**Nursing Assistant Curriculum Map**

At the completion of each Unit the student will be able to:

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| **Class Day** | **Learning Outcomes (Goals)** | **Content Outline** | **Learning Activities** | **Time Allotted** |
| **Day 1** |  | Course Orientation  Introductions:  Students  Instructors  The role of Student Services  Review:  Textbook/Workbook  Forms/Exams/Clinical  Policies & Procedures |  | 60 Minutes |
| **Unit 1**  **Health**  **Care**  **Settings** | 1.1 Describe healthcare settings, including organization, structure, and essential functions.  1.2 Define the role of each member of the health care team.  1.3 State the role of the NA in the admission, discharge, and transfer process of patients.  1.4 Describe Nursing Care Patterns  1.5 Identify health care payment sources.  1.6 Identify methods of maintaining safety and quality in resident care. | Heath care Settings  Acute Care (Hospital)  In-patient Care  Ambulatory Care (Out-patient Care)  Subacute Care  Hospice Care  Long-Term Care Centers  Assisted Living Residences  Nursing Centers  Skilled Care (Rehabilitation)  Memory Care  Home Care  Roles of Members of the Health Care Team  Resident/Family  Registered Nurse (RN)  Licensed Practical Nurse  (LPN)  Advanced Practice Nurse  (APRN)  Certified Nursing Assistant (CNA/LNA)  Physician  Therapists – PT, OT, SLP  Registered Dietitian (RDT)  Social Worker  Activity Director  Role of the NA in admitting a patient to a facility:   * Prepare the room. * Greet the patient by name. * Secure the patient’s belongings. * Orient the patient to the room and call system. * Orient the patient to activities, such as mealtime. * Communicate observations and resident patient response to the nurse.   Role of the NA in discharging a patient from a facility:   * Assist the patient to gather their belongings. * Bring a wheelchair to the room. * Transport the patient to the vehicle. * Assist the patient to get into the vehicle. * Communicate observations and patient response to the nurse.   Role of the NA in transferring a patient from one room to another room is the same facility:   * Assist the patient to gather their belongings. * Place belongings in appropriate containers. * Bring a wheelchair to the patient’s room. * Transport the patient to the new room. * Assist the patient to secure their belongings. * Introduce the patient to the new staff person(S) who will be caring for the patient. * Assist the patient to get out of the wheelchair and get into bed or chair. * Communicate observations and patient response to the nurse.   Nursing Care Patterns  Functional Nursing  Team Nursing  Primary Nursing  Case Management  Patient-focused care  Health Care Payment Sources  Private Insurance  Medicare  Medicaid  Patient Protection & Affordable Care Act  Prospective Payment System  Meeting Standards of Care:  Department of Health & Human Services  (HHS)  Regulations related to:  Licensure  Certification  Accreditation  Policies  Procedures  Survey Process. | Lecture & Discussion  Chapter 1, Pages 1-3  Lecture & Discussion  Chapter 1, Pages 4 & 5  Table 1-1  Clinical Practice  Lecture & Discussion  Chapter 1, Pages 5 & 6  Figure 1-3  Lecture & Discussion  Chapter 1, Pages 6 & 7  Lecture & Discussion  Chapter 1, Page 7 & 8 |  |
| **Unit 2**  **Resident**  **Rights** | 2.1 List the components of *The Patient Care Partnership: Understanding Expectations, Rights, and Responsibilities.*  2.2 Describe the *Omnibus Budget Reconciliation Act of 1987 (OBRA)*.  2.3 Discuss specific Resident Rights  2.4 Define the role of a Resident’s representatives.  2.5 Describe OBRA’s actions to promote dignity and privacy.  2.6 Define the person’s unit.  2.8 Discuss factors affecting comfort in a resident’s unit.  2.8 Describe factors affecting bed safety.  2.9 Define entrapment.  2.10 Discuss risk factors associated with entrapment.  2.11 Describe the furniture and equipment in the person’s unit.  2.12 Identify ways the nursing assistant maintains the person’s unit.  213 Describe ways to promote safety and comfort.  2.14 Identify the management of the resident’s belongings. | Components of *The Patient Care Partnership*  High-Quality Care  Clean and Safe Setting  Involvement in Care  Protection of Privacy  Preparing to Leave the Hospital  Help with Bills and Insurance Claims  Role of the *Omnibus Budget Reconciliation Act of 1987*:   * Federal Law * Set minimum standards for quality of care in nursing centers. * Established Nursing Assistant and Evaluation * Identified Resident rights.   The Centers for Medicare & Medicaid enforce OBRA through the Survey process.  Resident rights.  Resident Rights under OBRA  Information  Refusing Treatment  Privacy & Confidentiality  Personal Choice  Grievances  Work  Resident Groups  Personal Items  Freedom from Abuse,  Mistreatment & Neglect  Freedom form Restraints  Quality of Life  Activities  Protecting Residents Rights   * Staff * Advocate * Ombudsmen – Established by the Older Americans Act (federal law)   Promoting dignity and privacy  Being courteous during interactions  Protecting personal privacy during care  Allowing personal choice & independence  Providing dignity when assisting Residents  The person’s unit is the space, furniture, and equipment used by the person in the agency.  Factors affecting comfort:   * Temperature & Ventilation * Noise * Odors * Lighting * The bed   Bed safety involves the condition of the bed system and attachments including bed rails.  Entrapment = getting caught, trapped, or entangled in spaces created by bed rails, the mattress, the bed frame, the headboard, or the footboard.  Risk factors associated with entrapment:  Age  Frail  Disoriented or confused.  Restless  Uncontrolled movements  Poor muscle control  Small size  Restrained residents  Furniture/equipment in the person’s unit.   * Bed, Bed Rails, Bed controls. * Light * Call system. * Chair * Tables/stands * Closets * Bathroom * Closet   Ways to maintain the person’s unit:   * Keep important items within the person’s reach. * Keep the unit clean. * Arrange belongings as the person prefers. * Adjust lighting & temperature for the person’s comfort.   Ways to promote safety and comfort:   * Orient new residents to the proper use of call system and other equipment. * Explain unfamiliar noises/sounds. * Control odors. * Adjust the bed position for comfort.   Management of resident’s belongings:   * Help residents choose the best place for their belongings.   The resident’s choices need to be safe, will cause accidents, and do not disturb the rights of others. | Lecture & Discussion  Chapter 2 Page 10  Appendix A Page 590  Chapter 2 Pages 10-16  Box 2-1  Box 2-2  Lecture & Discussion  Chapter 19  Figure 19-5  Clinical Practice |  |
| **Unit 3**  **Nursing Assistant Regulations** | 3.1. Identify laws and policies regulating Nursing Assistant (NA) performance.  3.2. Describe the nursing assistant’s *scope of practice.*  3.3 Discuss the qualities of a nursing assistant.  3.4 Discuss the effects of stress at work.  3.5 Identify problem solving steps to successfully deal with conflict.  3.6 Define harassment & bullying.  3.7 Define selected terms related to delegation.  3.8 State the four steps in the delegation process.  3.9 Discuss the ***Five Rights of Delegation.***  3.10 Discuss the Nursing Assistant’s possible responses to a delegated task. | Federal and State laws  Nurse Practice Acts   * Each State has a Nurse Practice Act * Nurse Practice Acts:   *The Omnibus Budget Reconciliation Act*  *of 1987 (OBRA)*  Training Programs  Competency Evaluation  Nursing Assistant Registry  Certification  Maintaining Competence  Nursing Assistant Standards  Job Description  Policy Procedure Manual    Nursing Assistant Roles  Bathing, & grooming  Assisting with toileting  Assisting with meals  Maintaining Resident’s room  Vital Signs  Nursing Assistant Qualities  Patient/Understanding/Unprejudiced  Honest/Trustworthy  Conscientious  Enthusiastic  Courteous  Empathetic  Dependable/Accountable  Effects of stress at work:  Physical effects  Mental effects  Social effects  Spiritual effects  Problem solving to resolve conflict:  Define the problem.  Collect information.  Identify possible solutions.  Select the best solution.  Carry out the selected solution.  Evaluate the results.  **Bullying** definition – repeated attacks or threats of fear, distress, or harm by a bully toward a target.  **Harassmen**t definition – to trouble, torment, offend, or worry a person by one’s behavior or comments. (age, race, ethnic background, gender identify, sexuality, religion, or disability)  Selected terms:  **Delegate** – to authorize or direct a nursing assistant to perform a task.  **Delegation**:  1. The process the nurse uses to direct a nursing assistant to perform a nursing task.  2. Allowing a nursing assistant to perform a nursing task that is beyond the nursing assistant’s usual role and not routinely done by the nursing assistant.  Four steps in the delegation process as outlined by the *National Council of State Boards of Nursing*  Assessment & Planning  Communication  Surveillance & Supervision  Evaluation & Feedback  ***Five Rights of Delegation***  The Right Task  The Right Circumstance  The Right Person  The Right Direction & Communication  The Right Supervision & Evaluation  The nursing assistant possible responses to a delegated task:  Accepting a task  Refusing a task  Use Policy and Procedure Manuals | Lecture & Discussion  Chapter 3 & 5  Box 3-1  Box 3-2  Box 3-3  Box 3-4  Box 3-5  Figure 5-1  Box 5-1  Figure 5-1  Box 5-3 |  |
| **Unit 4**  **Safety &**  **Body Mechanics** | 4.1. Explain the principles of body mechanics.  4.2. Identify ways to prevent Work-Related injuries. | Principles of body mechanics:  Alignment  Base of support  Bend at the knees.  Use larger muscle groups.  Face the work area.  Push, slide, or pull heavy objects.  Keep objects close to the body.    General ways to prevent Work-Related injuries:  Wear shoes with good traction.  Use equipment to assist.  Ask for help.  Plan and prepare for tasks.  Schedule harder tasks early  Lock brakes on beds & wheelchairs.  Give clear directions when working with  others  Adjust the height of the bed. | Lecture & Discussion  Chapter 16  Box 16-1 & 2  Box 16-3  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **Unit 5**  **Moving or Positioning a Resident**  **Unit 6**  **Infection Prevention** | 5.1Describe the benefits of positioning and re-positioning a resident in bed or other furniture.  5.2 Describe selected positions.  5.3 List the steps to safely position a resident.  5.4 Describe the proper way to position/reposition a resident in a chair.  5.5 Define *bed mobility.*  5.6 Define friction and shearing.  5.7 Identify ways to protect the skin from friction and shearing when moving a resident in bed.  5.8 Demonstrate how to move a resident in bed.  5.9. Demonstrate the proper procedure for positioning a resident on their side (**Lateral position**).  6.1 Define selected terms.  6.2 Discuss the links in the ***Chain of Infection***.  6.3 Define the purpose of medical asepsis.  6.4 List the rules of hand hygiene.  6.5 Demonstrate proper hand hygiene using soap and water and alcohol-based hand sanitizer.  6.6 Identify the 5 *Moments for Hand Hygiene*  6.7 Discuss care of supplies and equipment.  6.8 Discuss the Bloodborne Standard.  6.9 Identify types of precautions.  6.10 Demonstrate the proper procedure for donning and doffing (removing) personal Protective Equipment (PPE). | Benefits of positioning/repositioning:  Promotes comfort.  Breathing is easier.  Promotes circulation.  Prevents pressure injuries.  Prevent contractures.  Position/repositioning at least every 2 hours.  Positions:  Fowler’s position (45 to 60 degrees)  Semi-Fowler’s position (30 degrees)  High-Fowler’s position (90 degrees)  Supine position  Prone position  Left semi-prone position.  Lateral position  Chair position.  Steps to safely position a resident:  Follow the care plan.  Ask for help.  Explain the procedure to the resident.  Use pillows for support & alignment.    Proper chair position:  Back & buttocks against the back of the  chair  Feet are supported.  Backs of the knees & calves slightly away  from the edge of the chair.  Use supported devices to maintain proper  alignment.    Bed mobility – how a person moves to and from a lying position, turns from side to side, and re-positions in a bed or other sleeping furniture.  **Friction** definition – occurs when rubbing one surface against another. (example, rubbing against the bed sheets)  **Shearing** definition – occurs when the skin sticks to a surface while muscles slide in the direction the body is moving.  Ways to protect skin from friction & shearing:  Use friction/shearing-reducing devices:  Turning pads or sheets  Slide sheet/board.  Large re-usable under-pads  Trapeze  Moving a resident in bed:  Move a resident up in bed.  Move a resident to the side of the bed.  Turn a resident on to their side.  Logrolling a resident  Sitting a resident on the side of the bed  (dangling).  Proper procedure for positioning a resident on their side:  Selected terms:  1. **Infection** – is a disease state resulting from the invasion and growth of microbes in the body.  2. **Communicable disease** – are diseases caused by pathogens that can spread to others.  3. **Healthcare Associated Infections (HAI)** – an infection in a person cared for in any setting where health care is given. The infection is related to receiving health care.  4. **Disinfection** – the process of killing pathogens.  5. **Sterilization** – the process of destroying all microorganisms.  6. **Antiseptics** – kill, slow the grow of, reduce the amount of microbes on skin or mucous membranes. (anti=against & septic = infection)  7. **Bloodborne pathogens** – microbes that are present in blood and can cause infection.  Links in the ***Chain of Infection***:  Source  Reservoir  Portal of Exit  Method of Transmission  Portal of entry  Susceptible host  Purpose of medical asepsis  Reduce the number of microbes.  Prevent the spread of microorganisms.  Rules of hand hygiene:  Use soap and water when hands are:  Visibly dirty or soiled  Before eating.  After using the restroom  Exposure to *Clostridium Difficile*  Use alcohol-based hand sanitizer:  Before contact with a resident  After direct contact with a resident  After contact with a resident’s items  Steps for proper hand hygiene **(Soap & Water):**  Wet hands and wrist  Keep hands lower than the elbows.  Apply soap.  Lather hands, wrist & fingers -20 seconds  Clean under the fingernails  Rinse well.  Dry hands and wrists starting at the  fingernails  Turn off the faucets with a dry paper  towel.  Steps for proper hand hygiene **(Hand sanitizer):**  Apply hand sanitizer.  Rub hands together.  Interlock fingers.  Continue rubbing hands together until hands are dry.  *5 Moments for Hand Hygiene:*  1. Before touching a resident  2. Before a aseptic procedure  3. After body fluid exposure risk  4. After touching a resident  5. After touching a resident’s environment  Care of supplies & equipment:  Use of disposal items is preferred.  Label multiple-use items.  Do not borrow items.  Cleaning supplies & equipment:  Wear personal protective equipment (PPE).  Work from clean to dirty areas.  Rinse with cold water first.  