

Nursing Assistant Curriculum Map

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

Class Day	Learning Outcomes (Goals)	Content Outline	Learning Activities	Time Allotted
Day 1		<p style="text-align: center;">Course Orientation</p> <p>Introductions: Students Instructors The role of Student Services</p> <p>Review: Textbook/Workbook Forms/Exams/Clinical Policies & Procedures</p>		60 Minutes
Unit 1 Health Care Settings	1.1 Describe healthcare settings, including organization, structure, and essential functions.	Health care Settings Acute Care (Hospital) In-patient Care Ambulatory Care (Out-patient Care) Subacute Care Hospice Care Long-Term Care Centers Assisted Living Residences Nursing Centers Skilled Care (Rehabilitation) Memory Care Home Care	Lecture & Discussion Chapter 1, Pages 1-3	

	<p>1.4 Describe Nursing Care Patterns</p>	<ul style="list-style-type: none"> • Assist the patient to get into the vehicle. • Communicate observations and patient response to the nurse. <p>Role of the NA in transferring a patient from one room to another room is the same facility:</p> <ul style="list-style-type: none"> • 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. <p>Nursing Care Patterns Functional Nursing Team Nursing Primary Nursing Case Management Patient-focused care Health Care Payment Sources Private Insurance Medicare</p>	<p>Lecture & Discussion Chapter 1, Pages 5 & 6 Figure 1-3</p>	
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	<p>1.5 Identify health care payment sources.</p> <p>1.6 Identify methods of maintaining safety and quality in resident care.</p>	<p>Medicaid Patient Protection & Affordable Care Act Prospective Payment System</p> <p>Meeting Standards of Care: Department of Health & Human Services (HHS)</p> <p>Regulations related to: Licensure Certification Accreditation</p> <p>Policies Procedures Survey Process.</p>	<p>Lecture & Discussion Chapter 1, Pages 6 & 7</p> <p>Lecture & Discussion Chapter 1, Page 7 & 8</p>	
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		<p>Mistreatment & Neglect Freedom from Restraints Quality of Life Activities</p>		
	2.4 Define the role of a Resident's representatives.	<p>Protecting Residents Rights</p> <ul style="list-style-type: none"> • Staff • Advocate • Ombudsmen – Established by the Older Americans Act (federal law) 		
	2.5 Describe OBRA's actions to promote dignity and privacy.	<p>Promoting dignity and privacy Being courteous during interactions Protecting personal privacy during care Allowing personal choice & independence Providing dignity when assisting Residents</p>	Box 2-2	
	2.6 Define the person's unit.	<p>The person's unit is the space, furniture, and equipment used by the person in the agency.</p>	Lecture & Discussion Chapter 19	
	2.8 Discuss factors affecting comfort in a resident's unit.	<p>Factors affecting comfort:</p> <ul style="list-style-type: none"> • Temperature & Ventilation • Noise • Odors • Lighting • The bed 		
	2.8 Describe factors affecting bed safety.	<p>Bed safety involves the condition of the bed system and attachments including bed rails.</p>		

	<p>2.9 Define entrapment.</p> <p>2.10 Discuss risk factors associated with entrapment.</p> <p>2.11 Describe the furniture and equipment in the person's unit.</p> <p>2.12 Identify ways the nursing assistant maintains the person's unit.</p>	<p>Entrapment = getting caught, trapped, or entangled in spaces created by bed rails, the mattress, the bed frame, the headboard, or the footboard.</p> <p>Risk factors associated with entrapment:</p> <ul style="list-style-type: none"> Age Frail Disoriented or confused. Restless Uncontrolled movements Poor muscle control Small size Restrained residents <p>Furniture/equipment in the person's unit.</p> <ul style="list-style-type: none"> • Bed, Bed Rails, Bed controls. • Light • Call system. • Chair • Tables/stands • Closets • Bathroom • Closet <p>Ways to maintain the person's unit:</p> <ul style="list-style-type: none"> • Keep important items within the person's reach. • Keep the unit clean. • Arrange belongings as the person 	<p>Figure 19-5</p>	
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	<p>213 Describe ways to promote safety and comfort.</p> <p>2.14 Identify the management of the resident's belongings.</p>	<p>prefers.</p> <ul style="list-style-type: none"> • Adjust lighting & temperature for the person's comfort. <p>Ways to promote safety and comfort:</p> <ul style="list-style-type: none"> • Orient new residents to the proper use of call system and other equipment. • Explain unfamiliar noises/sounds. • Control odors. • Adjust the bed position for comfort. <p>Management of resident's belongings:</p> <ul style="list-style-type: none"> • Help residents choose the best place for their belongings. <p>The resident's choices need to be safe, will cause accidents, and do not disturb the rights of others.</p>	<p>Clinical Practice</p>	
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<p>Unit 3</p> <p>Nursing Assistant Regulations</p>	<p>3.1. Identify laws and policies regulating Nursing Assistant (NA) performance.</p> <p>3.2. Describe the nursing assistant's <i>scope of practice</i>.</p> <p>3.3 Discuss the qualities of a nursing assistant.</p>	<p>Federal and State laws</p> <p>Nurse Practice Acts</p> <ul style="list-style-type: none"> • Each State has a Nurse Practice Act • Nurse Practice Acts: <p><i>The Omnibus Budget Reconciliation Act of 1987 (OBRA)</i></p> <p>Training Programs</p> <p>Competency Evaluation</p> <p>Nursing Assistant Registry</p> <p>Certification</p> <p>Maintaining Competence</p> <p>Nursing Assistant Standards</p> <p>Job Description</p> <p>Policy Procedure Manual</p> <p>Nursing Assistant Roles</p> <p>Bathing, & grooming</p> <p>Assisting with toileting</p> <p>Assisting with meals</p> <p>Maintaining Resident's room</p> <p>Vital Signs</p> <p>Nursing Assistant Qualities</p> <p>Patient/Understanding/Unprejudiced</p> <p>Honest/Trustworthy</p> <p>Conscientious</p> <p>Enthusiastic</p> <p>Courteous</p>	<p>Lecture & Discussion</p> <p>Chapter 3 & 5</p> <p>Box 3-1</p> <p>Box 3-2</p> <p>Box 3-3</p> <p>Box 3-4</p> <p>Box 3-5</p> <p>Figure 5-1</p> <p>Box 5-1</p> <p>Figure 5-1</p> <p>Box 5-3</p>	
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	<p>3.4 Discuss the effects of stress at work.</p> <p>3.5 Identify problem solving steps to successfully deal with conflict.</p> <p>3.6 Define harassment & bullying.</p> <p>3.7 Define selected terms related to delegation.</p>	<p>Empathetic Dependable/Accountable</p> <p>Effects of stress at work: Physical effects Mental effects Social effects Spiritual effects</p> <p>Problem solving to resolve conflict: Define the problem. Collect information. Identify possible solutions. Select the best solution. Carry out the selected solution. Evaluate the results.</p> <p>Bullying definition – repeated attacks or threats of fear, distress, or harm by a bully toward a target. Harassment definition – to trouble, torment, offend, or worry a person by one’s behavior or comments. (age, race, ethnic background, gender identify, sexuality, religion, or disability)</p> <p>Selected terms: Delegate – to authorize or direct a nursing assistant to perform a task. Delegation: 1. The process the nurse uses to direct a nursing</p>		
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	<p>3.8 State the four steps in the delegation process.</p> <p>3.9 Discuss the <i>Five Rights of Delegation.</i></p> <p>3.10 Discuss the Nursing Assistant's possible responses to a delegated task.</p>	<p>assistant to perform a nursing task. 2. Allowing a nursing assistant to perform a nursing task that is beyond the nursing assistant's usual role and not routinely done by the nursing assistant.</p> <p>Four steps in the delegation process as outlined by the <i>National Council of State Boards of Nursing</i></p> <ul style="list-style-type: none"> Assessment & Planning Communication Surveillance & Supervision Evaluation & Feedback <p><i>Five Rights of Delegation</i></p> <ul style="list-style-type: none"> The Right Task The Right Circumstance The Right Person The Right Direction & Communication The Right Supervision & Evaluation <p>The nursing assistant possible responses to a delegated task:</p> <ul style="list-style-type: none"> Accepting a task Refusing a task Use Policy and Procedure Manuals 		
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<p>Unit 4 Safety & Body Mechanics</p>	<p>4.1. Explain the principles of body mechanics.</p> <p>4.2. Identify ways to prevent Work-Related injuries.</p>	<p>Principles of body mechanics: Alignment Base of support Bend at the knees. Use larger muscle groups. Face the work area. Push, slide, or pull heavy objects. Keep objects close to the body.</p> <p>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.</p>	<p>Lecture & Discussion Chapter 16 Box 16-1 & 2 Box 16-3</p> <p>Instructor Demonstration Supervised Practice Clinical Practice</p>	
<p>Unit 5 Moving or Positioning a Resident</p>	<p>5.1 Describe the benefits of positioning and re-positioning a resident in bed or other furniture.</p> <p>5.2 Describe</p>	<p>Benefits of positioning/repositioning: Promotes comfort. Breathing is easier. Promotes circulation. Prevents pressure injuries. Prevent contractures. Position/repositioning at least every 2 hours.</p> <p>Positions:</p>	<p>Lecture & Discussion Chapter 16, Pages 193-197 Figures 16-4 through 16-11</p>	

