**November 2019**

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.  1.2A. Define the role of each member of the health care team.  1.2B. State the role of the NA in the admission, discharge and transfer process of patients.  1.3. Describe Nursing Care Patterns  1.4. Identify health care payment sources.  1.5. Define methods to ensure standards of care are met by health care facilities. | Heath care Settings  Acute Care (Hospital)  Subacute Care  Outpatient Care  Rehabilitation  Hospice Care  Long-Term Care Centers  Care Homes  Assisted Living Residences  Nursing Centers  Roles of other 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  Survey Process Role  Nursing Assistant Role | Lecture & Discussion  Chapter 1, Pages 1-3  Skill: A Resident Care Unit  Chapter 17  Box 17-1  Review the space  Bed operation  Equipment found in a  resident care area  Lecture & Discussion  Chapter 1, Pages 3-5  Table 1-1  Clinical Practice  Lecture & Discussion  Worksheet  Lecture & Discussion  Chapter 1, Pages 5 & 6  Figure 1-3  Lecture & Discussion  Chapter 1, Pages 6  Lecture & Discussion  Chapter 1, Page 7 |  |
| **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)*. | 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  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  Environment | Chapter 2 Page 10  Lecture & Discussion  Appendix A Page 553  Chapter 2 Pages 10-15  Box 2-1  Clinical Practice |  |
| **Unit 3**  **Nursing Assistant Regulations** | 3.1. Identify laws and policies regulating Nursing Assistant (NA) performance.  3.2. Describe the nursing assistant *scope of practice.* | Federal and State laws  AZBN *Standards of Conduct for Nursing*  *Assistants*  *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 | Lecture & Discussion  Chapter 3, Pages 18-20  Lecture & Discussion  Chapter 3, Pages 21-24  Boxes 3-2, 3-3 & 3-4 |  |
| **Unit 4**  **Safety &**  **Body Mechanics** | 4.1. Explain the rules of body mechanics.  4.2. Identify ways to prevent Work-Related injuries. | Rules of body mechanics:  Good alignment  Wide base of support  Bend at the knees  Use larger muscle groups  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 14, Pages 174-175  Box 14-1  Instructor Demonstration  Supervised Practice  Lecture & Discussion  Chapter 14, Page 176-177  Box 14-2 |  |
| **Unit 5**  **Infection Prevention** | 5.1. Discuss the links in the ***Chain of Infection***.  5.2. Define the purpose of medical asepsis.  5.3. List the rules of hand hygiene.  5.4.  Demonstrate proper hand hygiene using soap and water and alcohol-based hand sanitizer.  5.5. Explain the role of disposable gloves in the prevention of contamination.  5.6.  Demonstrate the proper procedure for donning and doffing (removing) disposable gloves.  5.7. Identify types of precautions | 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 until hands are dry  Role of gloves in preventing the transmission of microbes:  Protect the nursing assistant from direct  contact with blood /body fluids  Protect the resident from microbes on the  nursing assistant’s hands  Proper Procedure for donning and doffing  disposable gloves  Grasp the palm of the glove  Pull the glove over the hand & hold glove  Insert two fingers inside the other glove  Pull the glove over the hand & glove  Dispose of the gloves  Types of precautions:   * Standard * Transmission-Based precautions | Lecture & Discussion  Chapter 13, Pages 150-151 and page 158  Box 13-3  Figure 13-1 & 13-2  Clinical Practice  Chapter 13, Page 152  Chapter 13, Page 154  Box 13-2  Chapter 13, Pages 153-156  Procedure Boxes:  Hand-Washing &  Figures: 13-5 thru 13-11  Video  Instructor Demonstration  Supervised Practice  Chapter 13, Page 156  Procedure Boxes:  Using Alcohol-Based Sanitizer  Figure 13-12  Lecture & Discussion  Chapter 13, Pages 163  Chapter 13, Pages 165 & 168  Figure 13-18  Instructor Demonstration  Supervised Practice  Chapter 13, Pages 159-161  Boxes 13-4, 13-5, & 13-6 |  |
| **Unit 6**  **Delegation** | 6.1. State the four steps in the delegation process.  6.2. Discuss the ***Five Rights od Delegation.***  6.3. Discuss the Nursing Assistant’s possible responses to a delegated task. | 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  Policy and Procedure Manuals | Lecture & Discussion  Chapter 3, Pages 25-28  Lecture & Discussion  Chapter 3, Pages 27  Box 3-5  Lecture & Discussion  Chapter 3, Pages 27-28 |  |