Then wash with soap & water.  Rinse with warm water.  Dry items thoroughly.  Disinfect/sterilize the item.  Disinfect the sink.  Discard PPE.    Bloodborne Standard:  Regulation from Occupational Safety & Health Administration (OSHA)  Protects healthcare workers.  Established Infection Prevention measures.  Hepatitis B vaccine  Engineering & work practice control  PPE  Regulations for equipment, biohazardous waste, and laundry  Requirements for exposure incidents  Types of precautions:   * Standard * Transmission-Based precautions   Proper procedure for Donning/Doffing Personal Protective Equipment: | Lecture & Discussion  Chapter 16, Pages 193-197  Figures 16-4 through 16-11  D&S *Candidate Handbook*  Instructor Demonstration  Supervised Practice  Clinical Practice  Lecture & Discussion  Chapters 14 & 15  Figure 14-1 & 2  Box 14-4    Handwashing:  Figures: 14-5 thru 14-11  Procedure Box, Page 166  Instructor Demonstration  Supervised Practice  Chapter 14,  Procedure Box:  Using Alcohol-Based Hand Sanitizer  Figure 14-12  Box 14-3  Box 14-4  Chapter 15, Pages 175-188  Box 15-1  Box 15-2  Figures 15-6 & 15-7  *Donning & Removing Personal Protective Equipment Procedure*  Page 185  D&S Candidate Handbook  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **Unit 7**  **Bed Making** | 7.1 Identify the benefits of clean, dry, & wrinkle-free beds.  7.2 Describe the types of beds.  7.3 List the linens used to make a bed.  7.4 State the proper way to handle linens.  7.5 Demonstrate the proper procedure for making an occupied bed. | Benefits of clean, dry wrinkle-free beds:  Promote comfort.  Prevent skin breakdown.  Prevent pressure injuries.  Types of beds:  Closed  Open  Unoccupied  Occupied  Surgical  Linens:  Bath blanket  Drawsheet  Waterproof under-pad  Bottom sheet (fitted or unfitted)  Top sheet  Blanket  Bedspread  Pillowcase(s)    Proper way to handle linen:  Soiled linens  Remove 1 piece at a time.  Roll each piece of linen away from you.  Soiled side is to on toward the inside.  Place soiled linen in a leak-proof bag.  Clean linens  Perform hand hygiene.  Collect linens with one hand.  Hold the collected linens in the other  hand.  Hold the linens away from the  body/uniform.  Do not shake linens.  Proper procedure for making an occupied bed: | Lecture & Discussion  Chapter 20, Pages 244-260  Figures 20-1through 20-4  Figure 20-8  Figures 20-16 through 20-24  Procedure Box – Making an Occupied Bed, pages 249 & 350.  *D&S Candidate Handbook*  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **Unit 8**  **Managing Pressure**  **Ulcers** | 8.1. Identify selected terms associated with pressure injuries.  8.2.  Recognize common bony prominences when the resident is in various positions.  8.3. Identify risk factors associated with pressure injuries.  8.4. Describe pressure injury stages.  8.5.  Identify ways to prevent pressure injuries.  8.6. Identify common complications associated with pressure injuries. | Selected terms associated with pressure injuries:  **Pressure injury -** *Localized damage to the skin and underlying soft tissue.*  *The injury is usually over a bony prominence or related to a medical or other device.*  *The injury results from pressure or pressure in combination with shearing.*  **Bony prominence…***bone sticks out or projects from a flat surface of the body (pressure point).*  **Eschar…***thick, leathery dead tissue. It is often black or brown in color.*  **Shear…***layers of skin rub against each other; skin remains place and the underlying tissues move and stretch, tearing the underlying capillaries and blood vessels causing tissue damage.*  **Slough…***dead tissue shed from the skin, light in color, soft and moist. It may be stringy at times.*  **Ulcer** …*a shallow or deep crater-like sore of the skin or mucous membrane.*  Bony prominences in various positions:   * Supine * Sacrum * Heels * Lateral (side lying) * Hip * Ankle * Heel * Semi Fowler’s position * Sacrum * Hip * Heels * Upright * Shoulders * Hip * Sacrum   Risk factors associated with pressure injuries:   * Age * Dry skin * Thinning skin * Decreased sensation. * Decreased mobility. * Poor nutrition * Poor hydration * Incontinence * Edema   Pressure Injury stages:   * Stage 1 – non-blanchable erythema (red) of intact skin * Stage 2 – Partial-thickness skin loss with exposed dermis (blister) * Stage 3 – Full-thickness skin loss * Stage 4 – Full-thickness skin & tissue loss (muscle, tendon, ligament, cartilage, or bone is exposed) * Unstageable – Obscured full-thickness skin loss (Slough &/or Eschar) * Deep tissue injury – Persistent non-blanchable deep red, maroon, or purple discoloration   Measures to prevent pressure injuries:   * Identifying residents at increased risk for the development of pressures. * Manage moisture for incontinence. * Provide good nutrition and fluid balance. * Follow the re-positioning schedule.   (at least every 2 hours)   * Float heels. * Use protective devices: * Bed cradle * Heel/elbow protectors * Heel/foot elevators * Gel/fluid-filled cushions * Special beds * Other   Common complications associated with pressure ulcers:   * Infection (Most Common) * Osteomyelitis * Pain | Lecture & Discussion  Chapter 36, Pages 464-474  Figure 36-7  Figure 36-1 7 36-6  Figures 36-2  Box 36-1  Figures 36-5 to 36-8  Figure 36-9 & 36-10  Box 36-2  Figures 36-11 to 36-14  Clinical Practice |  |
| **Unit 9**  **Ethical**  **&**  **Legal**  **Issues** | 9.1 Define the term ethics.  9.2Review  ethical and  professional  behaviors.  9.3 The role of a  *code of conduct.*  9.4 Define  *Professional*  *boundaries.*  9.5 Identify the  effects of  under-  involvement.  9.6 Identify the  effects of over-  involvement.    9.7 Define *Boundary*  *Signs.*  9.8 Define the  terms related to  the legal  aspects of care. | Definition of selected terms:  **Ethics**…*is knowledge of what is right and wrong conduct.*  **Prejudice** **or Biased**… *making judgements and having views before knowing the facts.*  Reasons for prejudice and biasinclude one’s culture, religion, education, & experience.  **Code of conduct…** *Rules or standards of conduct for group members to follow.*  **Professionalism**… *following laws, being ethical, having the skills to do the job.*  Role of a code of conduct:  Guides an NA’s thinking, actions, and behaviors.  Examples of ethical and professional/legal behaviors  Competent  Confidentiality  Honesty  Trustworthy  Reporting errors  Report abuse/neglect.  Team Player  Definition of ***professional boundaries****:*  …*a separation of helpful behaviors from behaviors that are not helpful.*  Professional interactions involve helpful behaviors that meet the resident’s needs.  Effects of under-involvement:  Disinterest  Avoidance  Neglect  Effects of over-involvement:  **Boundary crossing** - a brief act or behavior of being over-involved with a resident. The intent of the act or behavior is to meet the person’s need.  **Boundary violation** – an act or behavior that meets your needs, not the person’s needs.  **Professional sexual misconduct** – a violation of professional interactions with an act, behavior, or comment that is sexual in nature, even if the person consents or initiates the behavior.  N.B. Some boundary violations and some types of professional sexual misconduct are also crimes.  **Boundary Signs** definition– acts, behaviors, or thoughts that warn of a boundary crossing or boundary violation.  Define legal terms:  Law  Criminal laws  Civil laws  Unintentional Torts  Negligence  Malpractice  Intentional Torts  Defamation  Libel  Slander  Fraud  False Imprisonment  Assault  Battery  Invasion of privacy | Lecture & Discussion  Chapter 4, Page 30-41  Box 4-1  Figure 4-1  Boxes 4-2 |  |
|  | 9.9 Explain the  *Health Insurance*  *Portability and*  *Accountability Act*  *(HIPAA).*  9.10 Explain  Informed  Consent.  9.11 Identify  ways Informed  Consent can be  given.  9.12 Define abuse.  9.13 Describe the  “vulnerable” adult.  9.14 Describe types  of elder abuse.  9.14. Recognize  signs of Elder  Abuse. | The purpose of HIPAA is to protect health information regardless of the source (oral, paper or electronic)  Informed Consent:  …*process* *by which a person receives and understands information about a treatment or procedure and is able to decide if he or she will receive it.*  Ways Informed Consent can be given:  Written  Verbal  Implied  Definition of abuse:  …*willful infliction of injury, unreasonable confin*ement*, intimidation, or punishment that results in physical harm, pain, or mental anguish and or depriving a person of the goods or services needed to attain or maintain well-being.*  **Vulnerable adult**… *a person 18 years old or older who has a disability or condition that causes the person to be at risk of harm.*  Types of abuse  Physical or verbal Abuse  Neglect  Financial Abuse  Involuntary seclusion  Emotional or psychological abuse  Sexual abuse  Abandonment    ***CNAs are legally bound to report suspected or actual abuse/neglect (Mandated Reporters)***  Signs of Elder Abuse:  Self-report  Lacking personal hygiene  Frequent injuries  Missing assistive devices  Bleeding or bruising around breasts.  or genital/rectal area  Burns  Individual is withdrawn.  An individual is restrained. | Boxes 4-3 & 4-4  *Focus on communication* – *Informed Consent*  Page 35  *Focus on Older Person*  *Page 36*  *Focus on Communication – Reporting Abuse*  Page 35  Box 4-5 & 4-6  Figure 4-3  Clinical Practice |  |
| **Unit 10**  **Accident**  **Prevention** | 10.1. Describe risk factors associated with accidents.  10.2. Describe the steps to properly identify a resident before providing care.  10.3. List types of possible accidents.  10.4. Identify ways to prevent burns.  10.5. Identify ways to prevent poisoning.  10.6. Identify ways to prevent suffocation.  10.7. Identify ways to prevent equipment accidents.  10.8. Identify ways to prevent accidents from hazardous chemicals.  10.9 State the information listed on Safety Data Sheets.  10.10 Identify types of disasters.  10.11 Identify actions to take in the event of a bomb threat.  10.21 Identify ways to prevent a fire.  10.12. Identify actions to take in the event of a fire.  10.13 Define elopement.  10.14. Identify ways to prevent elopement of a resident.  10.15. Identify risk factors related to  workplace violence.  10.16 Identify safety measures related to workplace violence.  10.17 Identify the role of a Risk Management Department.  10.18 Discuss the reason an incident report should be completed. | Risk factors associated with accidents:  Age  Awareness of surroundings  Agitated/Aggressive behavior  Hearing loss  Impaired senses (vision, hearing, smell,  or touch)  Impaired mobility  Medications  Steps to properly identify a resident:  Identification bracelet (ID)  Compare the name on the assignment  sheet to the ID bracelet before  providing care.  Check the resident’s name and date of  birth (DOB)  Use two identifiers.  Room numbers/bed number can not  be used.  Ask the resident to state/spell their name.  Verify the medical record number.  Call the resident by name when checking  the ID bracelet.  Use a photo ID system.  Types of accidents:  Burns  Poisoning  Suffocation including Choking  Equipment related  Hazardous chemicals  Disasters  Bomb threats  Fire  Elopement  Workplace violence  Ways to prevent burns:  Assist residents with eating/drinking.  Keep hot items in the center of the table.  Pour hot liquids away from the resident.  Measure the temperature of bath/shower  water.  Do not the resident sleep with a heating  pad or electric blanket.  Use safety precautions for residents who  smoke.  Ways to prevent poisoning:  Keep hazardous materials out of reach.  Keep harmful products in the original  Container  Store personal care items safely.  Read labels before use.  Ways to prevent suffocation:  Choking is the primary cause of  Suffocation  Care measures to prevent suffocation:  Do not leave a resident unattended in a  bathtub/shower.  Prevent entrapment.  Remove residents from the area if there  is a smoke smell.  Ways to prevent Choking:  Cut food into small bite-size pieces.  Make sure dentures fit properly.  Note loose teeth.  Follow the dietary care plan.  Follow aspiration precautions.  ***If a resident is choking, perform abdominal thrusts (Heimlich maneuver) to dislodge the foreign body and relieve airway obstruction.***  ***Chest thrusts are used for obese residents and in a pregnant woman.***  Ways to prevent equipment accidents:  Do not use unfamiliar items.  Do not use broken/damaged items.  Avoid using extension cords.  Do not cover electrical cords.  Have maintenance staff check resident  personal electrical items.  Check electrical cords for damage.  Make sure brakes (including wheelchairs  and stretchers) work properly.  Ways to prevent hazardous chemical accidents:  Keep original labels intact and readable.  ***If the label is damaged or removed do not use the substance. Show the container to the nurse.***  Do not leave containers unattended.  Know the location of the *Safety Data*  *Sheets (SDS)*  Information on Safety Data Sheets:  Name & common names.  Hazards about the chemical  Chemical ingredients  Emergency measures  Fire-fighting measures.  Accidental release measures  Safe handling & storage  Personal protection measures  Types of disasters:  Weather/environmental events  Human-made events  Bomb Threats  Power failures  Communication (cyber-attack)  Pandemics  Elopement  Actions during a real or potential bomb threat:  Report all suspicious individuals.  Report all suspicious items or packages.  Ways to prevent a fire:  Follow the oxygen use policy of the center.  Follow the smoking policy of the center.  Secure all smoking materials.  Do not leave cooking unattended.    Actions to take in the event of a fire:  Know the center’s emergency and  evacuation policy  Know the location of extinguishers,  alarms and emergency exits.  Attend fire drills.  Remember *RACE* and *PASS*  Define the term **elopement**:  …*when a patient or resident leaves the agency without staff knowledge.*  Ways to prevent elopement of a resident:  Identify residents at risk for elopement.  Monitor/supervise the resident.  Address elopement in the care plan.  Have a plan for finding the resident.  Risk factors related to workplace violence:  Working with persons with a history of violence.  Working alone.  Poorly lit hallways  Working in high crime areas  Limited security  Visitors being allowed to go anywhere in the agency.  Safety measures related to workplace violence:  If the individual is agitated/aggressive:  Stay close to the door.  Move away from the person.  Stay calm, speak in a calm manner.  Do not touch the individual.  Leave the room as quickly as possible.  Potential weapons in the environment:  Do not wear jewelry or scarves.  Keep long hair up and off the collar.  Keep keys, scissors, and pen in pockets.  Staff safety measure:   * Use the “buddy system” in elevators or caring for persons with agitated or aggressive behaviors. * Wear well-fitting uniforms and shoes with good soles. * Use security escorts.   Role of Risk Management:   * Protect all people in the agency. * Protect all property. * Prevent accidents/injuries. * Investigate safety issues. * Accidents * Fire * Negligence * Malpractice * Abuse * Workplace violence * Federal/State requirements   Risk managers look for patterns & trends in incident investigations. Corrections are made, procedures are changed, and training is done to prevent further incidents.  Examples of safety procedures:   * Color-coded wristbands * Red = Allergy * Yellow = Fall Risk * Purple = DNR/AND * Pink = Limb Alert * Resident belongings * Complete a belonging list. * Itemize all jewelry items. * Label clothing. * Have the resident/family co-sign the belongings list/envelope.   Purpose of an incident reports:   * Accidents * Errors in care * Broken or lost items * Hazardous chemical incidents * Workplace violence incidents   ***Complete an incident report as soon as possible.*** | Lecture & Discussion  Chapter 11, Page 117-132  Figures 11-1, 11-2 & 11-3  Box 11-1  Box 11-2  Figures 11-4 thru 18-8  Box 11-3  **Procedural Box** – *Relieving Choking* (Adult or Child over 1 year of age)  Page 122  Box 11-4  Figure 11-10 A&B  Figure 11-11  Box 11-5  Figures 11-12 & 11-13  Procedure Box: *Using a Fire Extinguisher*  Page 127  Box 11-6  Figure 11-14  Clinical Practice |  |