	<p>selected positions.</p> <p>5.3 List the steps to safely position a resident.</p> <p>5.4 Describe the proper way to position/reposition a resident in a chair.</p> <p>5.5 Define <i>bed mobility</i>.</p> <p>5.6 Define friction and shearing.</p>	<p>Fowler’s position (45 to 60 degrees) Semi-Fowler’s position (30 degrees) High-Fowler’s position (90 degrees) Supine position Prone position Left semi-prone position. Lateral position Chair position.</p> <p>Steps to safely position a resident: Follow the care plan. Ask for help. Explain the procedure to the resident. Use pillows for support & alignment.</p> <p>Proper chair position: Back & buttocks against the back of the chair Feet are supported. Backs of the knees & calves slightly away from the edge of the chair. Use supported devices to maintain proper alignment.</p> <p>Bed mobility – how a person moves to and from a lying position, turns from side to side, and repositions in a bed or other sleeping furniture.</p> <p>Friction definition – occurs when rubbing one surface against another. (example, rubbing</p>		
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	<p>5.7 Identify ways to protect the skin from friction and shearing when moving a resident in bed.</p> <p>5.8 Demonstrate how to move a resident in bed.</p> <p>5.9. Demonstrate the proper procedure for positioning a resident on their side (Lateral position).</p>	<p>against the bed sheets) Shearing definition – occurs when the skin sticks to a surface while muscles slide in the direction the body is moving.</p> <p>Ways to protect skin from friction & shearing: Use friction/shearing-reducing devices: Turning pads or sheets Slide sheet/board. Large re-usable under-pads Trapeze</p> <p>Moving a resident in bed: Move a resident up in bed. Move a resident to the side of the bed. Turn a resident on to their side. Logrolling a resident Sitting a resident on the side of the bed (dangling).</p> <p>Proper procedure for positioning a resident on their side:</p>	<p><i>D&S Candidate Handbook</i></p> <p>Instructor Demonstration Supervised Practice Clinical Practice</p>	
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	<p>6.3 Define the purpose of medical asepsis.</p> <p>6.4 List the rules of hand hygiene.</p> <p>6.5 Demonstrate proper hand hygiene using soap and water and alcohol-based hand sanitizer.</p>	<p>Purpose of medical asepsis Reduce the number of microbes. Prevent the spread of microorganisms.</p> <p>Rules of hand hygiene: Use soap and water when hands are: Visibly dirty or soiled Before eating. After using the restroom Exposure to <i>Clostridium Difficile</i> Use alcohol-based hand sanitizer: Before contact with a resident After direct contact with a resident After contact with a resident's items</p> <p>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.</p> <p>Steps for proper hand hygiene (Hand sanitizer): Apply hand sanitizer.</p>	<p>Handwashing: Figures: 14-5 thru 14-11 Procedure Box, Page 166 Instructor Demonstration Supervised Practice</p> <p>Chapter 14, Procedure Box: Using Alcohol-Based Hand Sanitizer Figure 14-12</p>	
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	<p>6.6 Identify the 5 Moments for Hand Hygiene</p> <p>6.7 Discuss care of supplies and equipment.</p>	<p>Rub hands together. Interlock fingers. Continue rubbing hands together until hands are dry.</p> <p><i>5 Moments for Hand Hygiene:</i></p> <ol style="list-style-type: none"> 1. Before touching a resident 2. Before a aseptic procedure 3. After body fluid exposure risk 4. After touching a resident 5. After touching a resident’s environment <p>Care of supplies & equipment: Use of disposal items is preferred. Label multiple-use items. Do not borrow items.</p> <p>Cleaning supplies & equipment: Wear personal protective equipment (PPE). Work from clean to dirty areas. Rinse with cold water first. Then wash with soap & water. Rinse with warm water. Dry items thoroughly. Disinfect/sterilize the item. Disinfect the sink. Discard PPE.</p>	<p>Box 14-3 Box 14-4</p>	
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	<p>6.8 Discuss the Bloodborne Standard.</p> <p>6.9 Identify types of precautions.</p> <p>6.10 Demonstrate the proper procedure for donning and doffing (removing) personal Protective Equipment (PPE).</p>	<p>Bloodborne Standard: Regulation from Occupational Safety & Health Administration (OSHA) Protects healthcare workers. Established Infection Prevention measures. Hepatitis B vaccine Engineering & work practice control PPE Regulations for equipment, biohazardous waste, and laundry Requirements for exposure incidents</p> <p>Types of precautions:</p> <ul style="list-style-type: none"> • Standard • Transmission-Based precautions <p>Proper procedure for Donning/Doffing Personal Protective Equipment:</p>	<p>Chapter 15, Pages 175-188 Box 15-1 Box 15-2 Figures 15-6 & 15-7 <i>Donning & Removing Personal Protective Equipment Procedure</i> Page 185</p> <p>D&S Candidate Handbook Instructor Demonstration Supervised Practice Clinical Practice</p>	
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<p>Unit 7</p> <p>Bed Making</p>	<p>7.1 Identify the benefits of clean, dry, & wrinkle-free beds.</p> <p>7.2 Describe the types of beds.</p> <p>7.3 List the linens used to make a bed.</p> <p>7.4 State the proper way to handle linens.</p>	<p>Benefits of clean, dry wrinkle-free beds: Promote comfort. Prevent skin breakdown. Prevent pressure injuries.</p> <p>Types of beds: Closed Open Unoccupied Occupied Surgical</p> <p>Linens: Bath blanket Drawsheet Waterproof under-pad Bottom sheet (fitted or unfitted) Top sheet Blanket Bedspread Pillowcase(s)</p> <p>Proper way to handle linen: Soiled linens Remove 1 piece at a time. Roll each piece of linen away from you. Soiled side is to on toward the inside. Place soiled linen in a leak-proof bag. Clean linens Perform hand hygiene.</p>	<p>Lecture & Discussion</p> <p>Chapter 20, Pages 244-260</p> <p>Figures 20-1through 20-4</p> <p>Figure 20-8</p>	
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	7.5 Demonstrate the proper procedure for making an occupied bed.	<p>Collect linens with one hand. Hold the collected linens in the other hand. Hold the linens away from the body/uniform. Do not shake linens.</p> <p>Proper procedure for making an occupied bed:</p>	<p>Figures 20-16 through 20-24 Procedure Box – Making an Occupied Bed, pages 249 & 350.</p> <p><i>D&S Candidate Handbook</i></p> <p>Instructor Demonstration Supervised Practice Clinical Practice</p>	
Unit 8 Managing Pressure Ulcers	8.1. Identify selected terms associated with pressure injuries.	<p>Selected terms associated with pressure injuries:</p> <p>Pressure injury - <i>Localized damage to the skin and underlying soft tissue.</i> <i>The injury is usually over a bony prominence or related to a medical or other device.</i> <i>The injury results from pressure or pressure in combination with shearing.</i></p> <p>Bony prominence...<i>bone sticks out or projects from a flat surface of the body (pressure point).</i></p> <p>Eschar...<i>thick, leathery dead tissue. It is often black or brown in color.</i></p>	<p>Lecture & Discussion Chapter 36, Pages 464-474</p> <p>Figure 36-7</p>	