| **Unit 7**  **Resident**  **Positioning** | 7.1. Describe the benefits of positioning and re-positioning a resident in bed or other furniture.    7.2. Describe the various positions  7.3. Describe procedures for moving a resident in bed.  7.4. Demonstrate the proper procedure for positioning a resident on their side (Lateral  position). | Benefits of positioning and re-positioning (at least every two hours)  Promote comfort  Ease breathing  Promote circulation  Friction and Shearing  Prevent pressure injuries  Prevent contractures  Positions  Fowler’s Positions - 45 degrees  High-Fowler’s – 60 to 90 degrees  Semi-Fowler’s – 30 degrees  Supine  Prone  Lateral  Sim’s  Dangling  Procedures used to move a resident in bed (Bed mobility):196  Trapeze  Assistive device (Lift sheet, board)  The resident is moved in sections  Logrolling  Proper procedure for positioning a resident on their side (Lateral position). | Lecture & Discussion  Chapter 14, Pages 178-182  Figures 14-5 – 14-13  Chapter 17, Pages 224 -225  Figures 17-2 thru 17-7  Chapter 15, Pages 197-199  Figures: 15-9 & 15-10  Procedure Box: Dangling  Lecture & Discussion  Chapter 15, Pages 185-200  Figures 15-1 thru 15-12  Video  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 ulcers. | Selected terms associated with pressure injuries:  **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.*  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 * 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 29, Pages 429-439  Chapter 29, Page 430  Figures 29-2  Chapter 29, Page 431  Box 20-1  Figure 29-4  Chapter 29, Pages 432-435  Box 29-2  Figures 29-5 through 29-17  Chapter 29, Page 436-437  Box 29-3  Chapter 29, Pages 438-439  Figures 29-20 – 29-23 |  |
| **Unit 9**  **Ethical**  **&**  **Legal**  **Issues** | 9.1. Review  ethical and  professional  behaviors.  9.2. Define the  term “ethics”.  9.3. Discuss the  terms of *prejudice*  and *biased.*    9.4. The role of a  *code of conduct.*  9.5. Define  *Professional*  *boundaries.*  9.6. Identify the  effects of  under-  involvement.  9.7. Identify the  effects of over-  involvement.  9.8. Define the  terms associated  with the legal  aspects of care. | Examples of ethical and professional/legal behaviors  Competent  Confidentiality  Honesty  Trustworthy  Reporting errors  Report abuse/neglect  Team Player    Definition of the term “ethics”:  …*is knowledge of what is right and wrong conduct.*  Concepts of prejudice and bias:  … *making judgements and having views before knowing the facts.*  Reasons for prejudice and biasinclude one’s culture, religion, education, & experience.  Role of a *code of conduct*:  Rules or standards of conduct  Definition of *professional boundaries:*  …*a separation of helpful behaviors from behaviors that are not helpful*  Effects of under-involvement:  Disinterest  Avoidance  Neglect  Effects of over-involvement:  Boundary crossing  Boundary violation  Professional sexual misconduct  Define legal terms:  Law  Criminal laws  Civil laws  Unintentional Torts  Negligence  Malpractice  Intentional Torts  Defamation  Libel  Slander  False Imprisonment  Invasion of privacy  Fraud  Assault & Battery | Lecture & Discussion  Review Chapter 3  Chapter 4, Page31  Box 4-1  Lecture & Discussion  Chapter 4, Page 31  Lecture & Discussion  Chapter 4, Page 31  Chapter 4, Page 31  Box 4-1  Lecture & Discussion  Chapter 4, Pages 31-32  Figure 4-1  Boxes 4-2 and 4-3  Lecture & Discussion  Chapter 4, Page 33 |  |
|  | 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 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:  …*willfull 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.*  Types of abuse  Physical Abuse  Verbal Abuse  Involuntary seclusion  Emotional or mental Abuse  Sexual abuse  Financial 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  Individual is restrained  Personal conversations are allowed | Lecture & Discussion  Chapter 4, Pages 33-35  Boxes 4-4 & 4-5  Lecture & Discussion  Chapter 4, Page 35  Chapter 4, Page 35  “Focus on Communication”  Lecture & Discussion  Chapter 4, Pages 36-39  Lecture & Discussion  Chapter 4, Pages 37  Boxes 4-6  Lecture & Discussion  Chapter 4, Pages 37-39  Box 4-7 & 4-8  Figure 4-3 |  |