| **Unit 11**  **Health Team**  **Communication** | 11.1  Define the term communication.    11.2 Identify components of “good” communication.  11.3 Define the term medical record.  11.4 List the parts of a medical record.  11.7 State the legal and ethical aspects related to a resident’s medical record.  11.5 Describe the Nursing Process.  11.6 Describe the difference between objective and subjective observations.  11.6. List the observations the nursing assistant needs to report immediately to the charge nurse.  11.8 Identify the role of the nursing assistant in the completion of the Minimum Data Set (MDS).  11.9 Identify the role of the care plan.  11.10 Explain the terms reporting and recording.  11.11 Convert conventional time to military /international time.  12.12 Explain proper etiquette when using a facility telephone. | Definition of the term **communication**:  …*exchange of information-a message sent is received and correctly interpreted by the intended person.*  Components of “good” communication:  Avoid words with more than one  meaning.  Avoid terms the resident/family does not  Understand.  Be brief and concise.  Give information in a logical way.  Give the facts.  Be specific.  Definition of the term **medical record**:  …*legal account of a person’s condition and responses to treatment and care.*  Electronic Medical Record (EMR)  Electronic Health Record (EHR)  Parts of a medical record:  Admission information  Health history  Flow sheets/graphic sheets.  Progress notes  Laboratory Reports  Legal & ethical aspects of a medical record:  It is the duty of the nursing assistant to keep resident information confidential. The nursing assistant can only read the medical record of the resident on his/her assignment. Reading other residents’ medical records is considered an invasion of privacy.  The Nursing Process:  Definition…methods nurses use to plan and deliver nursing care. There are 5 steps:  Assessment  Nursing Diagnosis  Planning  Implementation  Evaluation  **Objective data (signs):**  Observations or signs that can be seen,  heard, felt, or smelled by an observer.  Examples include a pulse or color of urine.    **Subjective data (symptoms):**  Refers to information the resident shares  with the observer. These data are  referred to as symptoms. Pain, nausea,  or fear are examples of subjective data.    Observations to be **reported immediately**:  Change in a resident’s ability to  respond  Changes in a resident’s mobility  Complaints of sudden, severe pain  A reddened area, bruise, or open area  Complaints of vision changes  Vital signs out of the resident’s range  Role of the nursing assistant in completing the MDS:  The observations of the nursing assistant are used to complete the MDS. The MDS nurse may interview the nursing assistants caring for a resident.  Role of the Comprehensive care plan (CCP):  The nurse uses data from the MDS to create a CCP. It outlines all the interventions required to meet a resident’s needs. It is updated periodically through medical record review and care conferences. The interventions to be completed by the direct care provider are entered onto an assignment sheet.  **Reporting**:  …*oral account of care and observations*  **Recording**:  …*written account of care and observations*  Reporting and recording are done as needed throughout the shift and at the end of the shift. If a caregiver leaves before their shift is scheduled to end the caregiver is obligated to report and record care and observations occurring during the time the caregiver was assisting a resident.  Military time has four (4) digits. The first two represent the hour and the last two represent the minutes. In this system the colons and AM and PM are not used.  Example: 9:00 AM = 0900  Military time used a 24-hour clock  Example: 9:00 PM = 2100  Proper telephone etiquette:  Answer the call after the first ring, however the telephone should be answered before the fourth ring.  Give a courteous greeting including  facility, location, your name and  position.  Put the caller on hold if necessary.  Do not give confidential information.  At the end of the call thank the caller. | Lecture & Discussion  Chapter 7, Pages 64-77  Box 7-1  Table 7-1  Box 7-3 Basix Observations  Box 7-2  Figure 7-5  Box 7-5  Box 6-6  Box 7-7  Box 7-4  Figure 7-6 & 7-7  Box 7-8  Clinical Practice |  |
| **Unit 12**  **Medical**  **Terminology** | 12.1 Identify the parts of words or word elements.  12.2 Define word elements.  12.3 Discuss common prefixes.  12.4 Discuss common roots.  12.5 Discuss common suffixes.  12.6 Identify abdominal quadrants.  12.7 Identify directional terms of the body.  12.8 Define common abbreviations. | Parts of a word or word elements:  Prefixes  Roots  Suffixes  Word elements are combined to form medical terms.  Word elements:  **Prefix**…added to the beginning of a word. It changes the meaning of the word.  **Root**…contains the basic meaning of the word.  **Suffix**…added to the end of the word. It changes the meaning of the word.  Common prefixes:  Common roots:  Common Suffixes:  Abdominal quadrant:  Used to describe the location of body structure, pain, or discomfort.  Right Upper Quadrant (RUQ)  Left Upper Quadrant (LUQ)  Right Lower Quadrant (RLQ)  Left Lower Quadrant (LLQ)  Directional terms:  Anterior (ventral)  Posterior (dorsal)  Proximal  Distal  Lateral  Medial  Superior  Inferior  Superficial  Deep    Common abbreviations: | Lecture & Discussion  Chapter 8, Pages 78-88  Figure 8-2 & 8-3  Table 8-1  Table 8-2  Table 8-3  Figure 8-5  Figure 8-6  Table 8-5  Clinical Practice |  |
| **Unit 13**  **Communicating**  **with**  **Residents** | 13.1 Define the term *Holism*.  13.2 Identify the proper way to address a resident.  13.3 Define the term *need.*  13.4. Discuss Maslow’s basic needs.  13.5. Define the term *culture.*  13.6. Define the term *religion.*  13.7 Define communication.  13.8 Discuss types of communication.  13.9 Explain various communication methods.  13.10 Describe barriers to communication.  13.11 Identify behaviors communicating a resident’s need.  13.12 Discuss ways to manage difficult behaviors.  13.13 Recognize methods to communicate with residents with special needs. | Definition of the term *holism:*  *…concept that considers the whole person. The person has physical, social, psychological, and spiritual parts. These parts are woven together and cannot be separated.*  Proper way to address a resident:  Greet the resident by title –  Miss, Mr., Mrs.  Do not call a resident by their first name.  Do not call them by other names, such as  sweetheart, honey, pops.  Definition of the term *need*:  …*something necessary or desired for maintaining life and mental well-being.*  Maslow’s basic needs:  Physical  Safety and security  Love and belonging.  Self-esteem  Self-actualization  Definition of the term *culture*:  …*characteristics of a group of people-language, values, beliefs, likes, dislikes, and customs. They are passed from 1 generation to the next*.  Definition of the term *religion*:  …*relates to spiritual beliefs, needs, and practices.*  ***N.B.*** *Do not judge the person by your standards/religion. Also, do not force your ideas on the other person.*  Communication definition…*exchange of information.*  Types of communication:  **Verbal** communication – uses written or spoken words.  When speaking to another person consider the following rules:  Look directly at the person.  Position yourself at eye level with the  person  Do not speak loudly.  Speak clearly & slowly.  Do not use slang words.  Repeat information as needed.  Ask one question at a time.  Wait for the person to answer.  Be kind and courteous.  When writing a message follow these guidelines:  Keep the note simply.  Use black ink on white paper.  Print the message in large letters.  Use a large font if using a computer.  **Nonverbal** Communication – no words are used.  Gestures, facial expressions, posture, body movements, touch, and smell are used.  These messages more accurately reflect a person’s feelings. They are usually involuntary and hard to control.  Tools such as Magic slates and Picture boards may be helpful when the person does not speak.  Communication methods:  Listening  Paraphrasing  Direct questions  Open-ended questions  Clarifying  Focusing  Silence  Barriers to communication:  Unfamiliar language  Cultural differences  Changing the subject  Giving opinion  Talking a lot  Failure to listen.  “Pat” answers  Illness including coma.  Age  Behaviors communicating needs:  Anger  Demanding/Self-centered behavior  Aggressive behavior  Withdrawal  Inappropriate sexual behavior  Ways to manage difficult behaviors:  Recognize the behavior.  Treat the person with dignity & respect.  Keep the person informed.  Listen, use silence.  Protect yourself.  Methods to communicate with residents with special needs:   * Comatose resident * Knock before entering the resident’s room. * Introduce yourself. * Tell the resident the date and time. * Explain procedures to the resident. * Tell the resident when you are leaving the room and when you will be back. * Residents with disabilities * Speak directly to the resident. * Speak with the resident at eye level. * Ask if help is needed before acting. * Let the resident set the pace for activities. | Lecture & Discussion  Chapter 6, Pages 53-63  Figure 6-2  Box 6-1  Figure 6-3  Box: *Focus on Older Persons – Effective communication*  *Box: Caring about Culture*  Box: *Caring about Culture – Touch*  Box: *Caring about Culture – Body Language*  Box: *Caring about Culture - Listening*  Figure 6-5  Box*: Focus on Communication – Communication Barriers*    Box 6-2  Box 6-3  Instructor Demonstration  Skill Lab Practice  Clinical Practice |  |
| **Unit 14**  **Measuring**  **Vital Signs** | I4.1 Define vital signs.  14.2 Identify factors that may affect vital signs.  14.3 List the types of thermometers used to take a resident’s temperature.    14.4 List the sites used to take a resident’s temperature.  14.5 State the normal ranges for body temperature by site used.  14.6 Demonstrate competency with the procedure of measuring temperature.  14.7 Define selected terms related to taking a pulse.  14.8 List pulse sites.  14.9 State the normal adult pulse range.  14. 10 Demonstrate competency with the procedure for counting a pulse.  14.10 Define the term respiration.  14.11 Identify the respiratory range for a healthy adult.  14.12 State the normal quality of respiration.  14.13 Demonstrate competency with the procedure for counting respirations.  14.14  Define selected terms associated with measuring a person’s oxygen levels.  14.15 State the normal range of oxygen saturation.  14.16 Identify types of probes used to measure a person’s oxygen saturation.  14.17 Recognize factors that affect the accurate measurement of oxygen saturation>  14.18 Demonstrate competency with the procedure for measuring a person’s oxygen saturation.  14.19 Define selected terms associated with blood pressure measurement.  14.20 Identify sphygmomanometer types.  14.21 List the parts of an aneroid sphygmomanometer  14.22 State which artery is usually used to measure blood pressure.  14.23 List guidelines for measuring blood pressure.  14.24 Demonstrate competency with the procedure for measuring blood pressure.  14.25 Identify selected terms associated with pain.  14.26 Discuss types of pain.  14.27 State factors that affect pain.  14.28 List signs and symptoms of pain.  14.29 Recognize comfort and pain-relief measures.  14.30 Identify reasons to weigh a person.  14.31 Identify types of scales.  14.32 State the guidelines for weighing a person.  14.33 Describe how to convert pounds to kilograms.  14.34 Describe how to convert inches to centimeters. | Vital signs reflect the function of three body processes including regulation of body temperature, breathing, and heart function. Pain is also considered a vital sign.  Factors that may affect vital signs:  Activity  Age  Anger  Medications  Eating  Gender  Pain  Illness  Thermometer types used to take a resident’s temperature:  Standard electronic  Tympanic membrane  Temporal artery  Non-contact Infrared  Digital  Glass (Blue Stem)  Sites used to take a temperature:  Oral  Rectal  Axillary  Tympanic  Normal body temperature ranges by site:  Oral 97.6 to 99.6 degrees F  Rectal 98.6 to100.6 degrees F  Axillary 96.6 to 98.6 degrees F  Tympanic 98.6 degrees F  Temporal 99.6 degrees F  Oral 36.5 degrees C to 37.5 degrees C  Rectal 37.0 degrees C to 38.1 degrees C  Axillary 35.9 degrees C to 37.0 degrees C  Tympanic 37.0 degrees C  Temporal 37.5 degrees C  Procedure of measuring temperature:    Definition of selected terms:  **Pulse**…*the beat of the heart felt over an artery as a wave of blood passing through the artery.*  **Pulse rate**…*the number of heartbeats or pulses in 1 minutes.*  **Pulse rhythm**…*refers to the pattern of the heartbeats – regular or irregular.*  **Pulse force** – *relates to the pulse strength – strong, full, bounding, or weak, thread, or feeble.*  **Stethoscope**… *instrument used to listen to the sounds produced by the heart, lungs, and other body organs.*  Pulse sites:   * Temporal * Carotid * Apical * Brachial * Radial * Femoral * Popliteal * Posterior tibial pulse * Dorsalis pedis pulse   ***All pulses are present on both sides of the body except the Apical pulse.***  ***The radial pulse is most often used to count a pulse.***  ***Normal pulse range for an adult resident is 60 to 100 beats per minute (bpm).***  Procedure for counting a radial pulse:  Definition of the term **respiration**:  …*breathing air into (inhalation) and out of (exhalation) the lungs. Both sides of the chest rise and fall equally.*  Respiratory range for a healthy adult:  **12 to 20 respirations per minute**  Normal qualities of respirations:   * Quiet * Effortless * Regular   Procedure for counting respirations:  Definition of selected terms associate with measuring a person’s oxygen level:  **Pulse oximetry…***measures the oxygen concentration in arterial blood.*  **Oxygen concentration…***amount (%) of hemoglobin containing oxygen.