	<p>8.2. Recognize common bony prominences when the resident is in various positions.</p> <p>8.3. Identify risk factors associated with pressure injuries.</p>	<p>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.</p> <p>Slough...dead tissue shed from the skin, light in color, soft and moist. It may be stringy at times.</p> <p>Ulcer ...a shallow or deep crater-like sore of the skin or mucous membrane.</p> <p>Bony prominences in various positions:</p> <ul style="list-style-type: none"> • Supine <ul style="list-style-type: none"> ▪ Sacrum ▪ Heels • Lateral (side lying) <ul style="list-style-type: none"> ▪ Hip ▪ Ankle ▪ Heel • Semi Fowler’s position <ul style="list-style-type: none"> ▪ Sacrum ▪ Hip ▪ Heels • Upright <ul style="list-style-type: none"> ▪ Shoulders ▪ Hip ▪ Sacrum <p>Risk factors associated with pressure injuries:</p> <ul style="list-style-type: none"> • Age • Dry skin • Thinning skin 	<p>Figure 36-1 7 36-6</p> <p>Figures 36-2</p> <p>Box 36-1</p>	
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	8.6. Identify common complications associated with pressure injuries.	<ul style="list-style-type: none"> • Float heels. • Use protective devices: <ul style="list-style-type: none"> ▪ Bed cradle ▪ Heel/elbow protectors ▪ Heel/foot elevators ▪ Gel/fluid-filled cushions ▪ Special beds ▪ Other <p>Common complications associated with pressure ulcers:</p> <ul style="list-style-type: none"> • Infection (Most Common) • Osteomyelitis • Pain 	Figures 36-11 to 36-14	
			Clinical Practice	
Unit 9 Ethical & Legal Issues	9.1 Define the term ethics. 9.2 Review ethical and professional behaviors. 9.3 The role of a code of conduct.	<p>Definition of selected terms:</p> <p>Ethics...<i>is knowledge of what is right and wrong conduct.</i></p> <p>Prejudice or Biased... <i>making judgements and having views before knowing the facts.</i></p> <p>Reasons for prejudice and bias include one's culture, religion, education, & experience.</p> <p>Code of conduct... <i>Rules or standards of conduct for group members to follow.</i></p> <p>Professionalism... <i>following laws, being ethical, having the skills to do the job.</i></p> <p>Role of a code of conduct: Guides an NA's thinking, actions, and behaviors.</p>	Lecture & Discussion Chapter 4, Page 30-41 Box 4-1	

	<p>9.4 Define <i>Professional boundaries.</i></p> <p>9.5 Identify the effects of under-involvement.</p> <p>9.6 Identify the effects of over-involvement.</p>	<p>Examples of ethical and professional/legal behaviors</p> <ul style="list-style-type: none"> Competent Confidentiality Honesty Trustworthy Reporting errors Report abuse/neglect. Team Player <p>Definition of professional boundaries: <i>...a separation of helpful behaviors from behaviors that are not helpful.</i> Professional interactions involve helpful behaviors that meet the resident’s needs.</p> <p>Effects of under-involvement:</p> <ul style="list-style-type: none"> Disinterest Avoidance Neglect <p>Effects of over-involvement:</p> <p>Boundary crossing - a brief act or behavior of being over-involved with a resident. The intent of the act or behavior is to meet the person’s need.</p> <p>Boundary violation - an act or behavior that meets your needs, not the person’s needs.</p> <p>Professional sexual misconduct - a violation of professional interactions with</p>	<p>Figure 4-1 Boxes 4-2</p>	
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	<p>9.7 Define <i>Boundary Signs</i>.</p> <p>9.8 Define the terms related to the legal aspects of care.</p>	<p>an act, behavior, or comment that is sexual in nature, even if the person consents or initiates the behavior.</p> <p>N.B. Some boundary violations and some types of professional sexual misconduct are also crimes.</p> <p>Boundary Signs definition – acts, behaviors, or thoughts that warn of a boundary crossing or boundary violation.</p> <p>Define legal terms:</p> <ul style="list-style-type: none"> Law Criminal laws Civil laws Unintentional Torts <ul style="list-style-type: none"> Negligence Malpractice Intentional Torts <ul style="list-style-type: none"> Defamation <ul style="list-style-type: none"> Libel Slander Fraud False Imprisonment Assault Battery Invasion of privacy 		
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	<p>9.9 Explain the <i>Health Insurance Portability and Accountability Act (HIPAA)</i>.</p> <p>9.10 Explain Informed Consent.</p> <p>9.11 Identify ways Informed Consent can be given.</p> <p>9.12 Define abuse.</p> <p>9.13 Describe the “vulnerable” adult.</p>	<p>The purpose of HIPAA is to protect health information regardless of the source (oral, paper or electronic)</p> <p>Informed Consent: <i>...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.</i></p> <p>Ways Informed Consent can be given: Written Verbal Implied</p> <p>Definition of abuse: <i>...willful infliction of injury, unreasonable confinement, 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.</i></p> <p>Vulnerable adult... <i>a person 18 years old or older who has a disability or condition that causes the person to be at risk of harm.</i></p>	<p>Boxes 4-3 & 4-4</p> <p><i>Focus on communication – Informed Consent</i> Page 35</p> <p><i>Focus on Older Person</i> Page 36</p>	
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	<p>9.14 Describe types of elder abuse.</p> <p>9.14. Recognize signs of Elder Abuse.</p>	<p>Types of abuse Physical or verbal Abuse Neglect Financial Abuse Involuntary seclusion Emotional or psychological abuse Sexual abuse Abandonment</p> <p><i>CNAs are legally bound to report suspected or actual abuse/neglect (Mandated Reporters)</i></p> <p>Signs of Elder Abuse: Self-report Lacking personal hygiene Frequent injuries Missing assistive devices Bleeding or bruising around breasts. or genital/rectal area Burns Individual is withdrawn. An individual is restrained.</p>	<p><i>Focus on Communication – Reporting Abuse</i> Page 35</p> <p>Box 4-5 & 4-6 Figure 4-3</p> <p>Clinical Practice</p>	
<p>Unit 10 Accident Prevention</p>	<p>10.1. Describe risk factors associated with accidents.</p>	<p>Risk factors associated with accidents: Age Awareness of surroundings Agitated/Aggressive behavior Hearing loss Impaired senses (vision, hearing, smell, or touch)</p>	<p>Lecture & Discussion Chapter 11, Page 117-132</p>	

	<p>10.2. Describe the steps to properly identify a resident before providing care.</p> <p>10.3. List types of possible accidents.</p>	<p>Impaired mobility Medications</p> <p>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.</p> <p>Types of accidents: Burns Poisoning Suffocation including Choking Equipment related Hazardous chemicals Disasters Bomb threats Fire Elopement Workplace violence</p>	<p>Figures 11-1, 11-2 & 11-3</p>	
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	<p>10.4. Identify ways to prevent burns.</p>	<p>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.</p>	<p>Box 11-1</p>	
	<p>10.5. Identify ways to prevent poisoning.</p>	<p>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.</p>		
	<p>10.6. Identify ways to prevent suffocation.</p>	<p>Ways to prevent suffocation: Choking is the primary cause of Suffocation</p> <p>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.</p>	<p>Box 11-2</p>	