| **Unit 10**  **Bed Safety**  **&**  **Comfort**  **Needs** | 10.1. Define the  term entrapment.  10.2. Identify residents at greatest risk of entrapment.  10.3. The benefits associated with proper bedmaking.  10.4. Identify the various ways to make a bed based on the needs of the resident.  10.5. Demonstrate the proper procedure for making an occupied bed | Definition of the term ***entrapment***:  …*getting caught, trapped, or entangled in spaces created by the bed rails, the mattress, the bed frame, the head-board and /or the foot-board.*  Risk factors associated with entrapment:  Age  Frail  Disoriented or confused  Restless  Uncontrolled movements  Poor muscle control  Small size  Restrained residents    Benefits of making a bed:  Promote comfort  Prevent skin breakdown  Prevent pressure injuries  Types of beds:  Closed bed  Open bed  Occupied bed  Surgical/procedure bed  Proper procedure for making an occupied bed: | Lecture & Discussion  Chapter 17  Page 224 & 226  Figure 17-8  Lecture & Discussion  Chapter 17, Pages 224  Lecture & Discussion  Chapter 17, Page 230  Lecture & Discussion  Chapter 17, Page 230  Figures 17-14 – 17-17  Chapter 17, Pages 230-240  Figure 17-18, 17-19, 17-26, 17-28  Procedure Box Pages 237-239  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **Unit 11**  **Accident**  **Prevention** | 11.1. Describe risk factors associated with accidents.  11.2. Describe the steps to properly identify a resident before providing care.  11.3.  List types of possible accidents.  11.4. Identify ways to prevent burns.  11.5. Identify ways to prevent poisoning.  11.6. Identify ways to prevent suffocation.  11.7. Identify ways to prevent equipment accidents.  11.8. Identify ways to prevent accidents from hazardous chemicals.  11.9. Identify types of disasters.  11.10. Identify actions to take in the event of a bomb threat.  11.11 Identify ways to prevent a fire.  11.12. Identify actions to take in the event of a fire.  11.13. Identify ways to prevent elopement of a resident.  11.14. Identify ways to prevent/control  workplace violence.  11.15  Identify the role of a Risk Management Department.  11.16 Discuss the reason an incident report would 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  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.***  Additional 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 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 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)*    Types of disasters:  Bomb Threats  Fire  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 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*  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  Ways to prevent/control 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 quick as possible  Potential weapons in the environment:  Do not wear jewelry or scarves  Keep long hair up and off the collar  Keep keys, scissor, pen in pockets  Staff safety measure:   * Use the “buddy system” in elevators or caring for persons with agitated or aggressive behaviors * Wear well fitted 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 belongings 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 10, Page 107-120  Lecture & Discussion  Chapter 10, Page 109 & 110  Figures 10-1 & 10-2  Supervised Practice  Clinical Practice  Lecture & Discussion  Chapter 10, Pages 110-118  Chapter 10, Page 110  Box 10-1  Chapter 10, Pages 111-113  BLS Training class  Box 10-2  Figures 10-4 thru 10-8  Chapter 10, Page 114  Box 10-4  Figure 10-10  Chapter 10, Page 115  Figure 10-11  Chapter 10, Pages 115-116  Chapter 10 Page 116  Chapter 10, Page117  Box 10-5  Figure 10-12 & 10-13  Chapter 10, Page 116-117  Figures 10-12 & 10-13  Procedure Box: Using a Fire Extinguisher  Chapter 10, Page 118  Box 10-6  Chapter 10, Page 119  Figure 10-14  Chapter 10, Page 120 |  |