*  Normal oxygen saturation: **95 – 100 %**  Types of probes used to measure oxygen saturation:   * Finger (most common method) * Toe * Ear * Nose * Forehead   Factors that affect the accurate measurement of oxygen saturation:   * Avoid areas with edema (swelling). * Avoid sites with skin breakdown. * Avoid bright lights. * Remove nail polish. * Remove non-natural nails. * Keep the site still as possible. * Do not measure the blood pressure on the arm if a finger on that side is used for continuous oxygen saturation measurement.   Procedure for measuring oxygen saturation:  Selected terms associated with blood pressure:  **Blood pressure** - …*amount of force exerted against the walls of an artery by the blood.*  **Systolic pressure** *- …pressure in the arteries when the heart contracts.*  **Diastolic pressure** *- …pressure in the arteries when the heart is at rest.*  **Hypertension** - …*Systolic pressure is 130 mm Hg or higher or the diastolic pressure is 80 mm Hg or higher.*  **Hypotension** *-…Systolic pressure is below 90 mm Hg, or the diastolic pressure is below 60 mm Hg.*  **Normal blood pressure is considered 120/80 mm Hg**  **Sphygmomanometer** - …*a cuff and a measuring device used to measure blood pressure.*  Types of sphygmomanometers:   * Aneroid * Mercury * Electronic   Parts of an aneroid sphygmomanometer:  Cuff, Inflation Bulb, Air-release valve, Tube to manometer, Manometer  Artery usually used to measure blood pressure: **Brachial artery.**  **The brachial artery is found by palpating the inner aspect of the antecubital fossa.**  Guidelines for measuring blood pressure:   * Do not take the blood pressure on an arm with: * An IV infusing * An arm cast/injury * A dialysis access site * Breast surgery * Person should rest for 10 to 20 minutes. * Measuring blood pressure when sitting or standing. * Apply the cuff to bare arm. * Use the correct size cuff. * The entire diaphragm should have contact with the skin over the brachial artery. * Pump the cuff to 30 mm Hg over the resident’s usual systolic pressure. * The first sound heard is the systolic pressure. * The last sound heard is the diastolic pressure. * Wait 30-60 seconds before repeating the blood pressure. * If you cannot hear the blood pressure, tell the nurse.   Procedure for taking a manual blood pressure:  Selected terms associated with pain:  **Comfort**…*a state of well-being. The person has no physical or emotional pain and is calm and at ease.*  **Pain or Discomfort**… *to ache, hurt, or be sore.*  Types of pain:   * Acute pain – suddenly felt from injury, disease, trauma, or surgery. There is tissue damage. * Chronic pain – continues for a long time. * Radiating pain – felt at the site of tissue damage and in nearby areas. * Phantom pain – felt in a body part no longer there.   Factors affecting pain:   * Experience with pain. * Anxiety * Rest and Sleep * Attention * Responsibilities * The value of pain * Support * Culture * Illness   Signs & symptoms of pain:   * Location * Onset & Duration * Intensity * Rating scales * Numeric scale * Wang-Baker FACES scale * Description * Precipitating factors * Factors affecting the pain. * Vital signs – increasing. * Other signs & symptoms * Body responses * Behaviors   ***Pain is what the resident says it is.***  Comfort and pain-relief measures:   * Position * Adjust the room temperature. * Give back massage. * Avoid sudden or jarring movements. * Provide distraction (music). * Apply warm or cold measures, if ordered.   Reasons to weigh a person:  On admission  Daily  Monthly  Types of scales:  Standing scale  Chair scale  Bed scale  Mechanical Lift scale  Guidelines for measuring Weight & Height:  Know how to use the scale.  Person to be weighed wearing a gown.  Have the person void before weighing the  person.  Weigh the person at the same time each day.  Balance the scale to “o” before weighing the  person.  Use the same scale.  Converting pounds (lbs.) to kilograms (kg):  1 kg =2.2 pounds  1 inch = 2.54 inches  A resident weighs 234 pounds. What is the resident’s weight in kilograms?  Example:  234 pounds divided by 2.2 = 106.4 Kg  Converting inches to centimeters:  1 inch = 2.54 centimeters  Example:  Resident is 6.8 feet tall.  6 feet time 12 inches = 72 inches  Add the 8 inches = total of 80 inches    80 inches times 2.54 = 203.2 centimeters | Lecture & Discussion  Chapter 31, Page 388-411  Box 31-1  Table 31-2  Figures 31-1  Figure 31-1 through 31-5  Table 31-1  Box – *Taking a Temperature with an Electronic Thermometer*  *D&S Candidate Handbook*  Figure 31-13, 31-14, & 31-15  Box 31-3  Figure 31-11  Box – *Taking a radial pulse.*  Figure 31-16 & 3-18  *D&S Candidate Handbook*  Box – *Counting Respirations*  *D&S Candidate Handbook*  Chapter 37, Pages 475-478  Figure 37-2  Figure 37-2  *D&S Candidate Handbook*  Procedural Box – *Using a Pulse Oximeter*  Figures 31-19 & 31-21  Box 31-4  Procedural Box – *Measuring Blood Pressure with an Aneroid Manometer*  *D&S Candidate Handbook*  Lecture & Discussion  Chapter 33, Pages 425-428  Box – *Focus on Older Persons Pain*  Figure 33-1  Box 33-1  Figure 33-2 & 33-3  Figure 31-25 & 31-26  Box 31-5  Procedural Box – *Measuring Height and Weight with s standing Scale.*  **Vital Sign Skills Learning Activities include:**  Video  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **Unit 15**  **Body Structure and**  **Function** | 15.1.  Explain the relationship between cells, tissues and organs.  15.2 Describe the components and function(s) of the Integumentary System.    15.3 Describe the components and function(s) of the Musculoskeletal System.  15.4 Describe the components and function(s) of the Nervous System.  15.5 Describe the components and function(s) of the Circulatory System.  15.6 Describe the components and function(s) of the Lymphatic System.  15.7 Describe the components and function(s) of the Respiratory System.  15.8 Describe the components and function(s) of the Digestive System.  15.9 Describe the components and function(s) of the Urinary System.  15.10 Describe the components and function(s) of the male and female Reproductive Systems.  15.11 Describe the components and function(s) of the Endocrine System.  15.12 Describe the components and function(s) of the Immune System. | Relationship between cells, tissues, and organs:  **Cells:**  The cell is the basic unit of body structure.  All cells have the same structure.  Components of the cell include:  Membrane  Nucleus  Chromosomes - 46  Genes  Cell division - mitosis  **Tissues:**  Groups of cells with similar function  combine to form tissues.  Types of Tissues:  Epithelial  Connective  Muscle  Nerve  **Organs:**  Groups of tissue with the same function  form organs.  **Systems** are formed by organs working together to perform a special function. An example would the cardiovascular system.  Components and functions of the Integumentary System (Skin). Largest organ in the body.  **Components:**  Two layers:   1. Epidermis – outer, pigment 2. Dermis – inner   Blood vessels  Nerves,  Sweat glands  Oil glands  Hair roots  Nails  **Functions:**  Protective covering  Regulates water.  Regulates body temperature.  Sensations  Stores fat and water  Components and function of the musculoskeletal system:  **Components:**   1. Bones - 206 2. Joints – allow movement. 3. Muscles - 500   Voluntary  Involuntary  Cardiac  Sphincters – esophageal, anal, urethral, pyloric  **Functions:**   1. Movement 2. Maintain posture and tone 3. Production of body heat   Components and functions of the nervous system:  **Components:**  Central Nervous System –  Brain  Spinal cord  Peripheral Nervous System -  Nerves  12 cranial nerves  31 spinal nerves  Sense organs  5 Senses – Sight, Smell, Hearing,  Taste & Touch  **Functions:**  Controls, directs, & coordinates all  body functions.  Components and functions of the circulatory system:  **Components:**  Blood  Red Cells & Hemoglobin (RBC)  White Cells (Leukocytes WBC)  Platelets  Heart – 4 chambers  Blood Vessels – Arteries & Veins  **Functions:**  Carries food to the cells  Transports oxygen to the cells  Removes waste products from the cells  Maintains fluid balance  Regulates body temperature  Work with the immune system  Components and functions of the Lymphatic system:  **Components:**  Right lymphatic duct  Thoracic duct  Lymph nodes - Filters  Thymus – Develops T-lymphocytes.  Tonsils – Trap microorganisms  Adenoids – Trap microorganisms  Spleen – Filters bacteria. Destroys RBC,  Saves iron, Stores blood.  **Functions:**  Maintains fluid balance.  Defends against infection.  Absorbs fats from the intestines.  Components and functions of the respiratory system:  **Components:**  Nose  Pharynx Throat)  Larynx  Trachea  Lung  Bronchi  Bronchioles  Alveoli  Diaphragm  **Functions:**  Supplies the cells with oxygen.  Removes carbon dioxide.  Components and functions of the digestive system:  **Components:**  Alimentary canal (GI Tract)  Mouth, teeth, tongue, taste buds, &  Saliva  Pharynx (Throat)  Esophagus  Stomach  Small Intestine – 20 feet  Gallbladder  Pancreas  Large Intestine  Rectum & Anus  **Functions:**  Breaks down food physically &  chemically  Removes solid waste from the body  Components and functions of the urinary system:  **Components:**  Kidneys - 2  Nephron  Convoluted Tubule - Urine  Bowman’s Capsule -  Glomerulus - filter  Renal pelvis  Ureter  Bladder  Urethra  Meatus  **Functions:**  Removes waste products from blood.  Maintains electrolyte balance.  Maintains acid-base balance.  Components of the male reproductive system:  Components:  Testes – Sperm, Testosterone  Scrotum  Seminal vesicle – Sperm & Semen  Prostate Gland  Penis – Urethra  Components of the female reproductive system:  Components:  Ovary – Estrogen & Progesterone  Ovum (Egg) – One release monthly  Fallopian tube  Uterus  Fundus  Cervix  Endometrium - Menstruation  Vagina  Labia  Mammary glands  **Function of the male and female reproductive systems is to reproduce.**  Components and functions of the endocrine system:  **Components:**  Pituitary Gland  Growth Hormone  Thyroid-stimulating Hormone  Adrenocorticotropic (ATCH)  Antidiuretic Hormone (ADH)  Oxytocin – childbirth  Thyroid Gland - Metabolism  Parathyroid Glands – Calcium  Thymus  Pancreas  Adrenal Gland  **Functions:**  Secrete hormones into the blood stream to regulate the activities of other organs of the body.  Components and functions of the immune system:  **Components:**  Antibodies  Antigens  Phagocytes  Lymphocytes – (B cells & T cells)  **Function:**  Protects the body from disease and infection. | Lecture & Discussion  Chapter 9, Pages 89-107  Chapter 10, Pages 108-116 |  |
| **Unit 16**  **Personal Care** | 16.1 Explain the importance of personal hygiene.  16.2 Describe adaptive devices available to promote resident independence with hygiene needs.  16.3 Identify routine hygiene tasks to be completed throughout the day.  16.4 State the purpose of providing oral hygiene.  16.5 State observations during oral hygiene to report immediately.  16.6 Demonstrate the proper procedure for oral care, including brushing teeth for an alert resident and an unconscious resident.  16.6 Demonstrate the proper procedure for denture care.  16.7. State the benefits of bathing.    16.8. Discuss the rules for bathing.  16.9 Demonstrate the proper procedure for completing a bed bath.  16.10 List other types of baths.  16.11 Demonstrate the proper procedure for completing perineal care for the male and the female resident.  16.12 Define selected terms associated with skin and scalp conditions.  16.13 Describe the proper procedure for brushing, combing, and shampooing hair.  16.14 State the rules for shaving a resident.  16.15 Demonstrate the proper procedure for providing nail and foot care for residents.  16.16 Discuss the rules for dressing and undressing a resident.  16.17 Demonstrate the proper procedure for dressing and undressing a resident with a weak side. | Importance of personal hygiene:  Maintaining intact skin.  Prevent body odor.  Prevent breath odor.  Provide relaxation.  Promote circulation.    Adaptive (assistive) devices:  Toothpaste tube squeezer  Wash mitt with a pocket for a bar of soap.  Faucet adapter/extender  Long-handle sponge  Routine hygiene tasks:  Assist with elimination.  Assist with face & hand washing.  Assist with dressing/undressing.  Assist with hair care.  Assist with sensory devices, such as  Eyeglasses, hearing aids  These activities are done before breakfast (AM care), after breakfast, early afternoon and in the evening (PM care).    Purpose of oral hygiene:  Keeps the mouth& teeth clean.  Prevents odors and infection.  Increases comfort.  Reduces the risk for cavities & other  diseases  Observations to report **immediately:**  Dry, cracked, swollen or blistered lips  Mouth or breath odors  Redness, swelling, sores, or white  patches in the mouth or on the tongue  Bleeding, swelling or redness of the gums  Loose teeth  Rough, sharp, or chipped area on  dentures  Proper procedure for oral care for the alert and unconscious resident:  Proper procedure for denture care:  Benefits of bathing:  Cleans the skin and mucous membranes.  Removes microbes, dead skin,  perspiration, & excess oils  Promotes relaxation.  Stimulates circulation.  Exercises body parts    Rules for bathing:  Allow personal choice.  Follow standard precautions.  Remove hearing aids.  Provide privacy.  Assist with elimination before bathing.  Know the water temperature.  Wash from the cleanest to the dirtiest.  areas  Encourage the resident to help.  Rinse skin thoroughly.  Pat the skin dry.  Dry well under breasts and skin folds &  between toes.  Proper procedure for completing a bed bath:  Other types of baths:  The partial bath  Tub bath  Shower bath  Using a shower chair  Using a shower trolley  Proper procedure for perineal care for the male and the female resident:    Terms associated with hair care:  Alopecia  Dandruff  Pediculosis  Scabies    Proper procedure for brushing and combing hair:  ***Have the resident use a long-handled comb or brush to promote independence.***  Rules for shaving a resident:  Use electric razors for residents taking  anticoagulant medications and confused  residents.  Use a blade razor for residents using  continuous oxygen  Soften facial hair before shaving.  Lather the area.  Hold the skin taut.  Shave in the direction of hair growth-  face & axilla.  Shave against the direction of hair growth  legs & when using an electric razor.  Proper procedure for providing nail and foot care:  Rules for dressing and undressing a resident:  Provide privacy.  Let the resident select clothing.  Put clothing on the weak side first.  Remove clothing from the strong side  First  Put clothing on the weak side first.  Support the limb during dressing or  undressing.  ***Have the resident use assistive devices for independence with dressing such as a sock assist.***  Proper procedure for dressing and undressing a resident with a weak side: | Lecture & Discussion  Chapter 21  Chapter 22  Chapter 23  Chapter 24  *D&S Candidate Handbook*  Learning Activities for selected skills include:  Video & Discussion  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **Unit 17**  **Fall Prevention** | 17.1 Define the meaning of a fall according to the Centers for Medicare & Medicaid Services (CMS).  17.2 Identify the potential impact of a fall on a resident.  17.3 Discuss risk factors associated with falls.  17.4 Identify components of fall prevention measures.  