	<p>10.7. Identify ways to prevent equipment accidents.</p> <p>10.8. Identify ways to prevent accidents from hazardous chemicals.</p>	<p>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.</p> <p><i>If a resident is choking, perform abdominal thrusts (Heimlich maneuver) to dislodge the foreign body and relieve airway obstruction. Chest thrusts are used for obese residents and in a pregnant woman.</i></p> <p>Ways to prevent equipment accidents: Do not use unfamiliar items. Do not use broken/damaged items. Avoid using extension cords. Do not cover electrical cords. Have maintenance staff check resident personal electrical items. Check electrical cords for damage. Make sure brakes (including wheelchairs and stretchers) work properly.</p> <p>Ways to prevent hazardous chemical accidents: Keep original labels intact and readable. <i>If the label is damaged or removed do not use the substance. Show the container to the nurse.</i> Do not leave containers unattended. Know the location of the <i>Safety Data Sheets (SDS)</i></p>	<p>Figures 11-4 thru 18-8 Box 11-3</p> <p>Procedural Box – <i>Relieving Choking (Adult or Child over 1 year of age)</i> Page 122</p> <p>Box 11-4 Figure 11-10 A&B</p> <p>Figure 11-11</p>	
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	<p>10.9 State the information listed on Safety Data Sheets.</p> <p>10.10 Identify types of disasters.</p> <p>10.11 Identify actions to take in the event of a bomb threat.</p> <p>10.21 Identify ways to prevent a fire.</p>	<p>Information on Safety Data Sheets: Name & common names. Hazards about the chemical Chemical ingredients Emergency measures Fire-fighting measures. Accidental release measures Safe handling & storage Personal protection measures</p> <p>Types of disasters: Weather/environmental events Human-made events Bomb Threats Power failures Communication (cyber-attack) Pandemics Elopement</p> <p>Actions during a real or potential bomb threat: Report all suspicious individuals. Report all suspicious items or packages.</p> <p>Ways to prevent a fire: Follow the oxygen use policy of the center. Follow the smoking policy of the center. Secure all smoking materials. Do not leave cooking unattended.</p>	<p>Box 11-5</p>	
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	<p>10.12. Identify actions to take in the event of a fire.</p> <p>10.13 Define elopement.</p> <p>10.14. Identify ways to prevent elopement of a resident.</p> <p>10.15. Identify risk factors related to workplace violence.</p>	<p>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 <i>RACE</i> and <i>PASS</i></p> <p>Define the term elopement: <i>...when a patient or resident leaves the agency without staff knowledge.</i></p> <p>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.</p> <p>Risk factors related to workplace violence: Working with persons with a history of violence. Working alone. Poorly lit hallways Working in high crime areas Limited security Visitors being allowed to go anywhere in the agency.</p>	<p>Figures 11-12 & 11-13 Procedure Box: <i>Using a Fire Extinguisher</i> Page 127</p> <p>Box 11-6</p>	
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<p>Unit 11</p> <p>Health Team Communication</p>	<p>11.1 Define the term communication.</p>	<p>Definition of the term communication: <i>...exchange of information-a message sent is received and correctly interpreted by the intended person.</i></p>	<p>Lecture & Discussion</p> <p>Chapter 7, Pages 64-77</p>	
	<p>11.2 Identify components of “good” communication.</p>	<p>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.</p>	<p>Box 7-1</p>	
	<p>11.3 Define the term medical record.</p>	<p>Definition of the term medical record: <i>...legal account of a person’s condition and responses to treatment and care.</i> Electronic Medical Record (EMR) Electronic Health Record (EHR)</p>		
	<p>11.4 List the parts of a medical record.</p>	<p>Parts of a medical record: Admission information Health history Flow sheets/graphic sheets. Progress notes Laboratory Reports</p>	<p>Table 7-1</p>	
	<p>11.7 State the legal and ethical aspects</p>	<p>Legal & ethical aspects of a medical record: It is the duty of the nursing assistant to keep</p>		

	<p>related to a resident's medical record.</p> <p>11.5 Describe the Nursing Process.</p> <p>11.6 Describe the difference between objective and subjective observations.</p> <p>11.6. List the observations the nursing assistant needs to report</p>	<p>resident information confidential. The nursing assistant can only read the medical record of the resident on his/her assignment. Reading other residents' medical records is considered an invasion of privacy.</p> <p>The Nursing Process: Definition...methods nurses use to plan and deliver nursing care. There are 5 steps: Assessment Nursing Diagnosis Planning Implementation Evaluation</p> <p>Objective data (signs): Observations or signs that can be seen, heard, felt, or smelled by an observer. Examples include a pulse or color of urine.</p> <p>Subjective data (symptoms): Refers to information the resident shares with the observer. These data are referred to as symptoms. Pain, nausea, or fear are examples of subjective data.</p> <p>Observations to be reported immediately: Change in a resident's ability to respond Changes in a resident's mobility</p>	<p>Box 7-3 Basix Observations</p> <p>Box 7-2</p>	
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	<p>immediately to the charge nurse.</p> <p>11.8 Identify the role of the nursing assistant in the completion of the Minimum Data Set (MDS).</p> <p>11.9 Identify the role of the care plan.</p> <p>11.10 Explain the terms reporting and recording.</p>	<p>Complaints of sudden, severe pain A reddened area, bruise, or open area Complaints of vision changes Vital signs out of the resident's range</p> <p>Role of the nursing assistant in completing the MDS: The observations of the nursing assistant are used to complete the MDS. The MDS nurse may interview the nursing assistants caring for a resident.</p> <p>Role of the Comprehensive care plan (CCP): The nurse uses data from the MDS to create a CCP. It outlines all the interventions required to meet a resident's needs. It is updated periodically through medical record review and care conferences. The interventions to be completed by the direct care provider are entered onto an assignment sheet.</p> <p>Reporting: <i>...oral account of care and observations</i></p> <p>Recording: <i>...written account of care and observations</i></p> <p>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</p>	<p>Figure 7-5</p> <p>Box 7-5 Box 6-6 Box 7-7</p>	
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	<p>11.11 Convert conventional time to military /international time.</p> <p>12.12 Explain proper etiquette when using a facility telephone.</p>	<p>report and record care and observations occurring during the time the caregiver was assisting a resident.</p> <p>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</p> <p>Military time used a 24-hour clock Example: 9:00 PM = 2100</p> <p>Proper telephone etiquette: Answer the call after the first ring, however the telephone should be answered before the fourth ring. Give a courteous greeting including facility, location, your name and position. Put the caller on hold if necessary. Do not give confidential information. At the end of the call thank the caller.</p>	<p>Box 7-4 Figure 7-6 & 7-7</p> <p>Box 7-8</p> <p>Clinical Practice</p>	
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<p>Unit 12</p> <p>Medical Terminology</p>	<p>12.1 Identify the parts of words or word elements.</p>	<p>Parts of a word or word elements: Prefixes Roots Suffixes Word elements are combined to form medical terms.</p>	<p>Lecture & Discussion</p> <p>Chapter 8, Pages 78-88</p>	
	<p>12.2 Define word elements.</p>	<p>Word elements: Prefix...added to the beginning of a word. It changes the meaning of the word. Root...contains the basic meaning of the word. Suffix...added to the end of the word. It changes the meaning of the word.</p>	<p>Figure 8-2 & 8-3</p>	
	<p>12.3 Discuss common prefixes.</p>	<p>Common prefixes:</p>	<p>Table 8-1</p>	
	<p>12.4 Discuss common roots.</p>	<p>Common roots:</p>	<p>Table 8-2</p>	
	<p>12.5 Discuss common suffixes.</p>	<p>Common Suffixes:</p>	<p>Table 8-3</p>	
	<p>12.6 Identify abdominal quadrants.</p>	<p>Abdominal quadrant: Used to describe the location of body structure, pain, or discomfort. Right Upper Quadrant (RUQ) Left Upper Quadrant (LUQ) Right Lower Quadrant (RLQ) Left Lower Quadrant (LLQ)</p>	<p>Figure 8-5</p>	

	12.7 Identify directional terms of the body.	Directional terms: Anterior (ventral) Posterior (dorsal) Proximal Distal Lateral Medial Superior Inferior Superficial Deep	Figure 8-6	
	12.8 Define common abbreviations.	Common abbreviations:	Table 8-5	
			Clinical Practice	
Unit 13 Communicating with Residents	13.1 Define the term <i>Holism</i> .	Definition of the term <i>holism</i> : <i>...concept that considers the whole person. The person has physical, social, psychological, and spiritual parts. These parts are woven together and cannot be separated.</i>	Lecture & Discussion Chapter 6, Pages 53-63	
	13.2 Identify the proper way to address a resident.	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.		