| **Unit 12**  **Health Team**  **Communication** | 12.1.  Define the term communication.    12.2. Identify components of “good” communication.  12.3. Define the term medical record.  12.4. List the parts of a medical record.  12.5. Describe the difference between objective and subjective data.  12.6. List the observations the nursing assistant needs to report immediately to the charge nurse.  12.7. Identify the role of the nursing assistant in the completion of the Minimum Data Set (MDS).  12.8. Identify the role of the Comprehensive care plan.  12.9. Explain the terms reporting and recording.  12.10. Convert conventional time to military /international time.  12.11. Explain proper telephone  Etiquette.  12.12. Recognize common medical and nursing terminology. | 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.*  Parts of a medical record:  Admission information  Health history  Flow sheets/graphic sheets  Progress notes    **Objective data:**  Observations or signs that can be seen,  heard, felt, or smelled by an observer;  such as a pulse, color of urine.    **Subjective data:**  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 the nursing assistant documents are used to complete the MDS. The MDS nurse may interview the nursing assistants care 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 is 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  Give a courteous greeting including  facility, location, your name and  position  Do not give confidential information  Medical and nursing terminology:  Common prefixes and suffixes are listed in the textbook.  ***Only use the facility list of approved abbreviations*** | Lecture & Discussion  Chapter 6, Pages 53-66  Supervised Practice  Clinical Practice  Chapter 6, Page 55  Box 6-2  Chapter 6, Page 54  Box 6-1  Chapter 6, Pages 54-57  Chapter 6, Page 59-60  Box 6-5  Box 6-6  Box 6-7  Chapter 6, Page 58  Box 6-4  Figure 6-4  Chapter 6, Page 63  Box 6-8  Chapter 6, Pages 62-66  Boxes 6-9 |  |
| **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. Discuss types of communication.  13.8. Explain various communication methods.  13.9. Describe barriers to communication.  13.10. Recognize methods to communicate with residents with special needs  13.11. Discuss communication strategies when a person exhibits behavior issues. | 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.*  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  Pen-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  Methods to communicate with residents with special needs:   * 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 * 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   Communication strategies for persons exhibiting behavior issues:  Recognize the behavior and the possible  Cause  Maintain dignity and respect  Answer questions thoroughly  Keep the person informed  Answer call lights quickly  Stay calm  Use distraction  Do not argue with the person  Listen  Use silence  Encourage family participation | Lecture & Discussion  Chapter 7, Pages 68-77  Chapter 7, Page 69  Figure 7-2  Chapter 7, Page 71  Box 7-1  Chapter 7, Page 72  Figure 7-3  Chapter 7, Page 73  Boxes titled Caring about Culture  Chapter 7, Page 75  Box 7-2  Chapter 7, Page 77  Box 7-3 |  |
| **Unit 14**  **Measuring**  **Vital Signs** | I4.1. Identify factors that may affect vital signs.  14.2. Identify sites used to take a resident’s temperature.  14.3. State the normal range for body temperature by site used.  14.3. Demonstrate competency with the procedure of measuring temperature.  14.4. Define selected terms associated with taking a pulse.  14.5. List pulse sites.  14.6.  Demonstrate competency with the procedure for counting a pulse.  14.7 A.  Define the term respiration.  14.7 B.  Identify the respiratory range for a healthy adult.  14.8 A.  State the normal qualities of respirations.  14.8 B. Recognize abnormal respirations.  14.9.  Demonstrate competency with the procedure for counting respirations.  14.10.  Define selected terms associated with measuring a person’s oxygen levels.  14.11.  State the normal range of oxygen saturation.  14.12.  Identify types of probes used to measure a person’s oxygen saturation.  14.13.  Recognize factors that affect the accurate measurement of oxygen saturation>  14.13.  Demonstrate competency with the procedure for measuring a person’s oxygen saturation.  14.14.  Define selected terms associated with blood pressure measurement.  14.15.  