17.5 Explain the proper procedure to assist a person who starts to fall to the floor.  17.6 Identify situations when a restraint may be used.  17.7 Describe types of restraints.  17.8 Identify alternatives to the use of a restraint.  17.9 Identify examples of physical restraints.  17.10 Differentiate enablers from restraints.  17.11 List possible risks associated with restraint use.  17.12 Describe laws, rules, & guidelines associated with restraint use.  17.13 Explain safety guidelines associated with restraint use.  17.14 Define the term transfer.  17.15 List devices and equipment used to transfer a resident.  17.16 Define the term transfer/gait belt.  17.17 Demonstrate the proper procedure for using a transfer/gait belt.  17.18 Identify safety guidelines for using wheelchairs and stretchers.  17.19 Demonstrate the proper procedure to pivot transfer a resident to and from the wheelchair.  17.20 Discuss the purpose and types of mechanical lifts to transfer a resident.  17.21 Demonstrate the proper procedure to ambulate a resident using a gait belt and a walker.  17.22 Define Range of Motion (ROM).  17.23 Identify abbreviations related to Range of Motion exercises.  17.24 Demonstrate the proper procedure to assist a resident with range of motion (ROM) of their joints. | Definition of a fall:   * Unintentionally coming to rest on a lower level * A person loses his/her balance and would have fallen if staff did not prevent the fall. * When a person is found on the floor   Falls are the most common accident in nursing centers.  Impact of a fall on a resident:  Main cause of injury  Main cause of death  Serious injuries increase risk of death.  Hip Fractures  Head trauma.  Disability  Functional decline  Decrease quality of life  Risk factors for falls:   * The person * Over age 65 years * Balance problems * Blood pressure alterations * Confusion, Disorientation * Dizziness * Drug side effects. * Incontinence * Nocturia * Unsteady gait * Pain * Poor judgement * Slow reaction time * Poor fitting shoes * Vision problems * Weakness * Care setting: * Bed height * Care equipment – drainage tube * Floor – clutter, wet, uneven * Furniture out pf place * No hand rails or grab bars * Lighting - -poor or glare * Restraints * Throw rugs * Improper use or fit   Fall prevention measures:   * Meeting basic needs * Bathrooms and shower rooms * Floors and hallways * Furniture * Bed and other equipment * Lighting * Shoes and clothing * Call lights, alarms and barriers, mats * Use a Transfer/Gait Belt   Proper procedure to assist a person to the floor:   * Stand behind the person. * Bring the person close to your body. * Move your leg so the person’s buttocks rest on it. * Lower the person to the floor. * Stay calm and talk to the person. * If the person is bariatric move objects out of the way and protect the person’s head. * Call the nurse.   Situations in which a restraint may be used:   * To treat a medical symptom * For immediate physical safety of the person or others * Failure of less restrictive measures to protect the person/others.   Types of restraints:   * Physical – *any manual method or physical device, material, or equipment attached to or near the person’s body that he or she cannot remove easily and that restricts freedom of movement or normal access to one’s body. (CMS)* * Chemical *– any drug used for discipline or convenience and not required to treat medical symptoms. (CMS)*   Alternatives to restraint use:   * Meeting physical needs * Consider life-long habits. * Food, fluid, hygiene, & eliminations needs are met. * Personal items are in easy reach. * Comfort measures such as back massages. * Outdoor time is scheduled. * Visit every 15 minutes. * Staff assignments are consistent. * Meeting safety & security needs * Call light in reach. * Wander alerts are present. * Bed, chair, & door alarms are used. * Frequent explanations are given. * Meeting love, belonging, & self-esteem Needs * Diversional activities are provided. * Frequent visits or sitters * Reminiscing with the person   Examples of physical restraints:   * Trays, bars, belts attached to a chair. * Wrist restrains or mitts. * Locked chairs * Bed or chair close to a wall. * Bed rails. * Tucking sheets too tight   Differentiate enablers from restraints:  Definition of ***enablers*** – *a device that limits freedom of movement but is used to promote independence, comfort, or safety.* In addition, the device can be removed easily by the person.  Definition of ***restraints -*** *any manual method or physical device, material, or equipment attached to or near the person’s body that he or she cannot remove easily and that restricts freedom of movement or normal access to one’s body.*  Possible risks associated with restraint use:   * Constipation * Contractures * Physical function decline * Incontinence * Infections - pneumonia * Pressure injuries * Withdrawal * Strangulation   Laws, rules, & guidelines associated with restraint use:   * Restraints must protect the person. * A doctor’s order is required. * The least restricted method is used. * Restraints are used only after other measures fail to protect the person. * Using an unnecessary restraint is involuntary seclusion. * Informed consent is required.   Safety guidelines associated with restraint use:   * Observe for increased confusion. * Protect the person’s quality of life. * Apply restraints with enough help to prevent the person and staff injury. * Observe the person every 15 minutes or as often as directed by the nurse and the care plan. * Remove or release the restraint, re-position the person, and meet basic needs at least ever two (2) hours. * Report & Record restraint use.   Definition of the term transfer:  *…how a person moves to and from a surface.*  Devices and equipment used to transfer a resident:   * Bed attachments * Slide boards * Transfer belts * Mechanical lift (full-sling) * Mechanical lift (stand-assist)   The care plan will include information about the proper technique to safely transfer a resident.  Definition of the term transfer/gait belt:  …*a device applied around the waist and used to support a person who is unsteady or disabled.*  Proper procedure for using a transfer/gait belt:   * Assist the resident to a sitting position. * Wrap the belt around the resident. * **Always place the belt over clothing.** * Insert the metal tip into the buckle through the side with the teeth. * Tighten the belt – should be able to fit two finger under the belt.   Safety guidelines for using wheelchairs and stretchers:   * Maintenance – ensure all parts work correctly. * Transfers * Lock brakes. * Remove leg lifts/footplates. * Position feet on the footplates. * Transport * Push the wheelchair forward. * Pull the wheelchair backward when going through a doorway. * Pull the wheelchair backward when going down a ramp. * Stretcher * Use at least two staff to transfer a resident to and from a stretcher. * Locks the breaks. * Fasten the safety straps. * Raise the side rails. * Move the stretcher feet first. * Do not leave the resident alone on the stretcher.   Proper procedure for a pivot transfer:  Purpose of the mechanical lift:   * Residents cannot assist/participate with the transfer. * Residents are too heavy to be moved by staff.   Types of mechanical lifts:   * Stand-assist mechanical lift * Full-sling mechanical lift   Proper procedure to use to ambulate a resident using a gait belt and/or walker:  Definition of Range of Motion:  *The movement of a joint to the extent possible without causing pain.*  Range of Motion abbreviations:  AROM = Active ROM – done by the resident  PROM = Passive – done by staff  AAROM = Active-Assist done by the resident with staff assist  Proper procedure for assisting a resident with ROM of the shoulder, hip, and knee. | Lecture & Discussion  Chapter 12  Chapter 13  Chapter 18  Chapter 32  **Learning Activities for Selected Skills include:**  Video & Discussion  *D&S Candidate Handbook*  Instructor Demonstration  Supervised Practice  Clinical Practice  Box 12-2  Figure 12-12  Box 13-2  Box 13-4  Figures 32-4, 32-10, and 32-11  **Learning activities for selected skills include:**  Video & Discussion  *D&S Candidate Handbook*  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **Unit 18**  **Nutrition**  **&**  **Fluid Needs** | 18.1 State the  effects of poor  diet and poor  eating habits.  18.2 Define the  term *Nutrition.*  18.3 Define the  term *nutrient*.  18.4 Define the  term *calorie.*  18.5 Explain the  purpose of the  *MyPlate* symbol.  18.6 List weekly  physical activity  recommended by  USDA.    18.7 Describe the  Five food groups  and give examples of  each.  18.8 Identify  each nutrient and  its function.  18.9 Recognize  factors affecting  eating and  nutrition.  18.10 Discuss the  OBRA dietary  requirements.  18.11 Explain the  purpose of  special diets.  18.12 Define  selected special  diets.  18.13 Identify signs  and symptoms of  dysphagia.  18.14 Explain  aspiration  precautions.  18.15 Demonstrate  the proper  procedure for  feeding a dependent  resident.  18.16 Identify ways  to assist a visually  impaired  resident.  18.17 Identify the nursing assistant role in providing care for a resident who receives enteral nutrition.  18.18 Define selected terms associated with fluid balance.  18.19 Identify normal fluid requirements.  18.20 Explain special considerations associated with older adults.  18.21 List special fluid orders.  18.22 List common intake and output measurements.  18.23 Demonstrate proper procedure for measuring intake and output.  18.24 Demonstrate measure the amount of food intake of a resident.  18.24 Demonstrate the proper procedure for placing a resident on a bed pan and measuring urine output.  18.24 Identify the role of the nursing assistant in caring for a resident receiving intravenous (IV) therapy.  18.25.  Identify guidelines for measuring height and weight. | Effects of poor diet and eating habits:   * Increased risk of disease and infection * Causes chronic illnesses to become worse. * Difficulty healing * Increase in accidents and injuries.   Definition of the term *nutrition*:  …*process involved in the ingestion, digestion, absorption, and the use of food and fluids by the body.*  Definition of the term *nutrient*:  *…substance that is ingested, digested, absorbed, and used by the body.*  Definition of the term *calorie:*  *…fuel or energy value of food*  Examples:  1 gram of fat = 9 calories  1 gram of protein = 4 calories  1 gram of carbohydrate = 4 calories  Purpose of the MyPlate symbol:   * Balance calories * Increasing certain foods * Half the plate should be fruits and vegetables * At least half of the grains should be whole grains * Fat-free or low-fat milk * Reducing certain foods * Choosing low-sodium foods * Drinking water   Weekly physical activity:   * At least three days a week * Two hours & 30 minutes of moderate physical activity such as: * Walking rate of 3 & a half mph * Water aerobics * 75 minutes of vigorous physical activity such as: * Running at a rate of 5 mph * Swimming laps   The five food groups:   * Grains – Bread, Pasta, Oatmeal * Vegetables – Broccoli, Kale, Beans * Fruits – Any fruit or juice * Dairy – Milk, Yogurt, Cheese * Proteins – Beef, Chicken, Seafood, Eggs, Soy, Beans, Peas, and Nuts   Note: Oils are not a food group. Butter is included in the oil category.  Basic nutrients and their function:   * Protein – Tissue growth & repair * Carbohydrates – Provides energy & fiber.   Dietary Fiber & Sugar   * Fats – Provide energy and flavor. They also help the body to utilize certain vitamins. * Vitamins – Needed for certain body functions. Vitamins A, D, E, & K are stored. Vitamins C & B are not stored. * Minerals – Necessary for bone & teeth formation, nerve and muscle function, & fluid balance * Water – Necessary for all body function   Factors affecting eating and nutrition:   * Culture * Religion * Finance * Appetite * Personal choice * Body reaction & Age * Illness * Medication (Drugs) * Chewing problems * Swallowing problems * Disability * Impaired cognitive function   OBRA dietary requirements:   * Each resident’s dietary needs are   Met.   * The residents’ diet is well-balanced. * The food is appetizing. * Hot foods are served hot. * Cold foods are served cold. * Food is served promptly. * Substitutions are similar in   nutritional value   * Each resident receives at least 3   meals each day   * A bedtime snack is offered. * Adaptive equipment/utensils are   provided.  Purpose of special diets:  Special diets are ordered by the physician for one of the following reasons:   * A nutritional deficiency * An illness * To help with weight gain/loss * To remove/decrease certain substances in the diet.   Define special diets:   * Regular Diet – no limitations * Sodium-controlled – * Diabetic meal plan * Dysphagia Diet – Prevents choking.   Signs & symptoms of dysphagia:   * “Pockets” food * Complains the food will not go down * Coughs or chokes when swallowing * Tires during the meal * Regurgitates food after eating   In a dysphagia diet food and fluids consistency is changed to meet the resident’s needs. The change in consistency helps to prevent aspiration.  Aspiration precautions:   * Follow the dietary care plan. * Position the resident in high- Flower’s. * Maintain the upright position for 30 to 60 minutes after eating. * Question the use of straws. * Check the resident’s mouth after eating.   *Dysphagia means difficulty swallowing.*  *Aspiration means breathing fluid, food, vomitus, or an object into the lungs.*  Proper procedure for feeding a dependent resident including calculating the amount of food and fluid consumed:  ***To promote independence with eating use***  ***Provide the resident with assistive devices, such as built-up flat wear, eating device attached to a splint.***  Ways to assist a visually impaired resident:   * Describe the food on the tray. * Ask the resident what to eat first. * If the residents can feed themselves tell them where each food item is located on the plate/tray – use the numbers face of a clock.   In most nursing centers the nursing assistant does not administer enteral nutrition. It is important for the nursing assistant to know about the tubes used to administer enteral nutrition as they will need to ensure the tubes are not removed.  The nursing assistant may have the responsibility for cleaning around the tube.  Enteral feeding tubes:   * Naso-gastric * Gastrostomy * Jejunostomy   Preventing aspiration:   * Position the resident in a Fowler’s or semi-Fowler’s position.   Definition of selected terms:  Intake = *the amount of fluid taken in*  Output = *the amount of fluid loss*  Hydration = *having an adequate amount of*  *water in body tissues*  Edema = *swelling of body tissues with water*  Dehydration = *decrease in the amount of*  *water in body tissues*  Dehydration will be discussed in detail in the Unit titled ***Health Problems***  Normal fluid requirements:   * Adults need 1500 mL for survival. * Fluid balance require approximately 2000 to 2500 mL/day. * Water requirements increase with hot weather, exercise, fever, illness, and at times of fluid losses.   Special considerations associated with older adults, include:   * Body water decreases with age. * Older adults have a decreased thirst sensation.   Special fluid orders:   * Encourage fluids. * Restrict fluids – no water pitcher at the resident’s bedside. * Nothing by mouth (NPO) * Thickened liquids   Common measurements:   * 1 cubic centimeter = 1 mL * 1 ounce = 30 mL * 1 cup = 240 mL * 1 quart = 1000 mL * 1 liter = 1000 mL   Proper procedure for measuring intake and output:   * All fluids taken in and all fluids put out are measured and recorded. * All fluids are measured on a flat surface at eye level * All fluids are measured in milliliters (mL) * Fluids levels are totaled at the end of every shift and every 24 hours.   ***To promote resident independence, provide a lidded mug for sipping or a straw if ordered.***  Measuring food intake.  Percentage of food intake (0-100 %)  Calorie count  Proper procedure for assisting a resident to use a bedpan and measuring urine output:  Nursing assistant (NA) role in caring for a resident receiving IV therapy:   * Report signs and symptoms of local complications. * Bleeding * Blood backing up into the tubing * Swelling at the site * Pale or redness at site * Complaints of pain * Hot or cold skin near the site * Report signs or symptoms of systemic complications. * Fever * Itching * Drop in blood pressure * Increased pulse rate (> 100) * Change in mental status * Decreasing or no urine output * Chest pain   Guidelines for measuring height and weight:   * Resident wears a gown. * Resident voids before weighing. * Complete weight at the same time of day * Use the same scale. * Balance the scale at zero | Lecture & Discussion  Chapter 28  Chapter 29  Chapter 30  **Learning activities for selected skills include:**  Video & Discussion  *D&S Candidate Handbook*  Instructor Demonstration  Supervised Practice  Clinical Practice  Table 28-1  Table 28-2  Review Chapter 31  Page 406-410 |  |