	<p>13.3 Define the term <i>need</i>.</p> <p>13.4. Discuss Maslow’s basic needs.</p> <p>13.5. Define the term <i>culture</i>.</p> <p>13.6. Define the term <i>religion</i>.</p> <p>13.7 Define communication.</p> <p>13.8 Discuss types of communication.</p>	<p>Definition of the term <i>need</i>: <i>...something necessary or desired for maintaining life and mental well-being.</i></p> <p>Maslow’s basic needs: Physical Safety and security Love and belonging. Self-esteem Self-actualization</p> <p>Definition of the term <i>culture</i>: <i>...characteristics of a group of people-language, values, beliefs, likes, dislikes, and customs. They are passed from 1 generation to the next.</i></p> <p>Definition of the term <i>religion</i>: <i>...relates to spiritual beliefs, needs, and practices.</i></p> <p>N.B. <i>Do not judge the person by your standards/religion. Also, do not force your ideas on the other person.</i></p> <p>Communication definition...<i>exchange of information.</i></p> <p>Types of communication: Verbal communication – uses written or spoken words. When speaking to another person consider the following rules:</p>	<p>Figure 6-2</p> <p>Box 6-1</p> <p>Figure 6-3</p> <p>Box: <i>Focus on Older Persons – Effective communication</i></p>	
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	<p>13.10 Describe barriers to communication.</p> <p>13.11 Identify behaviors communicating a resident's need.</p> <p>13.12 Discuss ways to manage difficult behaviors.</p>	<p>Direct questions Open-ended questions Clarifying Focusing Silence</p> <p>Barriers to communication: Unfamiliar language Cultural differences Changing the subject Giving opinion Talking a lot Failure to listen. "Pat" answers Illness including coma. Age</p> <p>Behaviors communicating needs: Anger Demanding/Self-centered behavior Aggressive behavior Withdrawal Inappropriate sexual behavior</p> <p>Ways to manage difficult behaviors: Recognize the behavior. Treat the person with dignity & respect. Keep the person informed. Listen, use silence. Protect yourself.</p>	<p><i>Box: Focus on Communication – Communication Barriers</i></p> <p>Box 6-2</p>	
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	<p>13.13 Recognize methods to communicate with residents with special needs.</p>	<p>Methods to communicate with residents with special needs:</p> <ul style="list-style-type: none"> • Comatose resident <ul style="list-style-type: none"> ▪ Knock before entering the resident’s room. ▪ Introduce yourself. ▪ Tell the resident the date and time. ▪ Explain procedures to the resident. ▪ Tell the resident when you are leaving the room and when you will be back. • Residents with disabilities <ul style="list-style-type: none"> ▪ 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. 	<p>Box 6-3</p> <p>Instructor Demonstration Skill Lab Practice Clinical Practice</p>	
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<p>Unit 14</p> <p>Measuring Vital Signs</p>	<p>14.1 Define vital signs.</p>	<p>Vital signs reflect the function of three body processes including regulation of body temperature, breathing, and heart function. Pain is also considered a vital sign.</p>	<p>Lecture & Discussion Chapter 31, Page 388-411</p>	
	<p>14.2 Identify factors that may affect vital signs.</p>	<p>Factors that may affect vital signs:</p> <ul style="list-style-type: none"> Activity Age Anger Medications Eating Gender Pain Illness 	<p>Box 31-1</p>	
	<p>14.3 List the types of thermometers used to take a resident's temperature.</p>	<p>Thermometer types used to take a resident's temperature:</p> <ul style="list-style-type: none"> Standard electronic Tympanic membrane Temporal artery Non-contact Infrared Digital Glass (Blue Stem) 	<p>Table 31-2 Figures 31-1</p>	
	<p>14.4 List the sites used to take a resident's temperature.</p>	<p>Sites used to take a temperature:</p> <ul style="list-style-type: none"> Oral Rectal Axillary Tympanic 	<p>Figure 31-1 through 31-5</p>	