Identify types of sphygmo-manometers.  14.16.  State which artery is usually used to measure blood pressure.  14.17.  List guidelines for measuring blood pressure.  14.18.  Demonstrate competency with the procedure for measuring blood pressure.  14.19.  Identify selected terms associated with pain.  14.20.  Discuss types of pain.  14.21.  List signs and symptoms of pain.  14.22. State factors that affect pain.  14.23. Recognize comfort and pain-relief measures | Factors that may affect vital signs:  Activity  Age  Anger  Medications  Eating  Gender  Pain  Illness  Sites used to take a resident’s temperature:  Oral  Rectal  Tympanic  Temporal  Axillary  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 artery 99.6 degrees F  Procedure of measuring temperature:    Definition of the term pulse:  **Pulse**…*the beat of the heart felt at an artery as a wave of blood passes through the artery.*  **Pulse rate**…*the 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 for the body except the Apical pulse.***  ***The radial pulse is the most often used to count a pulse.***  ***Normal pulse range for an adult resident is 60 to 100 beats per minutes (bpm).***  Procedure for counting a pulse:  Definition of the term **respiration**:  …*breathing air into (inhalation) and out of (exhalation) the lungs.*  Respiratory range for a healthy adult:  **12 to 20 respirations per minute**  Normal qualities of respirations:   * Quiet * Effortless * Regular   Abnormal respirations:   * Tachypnea * Bradypnea * Apnea * Hypoventilation * Hyperventilation * Dyspnea * Cheyne-Stokes respirations * Orthopnea * Kussmaul respirations   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 * Forehead   Factors that affect the accurate measurement of oxygen saturation:   * Avoid areas with edema * Avoid sites with skin breakdown * Avoid bright lights * Remove nail polish * Remove “fake” finger nails * Keep the site still as possible * Do not take 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 m 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 sphygmomanometer:   * Aneroid * Mercury * Electronic   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 blood pressure:  Selected terms associated with pain:  **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   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.***  Factors affecting pain:   * Past experience with pain * Anxiety * Rest and Sleep * Attention * Responsibilities * The value of pain * Support * Culture * Illness   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 | Lecture & Discussion  Chapter 25, Page 360-382  Box 25-1  Chapter 25, Page 361-368  Box 25-2  Figures 25-1 through 25-5  Figures 25-6 through 25-9  Chapter 25, Page 31  Box 25-1  Video  Chapter 25, Page 363  Box – *Taking a Temperature with an Electronic Thermometer*  Supervised Practice  Clinical Practice  Chapter 25, Page 369  Figure 25-13, 25-14, 25-15  Box 25-4  Chapter 25, Page 368  Figure 25-12  Chapter 25, Pages 371-372  Box – *Taking a radial pulse*  Figure 25-17 & 25-18  Video  Instructor Demonstration  Supervised Practice  Clinical Practice  Chapter 25, Page 372  Chapter 30, Page 442  Chapter 25, Page 373  Box – *Counting Respirations*  Video  Instructor Demonstration  Supervised Practice  Clinical Practice  Chapter 30, Pages 443-444  Figure 30-2  Chapter 30, Page 444  Procedure Box: Using a Pulse Oximeter  Chapter 25, Page 373  Figures 25-19 & 25-20  Chapter 25, Page 374  Figures 25-19 & 25-20  Chapter 25, Page 375  Box 25-5  Chapter 25, Pages 376-377  Box - *Measuring Blood Pressure*  Figures 25-22 & 25-23  Video  Instructor Demonstration  Supervised Practice  Clinical Practice  Chapter 25, Page 378-379  Box 25-6  Chapter 25, Page 378-379  Box 25-6  Figures 25-25 & 25-26  Chapter 17, Page 241  Box 17-3  Chapter 17, Pages 242-243  Figures 17-33 & 17-34  Procedure Box: Giving a Back Massage |  |
| **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 8, Pages 80-95  Figure 8-1  Chapter 9, Pages 101 - 103  Boxes 9-1  Table 9-1  Chapter 8, Page 80  Figure 8-2  Chapter 8, Page 80  Figure 8-3  Chapter 8, Page 81  Figure 8-4  Chapter 8, Pages 82 & 83  Figures 8-5, 8-6, 8-7, & 8-8  Chapter 8, Pages 84 & 85  Figures 8-10, 8-11, 8-12  Chapter 8, Pages87-88  Figures 8-15, 8-16, & 8-17  Chapter 8, Pages 88-89  Figure 8-18  Chapter 8, Pages 89-90  Figure 8-19  Chapter 8, Page 90  Figure 8-20  Chapter 8, Page 91  Figure 8-21  Chapter 8, Page 92-93  Figures 8-23 thru 8-26  Chapter 8, Page 94  Figure 8-27  Chapter 8, Page 95  Figure 8-28 |  |
