4 Client's arm is positioned at level of heart with palm up and upper arm is exposed~~
~~5 Selects appropriate cuff size~~
~~6 Feels for brachial artery on inner aspect of arm, at bend of elbow~~
~~7 Places blood pressure cuff snugly on client's upper arm and sensor/arrow is over the brachial artery site~~
~~8 Turns on the machine and ensures device is functioning. If the machine has different settings for infants, children, and adults, selects the appropriate setting~~
~~9 Pushes start button. If cuff inflates to more than 200 mm Hg then stops machine and uses cuff on client's other arm~~
~~10 Waits until the blood pressure reading appears on the screen and for the cuff to deflate, then removes the cuff~~
~~11 Signaling device is within reach~~
~~12 Before recording, washes hands~~
~~13 After obtaining reading using BP cuff, records both systolic and diastolic pressures exactly as displayed on the digital screen~~

SKILL 13 — MEASURES AND RECORDS URINARY OUTPUT 1 Puts on clean gloves before handling bedpan 2 Pours the contents of the bedpan into measuring container without spilling or splashing urine outside of container 3 Rinses bedpan and pours rinse into toilet 4 Measures the amount of urine at eye level with container on flat surface (if between measurement lines, round up to nearest 25 ml/cc) 5 After measuring urine, empties contents of measuring container into toilet 6 Rinses measuring container and pours rinse into toilet 7 Before recording output, removes and disposes of gloves (without contaminating self) into waste container and washes hands 8 Records contents of container within plus or minus 25 ml/cc of evaluator's reading

SKILL 14 — MEASURES AND RECORDS WEIGHT OF AMBULATORY CLIENT 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Client has non-skid

shoes/footwear on before walking to scale 3 Before client steps on scale, candidate sets scale to zero 4 Asks client to step on center of scale and obtains client's weight 5 Asks client to step off scale 6 Before recording, washes hands 7 Records weight based on indicator on scale. Weight is within plus or minus 2 lbs of evaluator's reading (If weight recorded in kg weight is within plus or minus 0.9 kg of evaluator's reading)

SKILL 15 — PERFORMS MODIFIED PASSIVE RANGE OF MOTION (PROM) FOR ONE KNEE AND ONE ANKLE 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Ensures that client is supine in bed and instructs client to inform candidate if pain is experienced during exercise 4 While supporting the leg at knee and ankle, bends the knee and then returns leg to client's normal position (flexion/ extension) (AT LEAST 3 TIMES unless pain is verbalized). Moves joints gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain. 5 While supporting the foot and ankle close to the bed, pushes/pulls foot toward head (dorsiflexion), and pushes/pulls foot down, toes point down (plantar flexion) (AT LEAST 3 TIMES unless pain is verbalized). Moves joints gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain.
6 Signaling device is within reach and bed is in low position 7 After completing skill, washes hands

SKILL 16 — PERFORMS MODIFIED PASSIVE RANGE OF MOTION (PROM) FOR ONE SHOULDER 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Instructs client to inform candidate if pain experienced during exercise 4 While supporting arm at the elbow and at the wrist, raises client's straightened arm from side position upward toward head to ear level and returns arm down to side of body (flexion/extension) (AT LEAST 3 TIMES unless pain is verbalized). Moves joint gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain. 5 While supporting arm at the elbow and at the wrist, moves client's straightened arm away from the side of body to shoulder level and returns to side of body (abduction/adduction) (AT LEAST 3 TIMES unless pain is verbalized). Moves joint gently, slowly and smoothly through the range of motion, discontinuing exercise if client verbalizes pain. 6 Signaling device is within reach and bed is in low position 7 After completing skill, washes hands

SKILL 17 — POSITIONS ON SIDE 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Before turning, lowers head of bed 4 Raises side rail on side to which body will be turned 5 Candidate assists client to slowly roll onto side toward raised side rail 6 Places or adjusts pillow under head for support 7 Candidate repositions arm and shoulder so that client is not lying on arm 8 Supports top arm with supportive device 9 Places supportive device behind client's back 10 Places supportive device between legs with top knee flexed; knee and ankle supported 11 Signaling device is within reach and bed is in low position 12 After completing skill, washes hands

SKILL 18 — PROVIDES CATHETER CARE FOR FEMALE 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water
4 Puts on clean gloves before washing 5 Places linen protector under perineal area including buttocks before washing 6 Exposes area surrounding catheter (only exposing client between hip and knee) 7 Applies soap to wet washcloth 8 While holding catheter at meatus without tugging, cleans at least four inches of catheter from meatus, moving in only one direction, away from meatus, using a clean area of the washcloth for each stroke 9 While holding catheter at meatus without tugging, using a clean washcloth, rinses at least four inches of catheter from meatus, moving only in one direction, away from meatus, using a clean area of the washcloth for each stroke 10 While holding catheter at meatus without tugging, dries at least four inches of catheter moving away

from meatus using a dry cloth towel/washcloth 11 Empties, rinses, and dries basin 12 Places basin in designated dirty supply area 13 Disposes of used linen into soiled linen container and disposes of linen protector appropriately 14 Avoids contact between candidate clothing and used linen 15 Removes and disposes of gloves (without contaminating self) into waste container and washes hands 16 Signaling device is within reach and bed is in low position