| **Unit 19**  **Common**  **Health**  **Problems**  Hearing:  Meniere’s  Loss  Visual disorders:  Cataracts  Glaucoma  Low Vision  Blindness  Cancer  Arthritis  Fractures  Stroke  Aphasia  Parkinson’s  MS  ALS  Head Injury  Spinal cord  Injury  Heart Disease  Respiratory  COPD  Asthma  Influenza  Pneumonia  Tuberculosis  Digestive  Vomiting  Diverticulosis  IBD  Hepatitis  Cirrhosis  Urinary  UTI  BPH  Kidney Stones  Kidney Failure  Diabetes  Autoimmune  HIV/AIDS  Shingles | 19.1.  Discuss common  health problems  and interventions  related to the health  problems.  19.2 Demonstrate  the proper  procedure for  catheter care  and emptying a  urinary drainage  bag. | Common health problem and associated interventions:  **Hearing Problems**  **Meniere’s Disease** –  Involves the inner ear.  Signs & Symptoms:   * Vertigo * Tinnitus * Hearing loss * Pressure in the ear.   Interventions:   * Assist the resident to lie down. * Tell the resident to keep their head still. * Stand in front of them when speaking. * Avoid sudden movements. * Dim the lights in the room. * Keep the blinds closed.   **Hearing Loss –**  Limited to total deafness  Signs & Symptoms:   * Straining to understand conversation. * Answers to questions are inappropriate. * Ask others to repeat themselves. * Leaning forward to hear * Turning up devices (TV, Radio, etc.)   Interventions:   * Hearing aids * Watch facial expression, gestures, and body language. * Sign language. * Story boards * Hearing dogs * Face the person when speaking.   **Visual Problems**  **Cataracts-**  Clouding of the lens of the eye (one or both)  Signs & Symptoms:   * Cloudy, blurry, or dim vision * Colors seem faded or brownish * Blues and purples are hard to see * Sensitivity to light & glares * Poor vision at night * Halos around objects * Double vision   Interventions:   * Follow guidelines for visually impaired residents * Postoperative care * Glasses or eye shield * Eye shield to be worn for sleeping * Remind the resident not to rub or press on the affected eye * Report pain or drainage * Remind the resident not to bend, stoop, cough or lift things   **Age-Related Macular Degeneration**  Loss of central vision  Signs & Symptoms:   * Gradual loss of vision * Progressive   Interventions:   * Guidelines for caring for a resident who is visually impaired. * Laser surgery   **Diabetic Retinopathy**  Damage to the blood vessels in the retina.  Complication of Diabetes  Signs & Symptoms: (Both eyes usually)   * Blurred vision * Complaints of seeing spots floating * Blindness   Interventions:   * Control Diabetes * Control blood pressure. * Control cholesterol. * Laser surgery   **Glaucoma**  Buildup of fluid in the eye causing pressure on the optic nerve  Signs & Symptoms:   * Peripheral vision is lost. * Blurred vision * Objects are seen through a tunnel. * Halos around lights * Blindness   Interventions:   * No cure * Damage is irreversible. * Medications * Surgery   **Low Vision**  Vision loss that cannot be treated  Signs & Symptoms:   * Difficulty reading * Difficulty recognizing faces. * Difficulty doing tasks such as cooking. * Difficulty reading signs anywhere. * Light seems dimmer.   Interventions:   * Make reading glasses available. * Offer large-print books. * Hand-held magnifiers * Audio tapes * Computers with large fonts & sound * Adjustable lights * Large numbers on things like phones, clocks & watches   **Medical Problems**  **Cancer:** Second leading cause of death  Key terms:   * Tumor * Benign * Malignant * Metastasis   Risk Factors:   * Age – most important * Tobacco * Radiation * Infections * Immuno-suppressive drugs * Alcohol * Diet * Hormones * Obesity * Environment   Signs & Symptoms:   * Unexplained weight loss * Skin changes * Change in bowel habits * Sores that do not heal * White patches in the mouth * Unusual bleeding or discharge * Thickening or lump * Indigestion * Difficulty swallowing * Nagging cough * Hoarse   Treatment:   * Goals * Cure * Control * Reduce symptoms. * Surgery * Radiation * Chemotherapy * Immunotherapy * Report pain/discomfort. * Radiation site Skin Care * Dietary needs * Active listening   **Musculo-Skeletal Disorders**  (Disorders affecting movement)  **Arthritis**  Joint inflammation  Types:   * Osteoarthritis (OA) – Cartilage wears away allowing bone to rub on bone. * Rheumatoid (RA) – Autoimmune disorder attacks the lining of the joints.   Risk Factors:   * Age * Overweight * Women * Family history   Signs & Symptoms:   * Joint Swelling * Joint stiffness * Reduced range of motion of the joint   Interventions:   * Pain control * Heat & Cold * Exercise * Rest & joint care. * Assistive devices * Weight control * Assistance with ADLS as needed. * Surgery – Joint replacement (Arthroplasty * Care after Surgery * Prevent pressure injury. * Hip precautions: * Do not cross legs. * Do not sit in low chairs. * Avoid flexing hips past 90 degrees. * Use grabbers. * Use elevated toilet seats. * Abductor pillow   **Fracture**  A break in a bone  Types:   * Open – Bone is through the skin (compound) * Closed – Skin is intact (simple)   Signs & Symptoms:   * Pain * Swelling * Loss of function * Deformity * Bruising * Bleeding   Interventions:   * Reduction – realigns the bone. * Fixation – bone is held (fixed) in place. * Casting – Care guidelines * Traction   **Osteoporosis**  Bones become porous and brittle.  Risk Factors:   * Decreased estrogen. * Low levels of dietary calcium * Low levels of vitamin D * Family history * Lack of exercise * Immobility * Tobacco use * Eating disorders   Signs & Symptoms:   * Back pain * Loss of height * Stooped posture * Fracture   Interventions:   * Prevention * Medications/Supplements * Calcium * Vitamin D * Estrogen * Exercise Programs * Walking * Dancing * Weightlifting * Climbing stairs * Good body mechanics * Back supports/Corsets * Walking aids   **Loss of a Limb (Amputation)**  Removal of all or part of an extremity.  Causes:   * Severe injury * Tumors * Severe infection * Gangrene – death of tissue. * Vascular disorders   Interventions:   * Prosthesis * Care of a prosthetic device * Wash stump shrinker. * Observe the skin on the stump. * Apply shrinker. * Assist the patient to put on the prosthesis. * Manage Phantom pain. * Physical Therapy   **Nervous System Disorders**  **Stroke –** Brain Attack or Cerebrovascular accident (CVA)  Causes:   * Ruptured blood vessel in the brain (hemorrhage) * Blood flow to an area of the brain stops due to a blood clot. * Transient ischemic attack (TIA)   Signs & Symptoms:   * Hemiplegia * Redness of the face * Noisy breathing * Unconsciousness * High blood pressure * Slow pulse * Seizures * Incontinent * Changing emotions * Aphasia * Behavior changes   Interventions:   * Medications (Thrombolytics) * Prevent aspiration. * Anti-embolic stockings * Safety precautions * Establish communication methods. * Therapy – Physical, Occupational, Speech   **Parkinson’s Disease**  Progressive disorder affecting movement.  Signs & Symptoms:   * Tremors * Pill-rolling. * Trembling * Rigid, stiff muscles * Stooped posture * Impaired balance * Shuffling gait * Mask-like expression. * Fixed stare * Cannot blink or smile. * Swallowing & Chewing problems * Memory loss * Fear, insecurity. * Slow, monotone, & soft speech   Interventions: No cure   * Medications * Exercise * Therapy – physical, occupational, & speech * Safety measures   **Multiple Sclerosis (MS)**  Destruction of the myelin (cover nerve fibers) in the brain and spinal cord – functions are impaired or lost  Risk Factors:   * Age (15 to 60) * Gender (women) * Caucasian * Family history   Signs & Symptoms:   * Blurred or double vision * Muscle weakness * Balance/Coordination problems * Partial /complete paralysis * Remission/Relapse   Interventions: No cure   * Medications * Safety precautions * Care as needed * Range of motion   **Amyotrophic Lateral Sclerosis (ALS)**  ***Lou Gehrig’s Disease***  Attacks the nerve cells that control voluntary muscles.  Life expectance is 2-5 years  Risk Factors:   * Age (40-60)   Signs & Symptoms:   * Progressive muscle weakness   Interventions: No Cure   * Medications * Respiratory support * Care as needed * Safety Precautions   **Head Injuries (TBI) –**  Causes:   * Falls * Traffic accidents * Assaults * Fire arms * Sport injuries * Combat injuries   Signs & Symptoms:  Based on the area of the brain injured   * Change in level of consciousness. * Coma - unaware * Vegetative state – Sleep-wake cycles, open eyes, make sounds, may move cannot speak or follow commands. * Brain death – complete loss of brain function, spontaneous respirations are absent.   Interventions:   * Rehabilitation * Care as needed. * Safety precautions   **Spinal Cord Injury -**  Causes:   * Traffic accidents * Falls * Violence * Sport injuries * Cancer   Signs & Symptoms:   * Paralysis * Paraplegia – paralysis of the legs, lower trunk, and pelvic organs * Quadriplegia – arms, legs, trunk, and pelvic organs * Lumbar and thoracic injuries cause paraplegia * Cervical Injuries cause quadriplegia   Interventions:   * Care as needed. * Prevent pressure injuries. * Safety precautions   **Cardiovascular Disorders**  **Hypertension –** high blood pressure  Systolic blood pressure is 140 mm Hg or higher.  Diastolic blood pressure is 90 mm Hg or higher.  Causes:   * Narrow blood vessels * Kidney disorders * Head injuries. * Pregnancy * Adrenal tumors   Risk Factors:   * Age – men 45 & women 55 * Gender – men * Race – African American * Family history * Obesity * Stress * Smoking * High cholesterol * Diabetes   Signs & Symptoms:   * Headache * Blurred vision * Dizziness * Nose bleeds   Interventions:   * Medications * Lifestyle modifications   **Coronary Artery Disease** **(CAD)**  Coronary arteries become hardened and narrow causing the heart muscle to get decrease blood and oxygen.  Causes:   * Atherosclerosis   Signs & Symptoms:   * Angina – Chest pain * Irregular heart rate   Complications:   * Myocardial Infarction - * Heart Failure  1. Right-sided symptoms. 2. Left-sided symptoms.  * Sudden death   Interventions:   * Medications * Nitroglycerin * Diuretics * Antihypertension * Lifestyle modifications * Surgery (CABG)   **Respiratory Disorders**  **Chronic Obstructive Pulmonary Disease**  **(COPD) –** Involves **Chronic Bronchitis & Emphysema**  Obstruction of air flow (oxygen and carbon dioxide exchange. Lung function is gradually lost.  Risk Factor – cigarette smoking.  Signs & Symptoms:   * Cough * Mucus production * Difficulty breathing (SOB) * Tires easily * Low oxygen levels * Barrel chest. * SOB on exertion and at rest. * Fatigue   Interventions:   * Medications * Breathing exercises – pursed lip * Positioning – Upright * Meeting Oxygen needs * Positioning * Deep Breathing & Coughing * Supplemental Oxygen * Delivery systems   **Asthma**  Inflammation and narrowing of the airways.  Risk Factors:   * Allergies * Air pollutants/irritants * Smoking * Respiratory infections * Cold air   Signs & Symptoms:   * Shortness of breath (SOB) * Wheezing * Coughing * Increased pulse rate * Fear * Sweating * Cyanosis (Blue color to the skin)   Interventions:   * Medications * Meeting Oxygen needs   **Influenza**  Respiratory infection  Cause is a virus  Signs & Symptoms:   * High fever for several days * Headache * Cough * Cold symptoms   Interventions:   * Medications * Fluids & rest   **Pneumonia**  Inflammation and infection of lung tissue causing impaired gas exchange.  Signs & Symptoms:   * Fever * Chills * Cough * Shortness of breath (SOB) * Thick sputum (Mucous) * Tiredness   Interventions:   * Medications * Oxygen * Position – (semi-Fowler’s) * Increased fluids * Rest   **Tuberculosis**  Bacterial infection of the lungs  Risk Factors:   * Contact with an infected person * Age * Poor nutrition * HIV   Signs & Symptoms:   * Cough (blood) * Tiredness * Weight loss * Fever * Night sweats   Interventions:   * Medications * Care as needed. * Airborne precautions   **Digestive Disorders**  **Vomiting**  **Diverticular Disease**  **Inflammatory Bowel Diseases (IBD)**   * Crohn’s Disease & Ulcerative colitis * Signs & Symptoms * Diarrhea - blood * Abdominal pain * Cramping * Fever * Weight loss * Interventions: * Medications * Diet modifications. * Surgery – * Ileostomy * Colostomy   **Constipation**  **Fecal Impaction**  **Diarrhea**  **Fecal Incontinence**  **Flatulence**  **Bowel Training:**   * Goals of bowel training * To gain control of bowel movements (BM) * To develop a regular pattern of elimination * Interventions * Identify the resident’s usual time for BM. * Assist the resident to the bathroom at these times. * Provide privacy. * Increase fluids (warm) * Provide a high fiber diet. * Encourage activity.   **Liver Diseases**   * Hepatitis – Inflammation and infection of the liver caused by a virus. * Types * Hepatitis A – contaminated food and water * Hepatitis B – infected blood and body fluids * Hepatitis C – infected blood * Hepatitis D – HBV * Hepatitis E – contaminated food and water * Cirrhosis – scar tissue blocks blood flow through the liver; function is affected. * Causes: * Chronic alcohol abuse * Chronic Hepatitis B & C * Fatty liver * Obesity * Signs & Symptoms * Weakness * Loss of appetite * Itching * Edema * Ascites * Jaundice   **Urinary System Disorders**  **Urinary Tract infections – Lower tract, Cystitis, Pyelonephritis**  Microbes enter the urinary tract through the urethra.  Causes:   * Poor perineal hygiene * Immobility * Poor fluid intake * **Urinary catheters** * GU examinations * Intercourse   Signs & Symptoms:   * Frequency * Urgency * Dysuria - pain * Cloudy urine - pyuria (pus) * Foul-smelling urine * Hematuria – blood * High fever -   Interventions:   * Medications - antibiotics * Fluids – 2000 mL/day   Proper procedure for catheter care and emptying a urinary drainage bag.  **Prostate Enlargement – Benign Prostatic Hyperplasia (BPH)**  Cause is age.  Signs & Symptoms:   * Weak urine stream * Trouble starting to urinate. * Frequent voids of small amounts * Leakage of urine, dribbling of urine * Nocturia – Nighttime * Urinary retention * Pain   Interventions:   * Medications * Urinary Catheters * Surgery   **Kidney Stones – Calculi**  Risk Factors:   * Bedrest * Immobility * Poor fluid intake   Signs & Symptoms:   * Pain – back below the ribs * Fever * Chills * Dysuria * Hematuria * Cloudy urine   Interventions:   * Medications – pain * Increase fluid intake – 2000 to 3000mL/day. * Strain all urine. * Diet modifications. * Surgery   **Kidney Failure**  Kidneys do not function properly if at all. Waste products build up in the body. Fluid is retained.  Interventions:   * Fluid restrictions * Diet modifications – decreased protein, potassium, and sodium. * Daily weights * Postural blood pressure readings * Care as needed. * Dialysis   **Bladder Training**   * The goal is to control urinary elimination. * Often need after a urinary catheter is removed. * Methods * Bladder re-training * Urinate at scheduled times * Prompted voiding. * Recognizes when the bladder is full.. * Habit training * Every 2-4 hours while awake. * Catheter clamping   **Endocrine Disorders**  **Diabetes –**  Glucose intolerance  Risk factor is family history.  Types:   * Type 1 – little or no production of Insulin * Type 2 – Insulin production is normal, however the body does not utilize the Insulin well. * Gestational Diabetes – develops during pregnancy.   Signs & Symptoms:   * Thirst * Frequent urination * Hungry * Weight loss * Dry, itchy skin * Slow healing * Tingling in the feet * Blurred vision   Complications:   * Hypoglycemia * Hyperglycemia   Interventions:   * Diet modifications. * Exercise programs. * Medications * Foot care   **Immune System Disorders**  HIV/AIDS  A virus spreads through direct contact with infected blood or body fluids from a person who has the HIV virus.  Causes:   * Sex with an infected person * Sharing equipment used to prepare injection drugs.   Signs & Symptoms:   * Weight loss * Recurring fever * Night Sweats * Fatigue * Swollen lymph nodes * Diarrhea lasting more than 1 week * Sore throat * Sores in the mouth and elsewhere * Blotches under the skin   Interventions:   * Care as needed. * Medications * Blood borne precautions.   **jjjjjSkin Disorders**  **Shingles (herpes zoster)**  Caused by the virus that caused chicken pox.  Signs & Symptoms:   * Rash * Fluid-filled blisters * Burning, tingling pain * Numbness * Itching   Interventions:   * Medications * Care of the lesions * Contact precautions. | Lecture & Discussion  Chapter 25  Chapter 26  Chapter 27  Chapter 35  Chapter 37  Chapter 38  Chapter 39  Chapter 40  Box 39-6  Procedure Box: *Applying Elastic (Anti-embolic) Stockings*  Chapter 35, Page 451  Figure 35-5  Chapter 26  Pages 334-339 |  |

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| **Unit 20**  **Confusion**  **&**  **Dementia**  **Unit 21**  **Mental**  **Health**  **Disorders** | 20.1 Define selected  terms associated with  confusion and  dementia.  20.2 Describe nervous  system changes from  aging.  20.3 List causes of  confusion.  20.3 Identify selected  measures to  incorporate in the care  for residents who are  confused.  20.4 List causes of delirium.  20.5 State possible  signs and symptoms of  delirium.  20.6 List the early  warning signs of  dementia.  20.7 List the risk  factors associated with  AD.  20.8 Identify warning  signs of AD.  20.9 Identify signs of  AD.  20.10 Discuss the  Three Stages of AD.  20.11 Identify  communication  techniques to use  when interacting with  a resident with AD or  other types of  dementia.  20.11. Discuss  selected care  measures.  20.12  Describe *Validation*  *Therapy.*  21.1 Identify selected  terms associate with  mental health and  mental health  disorders.  21.2 List the possible  causes of mental  health disorders.  21.3 Describe  selected defense  mechanisms.  21.4 List types of  Mental health  disorders. | Selected terms:  **Cognitive function** – *involves memory, thinking, reasoning, ability to understand, judgement, and behavior.*  **Disoriented** – *to be apart from one’s awareness.*  **Confusion** - *…a state of being disoriented to person, time, place, situation, or identify.*  **Delirium** - *…a state of sudden, severe confusion and rapid changes in brain function.*  **Dementia** - *…the loss of cognitive function that interferes with routine personal, social, and occupational activities.*  Age related nervous system changes:   * Reflexes, responses, and reaction times are slower. * Senses decrease. * Sensitivity to pain decreases. * Sleep patterns change. * Memory is shorted; forgetfulness occurs. * Dizziness can occur.   Causes of confusion:   * Disease * Brain injury * Infection * Hearing & vision loss * Medication side effects   Selected care measures:   * Give the date & time each morning. * Keep a calendar & clock in sight. * Break tasks into small steps. * Place familiar objects & photos in view. * Discuss current events. * Maintain day-night cycle. * Follow the resident’s routine.   Causes of delirium:   * Surgery * Substance abuse * Medication side effects * Infections   Signs & symptoms of delirium:   * More alert in the AM * Drowsiness * Confusion about time or place * Concentration changes * Incontinence * Emotional changes * Speech is not clear.   **Delirium is usually temporary and reversible.**  **Delirium signals disease.**  **Delirium is an emergency.**  Early warning signs of dementia:   * Memory loss * Common tasks problems * Forgetting simple words * Poor judgment * Personality changes     **Alzheimer’s dementia (AD) is the most**  **common form of dementia**  Risk factors:   * Age – after age 65 * Gender – women * Family history   Warning signs of AD:   * Asking the same question * Repeats the same story * Gets lost in known places * Problems with budget * Neglects hygiene * Forgets how to do tasks   Signs of AD:   * Forgetting * Speaks native language. * Wanders * Distrusts others * Conversation problems * Slow, steady decline in mental function   Stages of AD:   * Mild * Memory problems * Tasks take longer. * Behavior changes * Wandering * Getting lost * Moderate * Problem with routine   tasks   * Difficulty recognizing   family/friends   * Cannot learn new things. * Sundowning * Hallucinations * Delusions * Paranoia * Impulsive behavior * Severe * Cared for by others. * Cannot communicate. * Difficulty swallowing * Incontinence     Communication techniques:   * Make eye contact. * Control distractions. * Use a calm, gentle voice. * Avoid negative body language. * Give simple instructions. * Give the person time to respond. * Do not criticize or argue. * Do not try to reason.   Care measures:   * Follow set routines. * Use picture signs. * Place large clock/calendars in view. * Select tasks based on ability. * Remove harmful items. * Consider electrical safety. * Provide safe storage for: * Personal items * Cleaning products * Car keys * Smoking materials * Lock doors. * Keep alarms on * Respond to alarms quickly. * Meet personal needs for food and elimination. * Avoid caffeine. * Play soft music.   *Validation therapy* is a communication technique used in dementia care.  **Validate** - …*to show that a person’s feelings and needs are fair and have meaning.*  Principles of *validation therapy*:   * All behavior has meaning. * A person may have unresolved issues from the past. * A person’s mind may return to the past to resolve issues and emotions. * Caregivers need to listen and provide empathy.   Selected terms:  **Mental** – *relates to the mind.*  **Stress** - *…response or change in the body caused by any emotional, physical, social, or economic factor.*  **Mental health** - …*involves a person’s emotional, psychological, and social well-being.*  **Mental health disorder** - *…disturbance in the ability to cope with or adjust to stress. Behavior and function are impaired.*  **Defense mechanism** - *…unconscious reaction that blocks unpleasant or threatening feelings.*  Causes of mental health disorders:   * Chemical imbalances * Genetics * Physical, biological, or psychological factors * Substance abuse * Social & cultural factors * Abuse   Selected defense mechanisms:   * Compensation * Conversion * Denial * Displacement * Identification * Projection * Rationalization * Reaction formation * Regression * Repression   Types of mental health disorders:   * Anxiety Disorders * Panic Disorders * Phobias * Agoraphobia * Aquaphobia * Claustrophobia * Mysophobia * Nyctophobia * Obsessive-Compulsive disorder * Post-traumatic stress disorder * Flashbacks * Schizophrenia * Bipolar Disorder * Depression * Older adults * Personality Disorders * Antisocial Personality * Borderline Personality * Substance abuse Disorder * Addiction * Withdrawal Syndrome * Eating Disorders * Anorexia Nervosa * Bulimia Nervosa * Binge eating disorder. * Suicide…*to ends one’s life on purpose.*   Risk factors:  Prior suicide attempt  Depression  Chronic pain  Family history | Lecture & Discussion  Chapter 342  Pages 539-554  Lecture & Discussion  Chapter 41  Pages 529-538  Box 41-10 |  |
| **22**  **Emergency**  **Care** | 22.1Define selected  terms associated with  emergency care.  22.2 State the  Emergency care rules.  22.3 State the three  major signs of sudden  cardiac arrest (SCA).  22.4 List the steps in  the Chain of Survival  for out-of-hospital  situations.  22.5 State the rate of  compressions during  CPR.  22.6 State the rate of providing rescue breaths.  22.7 State the rate for providing breaths during CPR.  22.8 Describe the role of the Automated External Defibrillator (AED).  22.8 Define respiratory arrest.  22.9 Discuss emergency care measures for a resident experiencing respiratory arrest.  22.10 Discuss emergency care measures for a resident experiencing poisoning.  22.11 Identify emergency care measures for a resident experiencing a heart attack.  22.12 Identify signs and symptoms of an internal hemorrhage.  22.13 Discuss emergency care measures for a resident experiencing internal hemorrhage.  22.14 Identify signs and symptoms of an external hemorrhage.  22.13 Discuss emergency care measures for a resident experiencing external hemorrhage.  22.14 Define Fainting.  22.15 Identify signs and symptoms of fainting.  22.16 Discuss emergency care measures for a resident experiencing fainting.  22.17 Define shock.    22.18 Identify the signs and symptoms associated with shock.  22.19 Identify emergency care measures for a resident experiencing  shock.  22.20 Define Anaphylactic Shock.  22.21 Identify the signs and symptoms associated with anaphylactic shock.  22.22 Identify emergency care measures for a resident experiencing  anaphylactic shock.  22.23 Define Stroke.  22.24 Identify signs and symptoms of stroke.  22.25 Identify emergency care measures for a resident experiencing  a stroke.  22.26 Define seizure.  22.27 Identify types of seizures.  22.28 Identify emergency care measures for a resident experiencing  a seizure.  22.29 Define concussion.  22.30 Identify emergency care measures for a resident experiencing  a concussion.  22.31 30 Identify emergency care measures for a resident experiencing  a burn. | Selected terms associated with emergency care:  **First aid**…*emergency care given to an ill or injured person before medical help arrives.*  **Sudden cardiac arrest (SCA)…***the heart stops suddenly and without warning.*  **Respiratory arrest*…****breathing stops but heart action continues for several minutes.*  **Rescue Breathing…***breaths given when there is a pulse but no breathing only agonal gasps.*  **Agonal respirations…***struggling to breath; agonal gasps do not bring enough oxygen into the lungs.*  ***Resuscitate…****to revive from apparent death or unconsciousness using emergency measures.*  **Recovery position…***used when the person is breathing and has a pulse but is not responding. This position keeps the airway open and prevents aspiration.*  **Defibrillation**…*shock the heart into a regular rhythm.*  **Anaphylaxis…***life-threatening sensitivity to an antigen*  Emergency care rules:   * Call for help. * Tell the operator the following: * Location * Phone number * What seems to have happened. * How many people are involved. * Condition of the victims * What aid is being given. * Assess the situation for safety. * Stay calm. * Know your limitations. * Follow standard/bloodborne precautions. * Do not move the person unless the situation is unsafe. * Do not remove clothing. * Do not given the person food or fluids.   Three major signs of SCA:   * No response * No breathing or no normal breathing * No pulse   Steps in the Chain of Survival:   * Recognize cardiac arrest. * Activate EMS * Perform CPR immediately. * Defibrillate quickly. * Provide BLS and ALS * Provide post -arrest care.   Rate of compressions during CPR:   * Compressions rate = 100-120 per minute   Rate of providing rescue breaths:   * Rescue breaths = 1 breath every 5-6 seconds   Rate for providing breaths during CPR:   * Each breath should take 1 second. * The chest should rise with each breath. * Two breaths are given after 30 chest compressions.   Role of an AED to deliver a shock to the heart. The shock stops ventricular fibrillation. The heart may resume a regular rhythm.    Definition of respiratory arrest…*breathing stops, however, the heart actions continue for several minutes.*  Emergency care measures for a resident experiencing respiratory arrest:  Initiate rescue breathing.  Emergency care measures for a resident experiencing poisoning:  Call the Poison Control Center.    Emergency care measures for a person experiencing a heart attack:  Activate EMS.  Start CPR  Sign and symptoms of an internal hemorrhage:  Pain, shock, vomiting blood, coughing up blood,  cool and pale skin and loss of consciousness  Emergency care measures for a resident experiencing an internal hemorrhage:  Activate EMS  Keep the person warm.  Do not give fluids.  Signs and symptoms of an external hemorrhage:  Bleeding from a vein is a steady flow of blood.  Bleeding from an artery occurs in spurts.    Emergency care measures for a resident experiencing an external hemorrhage:  Activate EMS  Do not remove any objects if one pierces the  skin.  Cover the wound.  Apply pressure to the wound until the bleeding  stops.    Fainting (syncope)…*sudden loss of consciousness from inadequate blood flow to the brain.*    Signs and symptoms of fainting:  Dizziness, perspiration, weakness, vision  changes, skin is pale, weak pulse  Emergency care measures for a resident experiencing fainting:  **If the person feels they might faint:**  Assist the person to sit or lie down.  If sitting position, the head between the leg.  If lying down, raise the legs.  Loosen tight clothing.  **If fainting occurs:**  Activate EMS  Raise the feet about 12 inches.  Initiate CPR for cardiac arrest.  Shock…*tissues and organs do not get enough blood.*  Signs and symptoms of shock:  Low blood pressure  Rapid/weak pulse  Rapid respirations  Cold, moist, and pale skin  Thirst  Nausea/vomiting  Restlessness  Confusion leading to loss of consciousness.  