	<p>14.5 State the normal ranges for body temperature by site used.</p> <p>14.6 Demonstrate competency with the procedure of measuring temperature.</p> <p>14.7 Define selected terms related to taking a pulse.</p>	<p>Normal body temperature ranges by site:</p> <p>Oral 97.6 to 99.6 degrees F Rectal 98.6 to 100.6 degrees F Axillary 96.6 to 98.6 degrees F Tympanic 98.6 degrees F Temporal 99.6 degrees F</p> <p>Oral 36.5 degrees C to 37.5 degrees C Rectal 37.0 degrees C to 38.1 degrees C Axillary 35.9 degrees C to 37.0 degrees C Tympanic 37.0 degrees C Temporal 37.5 degrees C</p> <p>Procedure of measuring temperature:</p> <p>Definition of selected terms: Pulse...<i>the beat of the heart felt over an artery as a wave of blood passing through the artery.</i></p> <p>Pulse rate...<i>the number of heartbeats or pulses in 1 minutes.</i></p> <p>Pulse rhythm...<i>refers to the pattern of the heartbeats – regular or irregular.</i></p> <p>Pulse force – <i>relates to the pulse strength –</i></p>	<p>Table 31-1</p> <p>Box – <i>Taking a Temperature with an Electronic Thermometer</i></p> <p><i>D&S Candidate Handbook</i></p>	
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	<p>14.10 Define the term respiration.</p> <p>14.11 Identify the respiratory range for a healthy adult.</p> <p>14.12 State the normal quality of respiration.</p> <p>14.13 Demonstrate competency with the procedure for counting respirations.</p> <p>14.14 Define selected terms associated with measuring a person's oxygen levels.</p>	<p>Definition of the term respiration: <i>...breathing air into (inhalation) and out of (exhalation) the lungs. Both sides of the chest rise and fall equally.</i></p> <p>Respiratory range for a healthy adult: 12 to 20 respirations per minute</p> <p>Normal qualities of respirations:</p> <ul style="list-style-type: none"> • Quiet • Effortless • Regular <p>Procedure for counting respirations:</p> <p>Definition of selected terms associate with measuring a person's oxygen level:</p> <p>Pulse oximetry...<i>measures the oxygen concentration in arterial blood.</i></p> <p>Oxygen concentration...<i>amount (%) of hemoglobin containing oxygen.</i></p>	<p><i>Box – Counting Respirations</i></p> <p><i>D&S Candidate Handbook</i></p> <p>Chapter 37, Pages 475-478 Figure 37-2</p>	
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	<p>14.15 State the normal range of oxygen saturation.</p> <p>14.16 Identify types of probes used to measure a person's oxygen saturation.</p> <p>14.17 Recognize factors that affect the accurate measurement of oxygen saturation></p> <p>14.18 Demonstrate competency with the procedure for measuring a person's oxygen saturation.</p>	<p>Normal oxygen saturation: 95 - 100 %</p> <p>Types of probes used to measure oxygen saturation:</p> <ul style="list-style-type: none"> • Finger (most common method) • Toe • Ear • Nose • Forehead <p>Factors that affect the accurate measurement of oxygen saturation:</p> <ul style="list-style-type: none"> • Avoid areas with edema (swelling). • Avoid sites with skin breakdown. • Avoid bright lights. • Remove nail polish. • Remove non-natural nails. • Keep the site still as possible. • Do not measure the blood pressure on the arm if a finger on that side is used for continuous oxygen saturation measurement. <p>Procedure for measuring oxygen saturation:</p>	<p>Figure 37-2</p> <p><i>D&S Candidate Handbook</i></p> <p>Procedural Box – <i>Using a Pulse Oximeter</i></p>	
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	<p>14.21 List the parts of an aneroid sphygmomanometer</p> <p>14.22 State which artery is usually used to measure blood pressure.</p> <p>14.23 List guidelines for measuring blood pressure.</p>	<p>Parts of an aneroid sphygmomanometer: Cuff, Inflation Bulb, Air-release valve, Tube to manometer, Manometer</p> <p>Artery usually used to measure blood pressure: Brachial artery.</p> <p>The brachial artery is found by palpating the inner aspect of the antecubital fossa.</p> <p>Guidelines for measuring blood pressure:</p> <ul style="list-style-type: none"> • Do not take the blood pressure on an arm with: <ul style="list-style-type: none"> ▪ 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 	<p>Box 31-4</p>	
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	<p>14.24 Demonstrate competency with the procedure for measuring blood pressure.</p> <p>14.25 Identify selected terms associated with pain.</p> <p>14.26 Discuss types of pain.</p>	<p>pressure.</p> <ul style="list-style-type: none"> • 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. <p>Procedure for taking a manual blood pressure:</p> <p>Selected terms associated with pain: Comfort...<i>a state of well-being. The person has no physical or emotional pain and is calm and at ease.</i> Pain or Discomfort... <i>to ache, hurt, or be sore.</i></p> <p>Types of pain:</p> <ul style="list-style-type: none"> • 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 	<p>Procedural Box – <i>Measuring Blood Pressure with an Aneroid Manometer</i></p> <p><i>D&S Candidate Handbook</i></p> <p>Lecture & Discussion</p> <p>Chapter 33, Pages 425-428</p> <p>Box – <i>Focus on Older Persons Pain</i></p> <p>Figure 33-1</p>	
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	<p>14.29 Recognize comfort and pain-relief measures.</p> <p>14.30 Identify reasons to weigh a person.</p> <p>14.31 Identify types of scales.</p> <p>14.32 State the guidelines for weighing a person.</p>	<p>Comfort and pain-relief measures:</p> <ul style="list-style-type: none"> • Position • Adjust the room temperature. • Give back massage. • Avoid sudden or jarring movements. • Provide distraction (music). • Apply warm or cold measures, if ordered. <p>Reasons to weigh a person:</p> <p>On admission Daily Monthly</p> <p>Types of scales:</p> <p>Standing scale Chair scale Bed scale Mechanical Lift scale</p> <p>Guidelines for measuring Weight & Height:</p> <p>Know how to use the scale. Person to be weighed wearing a gown. Have the person void before weighing the person. Weigh the person at the same time each day. Balance the scale to “o” before weighing the person. Use the same scale.</p>	<p>Figure 31-25 & 31-26</p> <p>Box 31-5 Procedural Box – <i>Measuring Height and Weight with s standing Scale.</i></p>	
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<p style="text-align: center;">Unit 15</p> <p style="text-align: center;">Body Structure and Function</p>	<p>15.1. Explain the relationship between cells, tissues and organs.</p>	<p>Relationship between cells, tissues, and organs:</p> <p>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</p> <p>Tissues: Groups of cells with similar function combine to form tissues. Types of Tissues: Epithelial Connective Muscle Nerve</p> <p>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 be the cardiovascular system.</p>	<p>Lecture & Discussion</p> <p>Chapter 9, Pages 89-107 Chapter 10, Pages 108-116</p>	
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	<p>15.6 Describe the components and function(s) of the Lymphatic System.</p>	<p>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</p> <p>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.</p>		
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	<p>15.9 Describe the components and function(s) of the Urinary System.</p> <p>15.10 Describe the components and function(s) of the male and female Reproductive Systems.</p>	<p>Functions: Breaks down food physically & chemically Removes solid waste from the body</p> <p>Components and functions of the urinary system:</p> <p>Components: Kidneys - 2 Nephron Convolved Tubule - Urine Bowman’s Capsule - Glomerulus - filter Renal pelvis Ureter Bladder Urethra Meatus</p> <p>Functions: Removes waste products from blood. Maintains electrolyte balance. Maintains acid-base balance.</p> <p>Components of the male reproductive system: Components: Testes – Sperm, Testosterone Scrotum Seminal vesicle – Sperm & Semen Prostate Gland Penis – Urethra</p>		
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	<p>15.11 Describe the components and function(s) of the Endocrine System.</p>	<p>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.</p> <p>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</p>		
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	15.12 Describe the components and function(s) of the Immune System.	<p>Functions: Secrete hormones into the blood stream to regulate the activities of other organs of the body.</p> <p>Components and functions of the immune system:</p> <p>Components: Antibodies Antigens Phagocytes Lymphocytes – (B cells & T cells)</p> <p>Function: Protects the body from disease and infection.</p>		
<p>Unit 16</p> <p>Personal Care</p>	<p>16.1 Explain the importance of personal hygiene.</p> <p>16.2 Describe adaptive devices available to promote resident independence with hygiene needs.</p>	<p>Importance of personal hygiene: Maintaining intact skin. Prevent body odor. Prevent breath odor. Provide relaxation. Promote circulation.</p> <p>Adaptive (assistive) devices: Toothpaste tube squeezer Wash mitt with a pocket for a bar of soap. Faucet adapter/extender Long-handle sponge</p>	<p>Lecture & Discussion Chapter 21 Chapter 22 Chapter 23 Chapter 24 <i>D&S Candidate Handbook</i></p> <p>Learning Activities for selected skills include: Video & Discussion Instructor Demonstration Supervised Practice Clinical Practice</p>	