| **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 through 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. | 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  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  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: | Lecture & Discussion  Chapter 18, Page 247-271  Chapter 18, Page 248  Figure 18-1  Chapter 18, Page 249  Box 18-1  Clinical Practice  Chapter 18, Pages 249-256  Chapter 18, Page 249  Box titled: Delegation Guidelines  Chapter 18, Pages 250-253  Figure 18-5  Video & Discussion  Instructor demonstration  Supervised practice  Clinical Performance  Chapter 18, Pages 254-256  Figure 18-9  Video & Discussion  Instructor demonstration  Supervised practice  Clinical Practice  Chapter 18, Page 256  Box 18-2  Chapter 18, Pages 258-261  Figures 18-10 - 18-17  Video & Discussion  Instructor demonstration  Supervised practice  Clinical Performance  Lecture & Discussion  Chapter 18, Pages 262-266  Figures 18-21-18-23  Clinical Practice  Lecture & Discussion  Chapter 18, Pages 266-271  Figures 18-24 – 18-29  Video  Instructor Demonstration  Supervised Practice  Clinical Practice  Lecture & Discussion  Chapter 19, Page 274  Figures 19-2 & 19-3  Lecture & Discussion  Chapter 19, Pages 274-279  Figures 19-1, 19-4 & 19-5  Clinical practice  Lecture & Discussion  Chapter 19, Pages 279-281  Box 19-1  Figure 19-9  Clinical practice  Lecture & Discussion  Chapter 19, Pages 282-284  Figures 19-10 – 19-12  Clinical Practice  Lecture & Discussion  Chapter 19, Pages 284-289  Figures 19-13 – 19-22  Chapter 19, Page 273  Figure 19-1  Chapter 19, Pages 285-287  Figures 19-13 – 19-20  Video  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.  17.12. Explain safety guidelines associated with restraint use.  17.13. Define the term transfer.  17.14. List devices and equipment used to transfer a resident.  17.15. Define the term transfer/gait belt.  17.16. Demonstrate the proper procedure for using a transfer/gait belt.  17.17. Identify safety guidelines for using wheelchairs and stretchers.  17.18-A. Demonstrate the proper procedure to pivot transfer a resident to and from the wheel chair.  17.18-B.  Discuss the purpose and types of mechanical lifts to transfer a resident.  17.19.  Demonstrate the proper procedure to ambulate a resident using a gait belt and a walker.  17.20.  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   Fall 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 * Observations   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 id 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 fail 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 * Unnecessary restraint is false imprisonment * 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:   * Resident cannot assist/participate with the transfer * Resident is 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:  Proper procedure for assisting a resident with ROM of the shoulder, hip and knee. | Lecture & Discussion  Chapter 11, Pages 122  Box: Focus on Surveys  Chapter 11, Page 123  Box 11-1  Chapter 11, Pages 123-127  Box 11-2  Figures 11-1 – 11-7  Chapter 11, Pages 130 – 131  Figure 11-12  Supervised Practice  Lecture & Discussion  Chapter 12, Page 133  Clinical Practice  Chapter 12, Pages 134-135  Box 12-1  Figures 12-1, 12-2, & 12-3  Clinical Practice  Chapter 12, Page 136  Clinical Practice  Lecture & Discussion  Chapter 12, Page 136  Box 12-2  Lecture & Discussion  Chapter 12, Page 137  Lecture & Discussion  Chapter 12, Page 137-146  Box 12-3  Figures 12-4 - 12-19  Clinical Practice  Chapter 16, Page 203  Lecture & Discussion  Chapter 16, Pages 204-217  Figures 16-1, 16-2, 16-12, 16-13, 16-14  Clinical Practice  Lecture & Discussion  Chapter 11, Page 127  Lecture & Discussion  Chapter 11, Pages 127-129  Figures 11-9, 11-10, 11-11  Instructor Demonstration  Supervised Practice  Clinical Practice  Lecture & Discussion  Chapter 16, Page 205  Box 16-1  Instructor Demonstration  Supervised Practice  Clinical Practice  Lecture & Discussion  Chapter 16, Pages 206-212  Figures 16-5 through 16-11  Instructor Demonstration  Supervised Practice  Clinical Practice  Chapter 16, Pages 212-217  Figures 16-12 – 16-14  Lecture & Discussion  Chapter 27, Pages 399-403  Figures 27-24, 27-25, and  27-26  Instructor Demonstration  Supervised Practice  Clinical Practice  Lecture & Discussion  Chapter 27, Pages 404-408  Figures 27-10 thru 27-21  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 various  special diets.  