Emergency care measures for a resident experiencing shock:  Raise legs 6-12 inches.  Maintain an open airway.  Control bleeding, if necessary.  Initiate CPR.  Anaphylactic Shock…*life-threatening sensitivity to an antigen.*  Sign and symptoms of anaphylactic shock:  Itchy rash, Swelling of the face, eye, or lips,  feeling warm, fast and weak pulse, or feeling  dread or doom.    Emergency care measures for a resident experiencing anaphylactic shock:  Activate EMS  Maintain an open airway.  Initiate CPR for cardiac arrest.  Start rescue breathing for respiratory arrest.  Administer epinephrine, if available.  Stroke…*brain is suddenly deprived of its blood supply. Usually, only part of the brain is affected.*  *Causes include thrombus, embolus, or hemorrhage.*  Signs and symptoms of stroke:  Sudden numbness or weakness of the face, arm,  or leg.  Sudden confusion or trouble speaking or  understanding speech.  Sudden trouble seeing.  Sudden trouble walking.  Sudden severe headache.  Emergency care measures for a resident experiencing a stroke:  Check the time symptoms started. **(Best outcome if treatment is started within 3 hours of symptom onset)**  Initiate EMS  Seizure…*violent and sudden contractions or tremors of muscle groups caused by abnormal activity in the brain.*  Signs and symptoms of seizure:  Generalized seizure –  Absence seizure  Tonic-clonic (grand mal) seizure  Focal seizure    Emergency care measures for a resident having a seizure: **You cannot stop a seizure.**  During the seizure the goal is to protect the resident from injury.  **Note the time seizure activity begins and the time seizure ends.**    Concussion…*a head injury resulting from a bump or blow to the head or a jolt to the head or body. The head and the brain move quickly back and forth.*  Emergency care measures for a resident experiencing a concussion:  Activate EMS.  Place hands on both sides of the head.  Do not apply direct pressure to the skull.  Logroll if repositioning is needed.  Apply ice to swollen areas.  Emergency care for a resident experiencing a burn:  Activate EMS  Do not touch the resident if the source is  electrical.  Do not remove clothing/jewelry.  Cover the area with a sterile/clean cloth.  Do not put anything on the burned area.  Keep blisters intact.  When possible, elevate the burned area above  the heart  Cover the resident to prevent heat loss. | Lecture & Discussion  Chapter 43  Pages 555-568  BLS Class |  |
| **23**  **End-of-life**  **Care** | 23.1 Identify selected  terms associated with  End-of-Life care.  23.2 Discuss how various age groups understand death.  23.3 Identify the 5 stages of dying/grief.  23.4 Discuss the comfort needs of the person who is dying.  23.5 Identify the needs of the family/friends of the person who is dying.  23.6 Discuss the legal documents associated with end-of-life.  23.7 Recognize the signs of death.  23.8 Identify the steps in the care of the person’s body after death has occurred.  (Post-Mortem Care) | Selected terms associated with End-of-Life Care:  **End-of-Life Care…***support and care given during the time surrounding death.*  **Terminal illness…***an illness or injury from which the person will not likely recover.*  **Palliative care…***relieving or reducing the intensity of uncomfortable symptoms without producing a cure.*  **Hospice care…***focuses on the physical, emotional, social, & spiritual needs of the dying person/family. Cure or life-saving measures are not concerns. Often the person has less than 6 months to live.*  **Reincarnation…***belief that the spirit or soul is reborn in another human body or in another form of life.*  **Grief…***person’s response to loss*  **Advanced Directives…***a document stating a person’s wishes about health care when that person cannot make his or her own decisions.*  **Post-mortem care…***care of the body after death has occurred.*  **Rigor mortis…***stiffness or rigidity of the skeletal muscles that occurs after death. (2-4 hours after death)*  **Autopsy…***the examination of the body after death*  Understanding death by various age groups:   * Infants and toddlers do not understand death. They sense the effects of the death of an individual. * Children 2 to 6 years of age think death is temporary. * Children 6 to 11 years of age learn death is final. They do not think they will die. * Adults fear pain and suffering, dying alone, and invasion of privacy. They worry about those left behind. * Older adults know death will occur. Some welcome death.   Five stages of dying/grief:   * Denial – “No, not me” * Anger – “Why me” * Bargaining – “Yes, me but…” * Depression – “Yes me” and is very sad * Acceptance – Calm and peaceful   ***The dying person does not always move through each stage and may move back and forth between the stages or stay in one stage for a long period of time.***  Comfort needs of the dying person:   * Listening * Touch * Silence * Physical Needs * Pain * Breathing problems * Noisy breathing (death rattle) * Sensory changes * Blurred vision – lights on * Speech – difficult * Hearing – last to leave. * Mouth, Nose, Skin * Frequent oral care * Clean the nose of secretions. * Skin is cool, sweating occurs Bathe the person and change linens. * Reposition the person frequently. * Note change in skin color – pale and mottled (blotchy) * Nutrition * Elimination * The person’s room.   Needs of the Family:   * Be available to listen. * Be courteous and considerate. * Respect privacy. * Provide food/beverages. * Provide care.   Legal documents associated with end-of-life:   * Advanced Directives * Living Will – relates to measures to support or maintain life when death is likely. Examples: resuscitation, ventilation, tube feeding * Durable Power of Attorney for **Health Care** – gives the power to make health care decisions to another person (*health care proxy*) * “Do Not Resuscitate” orders – DNR or No Code or AND means the person will not be resuscitated. The family and/or doctor make the decision if the person is not mentally able to do so.   Signs of death:   * Movement, muscle tone, and sensation are lost. * GI functions slows – nausea/vomiting, fecal incontinence occur. * Body temperature rises. * Excessive sweating occurs. * Skin is cool, pale, and mottled. * Pulse is weak and irregular. * Blood pressure starts to fall. * Noisy respirations (death rattle) * Pain decreases with loss of consciousness * When death occurs there is no pulse, no respirations, and no blood pressure.   ***The doctor determines death has occurred.***  Steps in the care of the person’s body after death:   * Bath the person’s body * Position the person’s body in good alignment. * Expect air to be expelled from the person’s body when moved. * Tubes and dressing may be removed. * Autopsy may be done. * Close the person’s eyes. * Close the person’s mouth. * Place a disposable bed protector under the person. * Brush/comb the person’s hair. * Gather all the person’s belongings. * Fill out the ID tags (ankle or toe) * Place the person in the body bag & tag | Lecture & Discussion  Chapter 44  Pages 569-577 |  |
| **Unit 24**  **Collecting**  **Specimens** | 24.1. State the  purpose of  collecting/testing  specimens (Samples).  24.2. State the rules  for specimen  collection.  24.3. List the types of  specimens to be  collected. | Purpose of collecting/testing specimens:   * To prevent disease * To detect disease * To treat disease   Rules for collecting specimens:   * Maintain medical asepsis. * Follow standard and bloodborne precautions. * Use the correct container. * Identify the resident using two identifiers. * Label the container at the time the specimen is collected in the presence of the resident. * Urine and stool specimen must not contain toilet tissue. * Secure the lid to the container. * Put the specimen in a biohazard bag. * Take the specimen & requisition to the lab.   **Each agency will have specific guidelines for specimen collection.**  Types of specimens to be collected:   * Random urine specimen * Midstream urine specimen * Urinary catheter specimen * 24-Hour urine specimen * Testing urine using a reagent strip. * Stool specimens * Sputum specimens * Blood Glucose testing | Lecture & Discussion  Chapter 34  Pages 434-445 |  |
| **Unit 25**  **Wound Care** | 25.1. Define selected  terms associated with  wound care.  25.2. Identify  common causes of  wounds.  25.3. State the most common complication associated with wounds.  25.3. List the possible causes of skin tears.  25.4. List ways to prevent circulatory ulcers.  25.5. Discuss the role of the NA in applying dressings.  25.6. State the purpose of binders/compression garments.  25.7. State the benefits of heat application.  25.8. List the types of heat applications.  25.9. State the common complication associated with heat application.  25.10. State the benefits of cold applications.  25.11. List types of cold applications.  25.12. Identify rules for applying heat and cold. | Definition of selected terms associated with wound care:  **Wound**…*a break in the skin or mucous membrane.*  **Skin tear**…*a break or rip in the outer layers of the skin*  **Ulcer**…*shallow or deep crater-like sore of the skin or mucous membrane*  **Dilate**…*to expand or open wider*.  Common causes of wounds:   * Trauma * Pressure * Decrease blood flow. * Nerve damage   The most common complication associated with wounds is **infection**.  Common causes of skin tears:   * Friction * Shearing * Holding limbs too tight * Parts of wheelchair or other equipment * Clothing * Jewelry * Fingernails   Interventions focus on prevention.  Ways to prevent circulatory ulcers:   * Remind the resident not to cross their legs. * Do not dress the resident in tight clothes. * Apply anti-embolic stocking, when ordered. * Provide good skin care. * Pat skin dry after bathing. * Keep pressure off the heels. * Re-position residents at least every 2 hours * Check residents’ skin and report wounds. * Do not massage over boney prominences.   NA role in applying dressings:  Follow nursing center policy for applying dressings. The most common role is to assist the license staff to apply dressings.  Purpose of binders/compression garments:   * Provide support. * Hold dressings in place.   Benefits of heat application:   * Relieve pain. * Relaxes muscles. * Promotes healing. * Reduces tissue swelling. * Decrease joint stiffness.   Types of heat applications:   * Moist heat applications * Hot compress * Sitz Bath * Hot pack * Dry applications * Aquathermia pad   Complication of heat application:  **Burns are the most common complication associated with heat application.**  Benefits of cold application:   * Reduce pain. * Prevent swelling. * Decrease circulation/bleeding. * Cool the body during a fever.   Types of cold applications:   * Cold compress * Cold packs   Rules for applying heat and cold:   * Follow agency policy for temperature ranges. * Cover dry heat & cold applications. * Observe the skin every 5 minutes during the application. * Leave the application in place for no more than 15 to 20 minutes. | Lecture & Discussion  Chapter 35  Pages 446-463 |  |
| **Unit 26**  **Care of the**  **Peri-**  **operative**  **resident** | 26.1. Identify the roles of the NA in the care of a patient prior to having surgery (pre-operative care).  26.2. Identify the roles of the NA in the care of a patient after surgery (post-operative care) | Role of the NA in pre-operative care:   * Psychological preparation * Listen to the patient. * Observe patient’s body language. * Report observations to the nurse. * Physical preparation * Place an identification band on the patient. * Follow nutrition orders. Patients are often NPO for 8-12 hours prior to surgery. * Assist with completing the surgical checklist: Complete set of vital signs, documenting the last voiding time. * Complete special bathing or showering policies/orders * Remove and secure dentures. * Remove nail polish. * Remove and secure jewelry. * Remove and secure prostheses including eyeglasses, artificial limbs.   Hearing aids maybe left in during the surgery.   * Bowel and urinary elimination orders are followed.   Role of the NA in post-operative care:   * Post Anesthesia Care Unit PACU) * The patient usually stays 1-2 hours. * Vitals signs are monitored frequently. * The patient leaves the PACU when vital signs are stable, Respiratory function is good and the patient is responsive and can call for help. * Preparation of the patient’s room * Make a surgical bed. * Stock the room with necessary supplies. * Vital Sign equipment * Emesis basin * Tissues * IV Pole * Care of the patient returning from the PACU * Assist with transferring the patient to the bed from the stretcher. * Frequent vital signs. * Measure and record first post-operative void. * Maintain standard and body fluid precautions. * Preventing complications * Assist the patient with turning, coughing, and deep breathing exercises. * Assist the patient to use the incentive spirometer. * Encourage leg exercises (ROM). * Apply Anti-embolic stockings. * Apply sequential compression devices (SCD). | Lecture & Discussion  Care of the Perioperative Patient Handout |  |
| **Unit 27**  **Care of the**  **resident with**  **special needs** | 27.1. Describe the role of the Nursing Assistant in the care of Residents with special needs | Tasks delegated to the nursing assistant for the medically stable resident with special needs:  **A. Wound dressings and nursing assistant responsibilities.**  1. Know the purpose.  2. Wound care per facility policy & procedure as  delegated.  3. Appropriate observations.  4. Report status, observations, and resident’s  response to nurse.  **B. Gravity drains and nursing assistant responsibilities.**  1. Know the purpose.  2. Care of drains per facility policy & procedure as  delegated.  3. Appropriate observations.  4. Report status, observations, and resident’s  response to nurse.  **C. Surgical evacuators and nursing assistant responsibilities.**  1. Know the purpose.  2. Care of resident with surgical evacuators per  facility policy & procedure as delegated.  3. Appropriate observations.  4. Report status, observations, and resident’s response to nurse.  **D. Sump drain systems and nursing assistant responsibilities.**  1. Know the purpose.  2. Care of residents with sump drains. per facility  policy & procedure as delegated.  3. Appropriate observations.  4. Report status, observations, and resident’s  response to nurse.  **E. Various types of abdominal binders and nursing assistant responsibilities.**  1. Know the purposes.  2. Applying binders per facility policy & procedure  as delegated.  3. Appropriate observations.  4. Report status, observations, and resident’s  response to nurse.  **F. Various types of immobilization devices**  1. Know the purpose.  2. Care of resident with immobilizing devices per  facility policy & procedure as delegated.  3. Appropriate observations.  4. Report status, observations and resident’s response to  **G. Ventilator therapy and nursing assistant responsibilities**  1. Know the purpose.  2. Care of resident on a ventilator per facility  policy & procedure as delegated.  3. Appropriate observations.  4. Report status, observations, and resident’s  response to the nurse. | Lecture & Discussion  Care of a Resident with special needs Handout |  |