SKILL 19 — PROVIDES FOOT CARE ON ONE FOOT 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water 4 Basin is in a comfortable position for client and on protective barrier 5 Puts on clean gloves before washing foot 6 Client's bare foot is placed into the water 7 Applies soap to wet washcloth 8 Lifts foot from water and washes foot (including between the toes) 9 Foot is rinsed (including between the toes) 10 Dries foot (including between the toes) with dry cloth towel/washcloth 11 Applies lotion to top and bottom of foot (excluding between the toes) removing excess with a towel/washcloth 12 Supports foot and ankle during procedure 13 Empties, rinses, and dries basin 14 Places basin in designated dirty supply area 15 Disposes of used linen into soiled linen container 16 Removes and disposes of gloves (without contaminating self) into waste container and washes hands 17 Signaling device is within reach

SKILL 20 — PROVIDES MOUTH CARE 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Before providing mouth care, client is in upright sitting position (75-90 degrees) 4 Puts on clean gloves before cleaning mouth 5 Places cloth towel across chest before providing mouth care 6 Secures cup of water and moistens toothbrush 7 Before cleaning mouth, applies toothpaste to moistened toothbrush 8 Cleans mouth (including tongue and all surfaces of teeth), using gentle motions 9 Maintains clean technique with placement of toothbrush 10 Candidate holds emesis basin to chin while client rinses mouth 11 Candidate wipes mouth and removes clothing protector 12 Disposes of used linen into soiled linen container 13 Rinses toothbrush and empties, rinses, and dries basin 14 Removes and disposes of gloves (without contaminating self) into waste container and washes hands 15 Signaling device is within reach and bed is in low position

SKILL 21 — PROVIDES PERINEAL CARE (PERI-CARE) FOR FEMALE 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water 4 Puts on clean gloves before washing perineal area 5 Places pad/ linen protector under perineal area including buttocks before washing 6 Exposes perineal area (only exposing between hips and knees) 7 Applies soap to wet washcloth 8 Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke 9 Using clean washcloth, rinses soap from genital area, moving from front to back, while using a clean area of the washcloth for each stroke 10 Dries genital area moving from front to back with dry cloth towel/washcloth 11 After washing genital area, turns to side, then washes rectal area moving from front to back using a clean area of washcloth for each stroke. 12 Using clean washcloth, rinses soap from rectal area, moving from front to back, while using a clean area of the washcloth for each stroke 13 Dries rectal area moving from front to back with dry cloth towel/washcloth 14 Repositions client 15 Empties, rinses, and dries basin 16 Places basin in designated dirty supply area 17 Disposes of used linen into soiled linen container and disposes of linen protector appropriately 18 Avoids contact between candidate clothing and used linen 19 Removes and disposes of gloves (without contaminating self) into waste container and washes hands 20 Signaling device is within reach and bed is in low position

SKILL 22 — TRANSFERS FROM BED TO WHEELCHAIR USING TRANSFER BELT 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Privacy is provided with a curtain, screen, or door 3 Before assisting to stand, wheelchair is positioned alongside of bed, at head of bed facing foot or foot of bed facing head 4 Before assisting to stand, footrests are folded up or

removed 5 Before assisting to stand, locks wheels on wheelchair 6 Before assisting to stand, bed is at a safe level 7 Before assisting to stand, checks and/or locks bed wheels 8 Before assisting to stand, client is assisted to a sitting position with feet flat on the floor 9 Before assisting to stand, client is wearing shoes 10 Before assisting to stand, applies transfer belt securely at the waist over clothing/gown 11 Before assisting to stand, provides instructions to enable client to assist in transfer including prearranged signal to alert when to begin standing 12 Stands facing client positioning self to ensure safety of candidate and client during transfer. Counts to three (or says other prearranged signal) to alert client to begin standing 13 On signal, gradually assists client to stand by grasping transfer belt on both sides with an upward grasp (candidates hands are in upward position) and maintaining stability of client's legs by standing knee to knee, or toe to toe with the client 14 Assists client to turn to stand in front of wheelchair with back of client's legs against wheelchair 15 Lowers client into wheelchair 16 Positions client with hips touching back of wheelchair and transfer belt is removed 17 Positions feet on footrests 18 Signaling device is within reach 19 After completing skill, washes hands

SKILL 23* — MEASURES AND RECORDS MANUAL BLOOD PRESSURE *STATE SPECIFIC (EVALUATOR: DO NOT SUBSTITUTE THIS SKILL FOR SKILL 12 'ELECTRONIC BLOOD PRESSURE') 1 Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible 2 Before using stethoscope, wipes bell/ diaphragm and earpieces of stethoscope with alcohol 3 Client's arm is positioned with palm up and upper arm is exposed 4 Feels for brachial artery on inner aspect of arm, at bend of elbow 5 Places blood pressure cuff snugly on client's upper arm, with sensor/arrow over brachial artery site 6 Earpieces of stethoscope are in ears and bell/ diaphragm is over brachial artery site 7 Candidate inflates cuff between 160mm Hg to 180 mm Hg. If beat heard immediately upon cuff deflation, completely deflate cuff. Re-inflate cuff to no more than 200 mm Hg 8 Deflates cuff slowly and notes the first sound (systolic reading), and last sound (diastolic reading) (If rounding needed, measurements are rounded UP to the nearest 2 mm of mercury) 9 Removes cuff 10 Signaling device is within reach 11 Before recording, washes hands 12 After obtaining reading using BP cuff and stethoscope, records both systolic and diastolic pressures each within plus or minus 8 mm of evaluator's reading