18.13.  Identify sign 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.  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 * 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 resident’s diet is well-balanced * 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, plate guard, or special handle cups.***  Ways to assist a visually impaired resident:   * Describe the food on the tray * Ask the resident what to eat first * If the resident 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;   * 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.***  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 23, Pages 331-346  Chapter 23, Page 332  Figure 23-1  Chapter 23, Page 332  Box 23-1  Chapter 23, Pages 333-334  Table 23-1  Chapter 23, Page 336  Figure 23-2  Chapter 23, Pages 336-339  Boxes 23-2, 23-3, 23-4  Chapter 23, Page 339  Box 23-3  Chapter 23, Page 339  Box 23-4  Chapter 23, Pages 339-345  Chapter 31, Page 452  Figures 23-2, 23-3, 23-4, & 23-7  Figure 31-1  Video  Instructor Demonstration  Supervised Practice  Clinical Practice  Chapter 23, Page 343  Figure 23-6  Clinical Practice  Chapter 23, Page 345  Figures 23-8, 23-9 & 23-10  Chapter 23, Page344  Chapter 24, Pages 349-356  Chapter 24, Page 350  Box 24-2  Chapter 24, Page 253  Figure 24-4  Chapter 23, Pages 355 & 356  Chapter 25, Pages 379-382  Box – *Measuring Weight and Height*  Instructor Demonstration  Supervised Practice  Clinical Practice |  |
| **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 common  interventions  associated with  the health  problem | 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**  Build up 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 any where * 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   ***General guidelines when caring for residents with impaired vision & blindness***  **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 attacking 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 seat * 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 * Weight lifting * 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  (130/80)  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 * Life style 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 * Life style 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 then 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 airway  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   **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 spread 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   **Skin 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 32, Pages 458-467  Chapter 32, Page 459  Box 32-1, 32-2, 32-3, 32-4  Figures 32-1 & 32-2  Chapter 32, Pages 462  Boxes 32-3  Chapter 32. Page 463  Box 32-4  Chapter 32, Pages 463-467  Box 32-6  Figures 32-5, 32-6, 32-7  Lecture & Discussion  Chapter 33, Pages 469-491  Chapter 33, Page 471  Box 33-1  Chapter 33, Page 472  Figure 33-3  Chapter 33, Pages 472-473  Box 33-2  Figure 33-5  Chapter 33, Page 473  Figure 33-6  Chapter 33, Page 474  Boxes 33-3, 33-4, 33-5  Figures 33-7, 33-8, 33-9, 33-10, 33-11  Chapter 33, Page 476  Figures 33-12 & 33-13  Chapter 33, Page 477  Boxes 33-6 & 33-7  Figure 33-14  Chapter 33, Page 478  Figure 33-15  Chapter 33, Page 479 - 480  Figure 33-16  Box 33-8  Chapter 33, Page 480  Box 33-9,  Chapter 33, Page 481  Figures 33-17, 33-18,  & 33-19  Chapter 28, Pages 415-416  Procedure Box: Applying Elastic (Anti-embolic) Stockings  Figure 28-6  Chapter 33, Page 483  Figure 33-20  Chapter 30, Pages 444-449  Chapter 22, Pages 327-329  Figures 22-5, 22-6, 22-7 & 22-8  Chapter 22, Pages 323-324  Chapter 33, Page 486  Figure 33-22  Chapter 33, Page 486  Box 33-13  Chapter 33, Page 487  Figure 33-23  Chapter 13, Pages 164-168  Chapter 21, Pages 309-318  Box 21-1  Procedures Boxes:  Giving Catheter Care  Emptying a Urine  Drainage Bag  Figure 21-5  Chapter 33, Page 487  Figures 33-24  Chapter 33, Page 487  Figures 33-25  Chapter 33, Page 488  Box 33-14  Chapter 33, Page 489  Table 33-1  Chapter 28, Page 414  Box 28-3  Chapter 33, Page 490  Boxes 33-15 & 33-16 |  |