	<p>16.3 Identify routine hygiene tasks to be completed throughout the day.</p> <p>16.4 State the purpose of providing oral hygiene.</p> <p>16.5 State observations during oral hygiene to report immediately.</p>	<p>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).</p> <p>Purpose of oral hygiene: Keeps the mouth& teeth clean. Prevents odors and infection. Increases comfort. Reduces the risk for cavities & other diseases</p> <p>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</p>		
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	<p>16.6 Demonstrate the proper procedure for oral care, including brushing teeth for an alert resident and an unconscious resident.</p> <p>16.6 Demonstrate the proper procedure for denture care.</p> <p>16.7. State the benefits of bathing.</p> <p>16.8. Discuss the rules for bathing.</p>	<p>Proper procedure for oral care for the alert and unconscious resident:</p> <p>Proper procedure for denture care:</p> <p>Benefits of bathing: Cleans the skin and mucous membranes. Removes microbes, dead skin, perspiration, & excess oils Promotes relaxation. Stimulates circulation. Exercises body parts</p> <p>Rules for bathing: Allow personal choice. Follow standard precautions. Remove hearing aids. Provide privacy. Assist with elimination before bathing.</p>		
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	<p>16.9 Demonstrate the proper procedure for completing a bed bath.</p> <p>16.10 List other types of baths.</p> <p>16.11 Demonstrate the proper procedure for completing perineal care for the male and the female resident.</p>	<p>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.</p> <p>Proper procedure for completing a bed bath:</p> <p>Other types of baths: The partial bath Tub bath Shower bath Using a shower chair Using a shower trolley</p> <p>Proper procedure for perineal care for the male and the female resident:</p>		
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	<p>16.12 Define selected terms associated with skin and scalp conditions.</p> <p>16.13 Describe the proper procedure for brushing, combing, and shampooing hair.</p> <p>16.14 State the rules for shaving a resident.</p>	<p>Terms associated with hair care: Alopecia Dandruff Pediculosis Scabies</p> <p>Proper procedure for brushing and combing hair: <i>Have the resident use a long-handled comb or brush to promote independence.</i></p> <p>Rules for shaving a resident: Use electric razors for residents taking anticoagulant medications and confused residents. Use a blade razor for residents using continuous oxygen Soften facial hair before shaving. Lather the area. Hold the skin taut. Shave in the direction of hair growth- face & axilla. Shave against the direction of hair growth legs & when using an electric razor.</p>		
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	<p>16.15 Demonstrate the proper procedure for providing nail and foot care for residents.</p> <p>16.16 Discuss the rules for dressing and undressing a resident.</p> <p>16.17 Demonstrate the proper procedure for dressing and undressing a resident with a weak side.</p>	<p>Proper procedure for providing nail and foot care:</p> <p>Rules for dressing and undressing a resident: Provide privacy. Let the resident select clothing. Put clothing on the weak side first. Remove clothing from the strong side First Put clothing on the weak side first. Support the limb during dressing or undressing.</p> <p><i>Have the resident use assistive devices for independence with dressing such as a sock assist.</i></p> <p>Proper procedure for dressing and undressing a resident with a weak side:</p>		
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<p>Unit 17</p> <p>Fall Prevention</p>	<p>17.1 Define the meaning of a fall according to the Centers for Medicare & Medicaid Services (CMS).</p> <p>17.2 Identify the potential impact of a fall on a resident.</p> <p>17.3 Discuss risk factors associated with falls.</p>	<p>Definition of a fall:</p> <ul style="list-style-type: none"> ✓ 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 <p>Falls are the most common accident in nursing centers.</p> <p>Impact of a fall on a resident:</p> <p>Main cause of injury</p> <p>Main cause of death</p> <p>Serious injuries increase risk of death.</p> <ul style="list-style-type: none"> • Hip Fractures • Head trauma. <p>Disability</p> <p>Functional decline</p> <p>Decrease quality of life</p> <p>Risk factors for falls:</p> <ul style="list-style-type: none"> ✓ The person <ul style="list-style-type: none"> • Over age 65 years • Balance problems • Blood pressure alterations • Confusion, Disorientation • Dizziness • Drug side effects. • Incontinence • Nocturia 	<p>Lecture & Discussion</p> <p>Chapter 12</p> <p>Chapter 13</p> <p>Chapter 18</p> <p>Chapter 32</p> <p>Learning Activities for Selected Skills include:</p> <p>Video & Discussion</p> <p><i>D&S Candidate Handbook</i></p> <p>Instructor Demonstration</p> <p>Supervised Practice</p> <p>Clinical Practice</p>	
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	<p>17.4 Identify components of fall prevention measures.</p>	<ul style="list-style-type: none"> • Unsteady gait • Pain • Poor judgement • Slow reaction time • Poor fitting shoes • Vision problems • Weakness ✓ Care setting: <ul style="list-style-type: none"> • 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 <p>Fall prevention measures:</p> <ul style="list-style-type: none"> ✓ Meeting basic needs ✓ Bathrooms and shower rooms ✓ Floors and hallways ✓ Furniture ✓ Bed and other equipment ✓ Lighting ✓ Shoes and clothing ✓ Call lights, alarms and barriers, mats ✓ Use a Transfer/Gait Belt 	<p>Box 12-2</p>	
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	<p>17.5 Explain the proper procedure to assist a person who starts to fall to the floor.</p> <p>17.6 Identify situations when a restraint may be used.</p> <p>17.7 Describe types of restraints.</p>	<p>Proper procedure to assist a person to the floor:</p> <ul style="list-style-type: none"> ✓ Stand behind the person. ✓ Bring the person close to your body. ✓ Move your leg so the person’s buttocks rest on it. ✓ Lower the person to the floor. ✓ Stay calm and talk to the person. ✓ If the person is bariatric move objects out of the way and protect the person’s head. ✓ Call the nurse. <p>Situations in which a restraint may be used:</p> <ul style="list-style-type: none"> ✓ To treat a medical symptom ✓ For immediate physical safety of the person or others ✓ Failure of less restrictive measures to protect the person/others. <p>Types of restraints:</p> <ul style="list-style-type: none"> ✓ Physical – <i>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)</i> ✓ Chemical – <i>any drug used for discipline or convenience and not required to treat medical symptoms. (CMS)</i> 	<p>Figure 12-12</p>	
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	<p>17.10 Differentiate enablers from restraints.</p> <p>17.11 List possible risks associated with restraint use.</p> <p>17.12 Describe laws, rules, & guidelines associated with restraint use.</p>	<ul style="list-style-type: none"> ✓ Bed rails. ✓ Tucking sheets too tight <p>Differentiate enablers from restraints: Definition of enablers – <i>a device that limits freedom of movement but is used to promote independence, comfort, or safety.</i> In addition, the device can be removed easily by the person. Definition of restraints - <i>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.</i></p> <p>Possible risks associated with restraint use:</p> <ul style="list-style-type: none"> ✓ Constipation ✓ Contractures ✓ Physical function decline ✓ Incontinence ✓ Infections - pneumonia ✓ Pressure injuries ✓ Withdrawal ✓ Strangulation <p>Laws, rules, & guidelines associated with restraint use:</p> <ul style="list-style-type: none"> ✓ Restraints must protect the person. ✓ A doctor's order is required. ✓ The least restricted method is used. ✓ Restraints are used only after other 		
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	<p>17.13 Explain safety guidelines associated with restraint use.</p> <p>17.14 Define the term transfer.</p> <p>17.15 List devices and equipment used to transfer a resident.</p>	<p>measures fail to protect the person.</p> <ul style="list-style-type: none"> ✓ Using an unnecessary restraint is involuntary seclusion. ✓ Informed consent is required. <p>Safety guidelines associated with restraint use:</p> <ul style="list-style-type: none"> ✓ 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, reposition the person, and meet basic needs at least every two (2) hours. ✓ Report & Record restraint use. <p>Definition of the term transfer: <i>...how a person moves to and from a surface.</i></p> <p>Devices and equipment used to transfer a resident:</p> <ul style="list-style-type: none"> ✓ Bed attachments ✓ Slide boards ✓ Transfer belts ✓ Mechanical lift (full-sling) ✓ Mechanical lift (stand-assist) <p>The care plan will include information about the proper technique to safely transfer a resident.</p>	<p>Box 13-4</p>	
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	<p>17.16 Define the term transfer/gait belt.</p> <p>17.17 Demonstrate the proper procedure for using a transfer/gait belt.</p> <p>17.18 Identify safety guidelines for using wheelchairs and stretchers.</p>	<p>Definition of the term transfer/gait belt: <i>...a device applied around the waist and used to support a person who is unsteady or disabled.</i></p> <p>Proper procedure for using a transfer/gait belt:</p> <ul style="list-style-type: none"> ✓ 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. <p>Safety guidelines for using wheelchairs and stretchers:</p> <ul style="list-style-type: none"> ✓ Maintenance – ensure all parts work correctly. ✓ Transfers <ul style="list-style-type: none"> • Lock brakes. • Remove leg lifts/footplates. • Position feet on the footplates. ✓ Transport <ul style="list-style-type: none"> • Push the wheelchair forward. • Pull the wheelchair backward when going through a doorway. • Pull the wheelchair backward when going down a ramp. ✓ Stretcher <ul style="list-style-type: none"> • Use at least two staff to transfer a resident to and from a stretcher. 		