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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  care 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   *Some dementia is reversible when the cause can be treated.*  **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** - …person copes with and adjusts to everyday stresses in ways accepted by society.  **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 | Lecture & Discussion  Chapter 35,  Pages 504-517  Chapter 35, Page 505  Box 35-2  Chapter 35, Page 505  Box 35-3  Chapter 35, Pages 507  Box 35-5  Chapter 35, Pages 507  Box 35-5  Chapter 35, Page 507  Box 35-7  Chapter 35, Page 511  Box 35-8  Focus on Communication Box  Chapter 35  Pages 513-515  Box 35-9  Lecture & Discussion  Chapter 34  Pages 494-502  Chapter 34, Page 495  Box 34-2  Chapter 34, Page 498  Box 34-5 |  |
| **22**  **Emergency**  **Care** | 22.1.  Define 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 to be given during CPR.  22.6.  State the rate of providing rescue breaths.  22.7.  State the rate of providing breaths during CPR. | 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 of 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 | Lecture & Discussion  Chapter 36  Pages 519-531  BLS Class  Chapter 36, Page 520  Box 36-1 |  |
| **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. | 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 37  Pages 533-539  Chapter 37  Pages 538 & 539 |  |
| **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 specimens * Midstream urine specimens * Testing urine using a reagent strip * Stool specimens * Sputum specimens | Lecture & Discussion  Chapter 26,  Pages 385 -394  Chapter 26, Page 385  Box 26-1 |  |
| **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 wheel chair 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 * Provide good skin care * Pat skin dry after bathing * Keep pressure of 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 28,  Pages 411-427  Chapter 28, Page 412  Box 28-1  Figure 28-1  Chapter 28, Page 413  Box 28-2  Figures 28-2 & 28-3  Chapter 28, page 419  Box 28-4  Chapter 28  Pages 421 & 422  Box 28-5  Figures 28-11 & 28-13  Chapter 28, Page 423  Figure 28-15  Chapter 28, Page 424  Figures 28-16 & 28-17  Chapter 28, Page 424  Box 28-6 |  |
| **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) * Report observations to the nurse |  |  |
| **Unit 27**  **Care of the**  **resident with**  **special needs** | 27.1. Describe the role of a NA in the care of stable residents with special needs. | Describe care of stable residents with special needs:   * Care of residents with non-sterile dressings and/or elastic bandages (ACE wraps): * Know the reason for the dressing or ACE bandage * Follow agency policy for applying non-sterile dressings/ACE bandages * Observe the resident’s skin * Report observations and the resident’s response to the nurse * Care of residents with surgical drains:   *A surgical drain is a tube used to remove pus, blood or other fluids from a wound or cavity. Drains may be attached to a suction machine or they may drain by self suction or gravity.*   * Know the purpose of the drain * Record the amount of drainage * Clean the drain insertion site * Monitor temperature * Check insertion site at the beginning of shift and after repositioning the resident * Report observations and resident response to the nurse * Care of residents with immobilizing devices: * Know the purpose for the device * Monitor the resident’s skin under the device * Report observations and resident response to the nurse * Care of residents on a ventilator: * Know the purpose of the ventilator therapy * Ask for assistance when repositioning the resident * Report observations and resident response to the nurse |  |  |

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