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	<p>17.19 Demonstrate the proper procedure to pivot transfer a resident to and from the wheelchair.</p> <p>17.20 Discuss the purpose and types of mechanical lifts to transfer a resident.</p> <p>17.21 Demonstrate the proper procedure to ambulate a resident using a gait belt and a walker.</p>	<ul style="list-style-type: none"> • 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. <p>Proper procedure for a pivot transfer:</p> <p>Purpose of the mechanical lift:</p> <ul style="list-style-type: none"> • Residents cannot assist/participate with the transfer. • Residents are too heavy to be moved by staff. <p>Types of mechanical lifts:</p> <ul style="list-style-type: none"> • Stand-assist mechanical lift • Full-sling mechanical lift <p>Proper procedure to use to ambulate a resident using a gait belt and/or walker:</p>		
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	<p>17.22 Define Range of Motion (ROM).</p> <p>17.23 Identify abbreviations related to Range of Motion exercises.</p> <p>17.24 Demonstrate the proper procedure to assist a resident with range of motion (ROM) of their joints.</p>	<p>Definition of Range of Motion: <i>The movement of a joint to the extent possible without causing pain.</i></p> <p>Range of Motion abbreviations: AROM = Active ROM – done by the resident PROM = Passive – done by staff AAROM = Active-Assist done by the resident with staff assist</p> <p>Proper procedure for assisting a resident with ROM of the shoulder, hip, and knee.</p>	<p>Figures 32-4, 32-10, and 32-11</p> <p>Learning activities for selected skills include: Video & Discussion <i>D&S Candidate Handbook</i> Instructor Demonstration Supervised Practice Clinical Practice</p>	
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<p>Unit 18</p> <p>Nutrition & Fluid Needs</p>	<p>18.1 State the effects of poor diet and poor eating habits.</p> <p>18.2 Define the term <i>Nutrition</i>.</p> <p>18.3 Define the term <i>nutrient</i>.</p> <p>18.4 Define the term <i>calorie</i>.</p> <p>18.5 Explain the purpose of the <i>MyPlate</i> symbol.</p>	<p>Effects of poor diet and eating habits:</p> <ul style="list-style-type: none"> ✓ Increased risk of disease and infection ✓ Causes chronic illnesses to become worse. ✓ Difficulty healing ✓ Increase in accidents and injuries. <p>Definition of the term <i>nutrition</i>: <i>...process involved in the ingestion, digestion, absorption, and the use of food and fluids by the body.</i></p> <p>Definition of the term <i>nutrient</i>: <i>...substance that is ingested, digested, absorbed, and used by the body.</i></p> <p>Definition of the term <i>calorie</i>: <i>...fuel or energy value of food</i></p> <p>Examples: 1 gram of fat = 9 calories 1 gram of protein = 4 calories 1 gram of carbohydrate = 4 calories</p> <p>Purpose of the MyPlate symbol:</p> <ul style="list-style-type: none"> ✓ Balance calories ✓ Increasing certain foods <ul style="list-style-type: none"> • Half the plate should be fruits and vegetables • At least half of the grains should be whole grains 	<p>Lecture & Discussion Chapter 28 Chapter 29 Chapter 30</p> <p>Learning activities for selected skills include: Video & Discussion D&S Candidate Handbook Instructor Demonstration Supervised Practice Clinical Practice</p>	
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	<p>18.6 List weekly physical activity recommended by USDA.</p> <p>18.7 Describe the Five food groups and give examples of each.</p>	<ul style="list-style-type: none"> • Fat-free or low-fat milk ✓ Reducing certain foods <ul style="list-style-type: none"> • Choosing low-sodium foods • Drinking water <p>Weekly physical activity:</p> <ul style="list-style-type: none"> ✓ At least three days a week ✓ Two hours & 30 minutes of moderate physical activity such as: <ul style="list-style-type: none"> • Walking rate of 3 & a half mph • Water aerobics ✓ 75 minutes of vigorous physical activity such as: <ul style="list-style-type: none"> • Running at a rate of 5 mph • Swimming laps <p>The five food groups:</p> <ul style="list-style-type: none"> ✓ 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 <p>Note: Oils are not a food group. Butter is included in the oil category.</p>	<p>Table 28-1</p>	
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	<p>18.16 Identify ways to assist a visually impaired resident.</p> <p>18.17 Identify the nursing assistant role in providing care for a resident who receives enteral nutrition.</p> <p>18.18 Define selected terms associated with fluid balance.</p>	<p>Ways to assist a visually impaired resident:</p> <ul style="list-style-type: none"> ✓ Describe the food on the tray. ✓ Ask the resident what to eat first. ✓ If the residents can feed themselves tell them where each food item is located on the plate/tray – use the numbers face of a clock. <p>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.</p> <p>The nursing assistant may have the responsibility for cleaning around the tube.</p> <p>Enteral feeding tubes:</p> <ul style="list-style-type: none"> ✓ Naso-gastric ✓ Gastrostomy ✓ Jejunostomy <p>Preventing aspiration:</p> <ul style="list-style-type: none"> ○ Position the resident in a Fowler’s or semi-Fowler’s position. <p>Definition of selected terms: Intake = <i>the amount of fluid taken in</i> Output = <i>the amount of fluid loss</i> Hydration = <i>having an adequate amount of</i></p>		
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	<p>18.19 Identify normal fluid requirements.</p> <p>18.20 Explain special considerations associated with older adults.</p> <p>18.21 List special fluid orders.</p>	<p><i>water in body tissues</i></p> <p>Edema = <i>swelling of body tissues with water</i></p> <p>Dehydration = <i>decrease in the amount of water in body tissues</i></p> <p>Dehydration will be discussed in detail in the Unit titled Health Problems</p> <p>Normal fluid requirements:</p> <ul style="list-style-type: none"> ✓ 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. <p>Special considerations associated with older adults, include:</p> <ul style="list-style-type: none"> ✓ Body water decreases with age. ✓ Older adults have a decreased thirst sensation. <p>Special fluid orders:</p> <ul style="list-style-type: none"> ✓ Encourage fluids. ✓ Restrict fluids – no water pitcher at the resident’s bedside. ✓ Nothing by mouth (NPO) ✓ Thickened liquids 		
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	<p>18.22 List common intake and output measurements.</p> <p>18.23 Demonstrate proper procedure for measuring intake and output.</p> <p>18.24 Demonstrate measure the amount of food intake of a resident.</p> <p>18.24 Demonstrate the proper procedure for placing a resident on a bed pan and measuring urine</p>	<p>Common measurements:</p> <ul style="list-style-type: none"> ✓ 1 cubic centimeter = 1 mL ✓ 1 ounce = 30 mL ✓ 1 cup = 240 mL ✓ 1 quart = 1000 mL ✓ 1 liter = 1000 mL <p>Proper procedure for measuring intake and output:</p> <ul style="list-style-type: none"> ✓ 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. <p><i>To promote resident independence, provide a lidded mug for sipping or a straw if ordered.</i></p> <p>Measuring food intake. Percentage of food intake (0-100 %) Calorie count</p> <p>Proper procedure for assisting a resident to use a bedpan and measuring urine output:</p>		
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	<p>output.</p> <p>18.24 Identify the role of the nursing assistant in caring for a resident receiving intravenous (IV) therapy.</p> <p>18.25. Identify guidelines for measuring height and weight.</p>	<p>Nursing assistant (NA) role in caring for a resident receiving IV therapy:</p> <ul style="list-style-type: none"> ✓ Report signs and symptoms of local complications. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • Fever • Itching • Drop in blood pressure • Increased pulse rate (> 100) • Change in mental status • Decreasing or no urine output • Chest pain <p>Guidelines for measuring height and weight:</p> <ul style="list-style-type: none"> • 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 	<p>Review Chapter 31 Page 406-410</p>	
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<p>Unit 19 Common Health Problems</p> <p>Hearing: Meniere's Loss</p> <p>Visual disorders: Cataracts Glaucoma Low Vision Blindness</p> <p>Cancer Arthritis Fractures Stroke Aphasia Parkinson's MS ALS Head Injury Spinal cord Injury Heart Disease Respiratory COPD Asthma Influenza Pneumonia</p>	<p>19.1. Discuss common health problems and interventions related to the health problems.</p>	<p>Common health problem and associated interventions:</p> <p>Hearing Problems</p> <p>Meniere's Disease – Involves the inner ear. Signs & Symptoms:</p> <ul style="list-style-type: none"> • Vertigo • Tinnitus • Hearing loss • Pressure in the ear. <p>Interventions:</p> <ul style="list-style-type: none"> • 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. <p>Hearing Loss – Limited to total deafness Signs & Symptoms:</p> <ul style="list-style-type: none"> • Straining to understand conversation. • Answers to questions are inappropriate. • Ask others to repeat themselves. • Leaning forward to hear • Turning up devices (TV, Radio, etc.) <p>Interventions:</p> <ul style="list-style-type: none"> • Hearing aids • Watch facial expression, gestures, and body language. 	<p>Lecture & Discussion</p> <p>Chapter 25 Chapter 26 Chapter 27 Chapter 35 Chapter 37 Chapter 38 Chapter 39 Chapter 40</p>	
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<p>Tuberculosis Digestive Vomiting Diverticulosis IBD Hepatitis Cirrhosis Urinary UTI BPH Kidney Stones Kidney Failure Diabetes Autoimmune HIV/AIDS Shingles</p>		<ul style="list-style-type: none"> • Sign language. • Story boards • Hearing dogs • Face the person when speaking. <p style="text-align: center;">Visual Problems</p> <p>Cataracts- Clouding of the lens of the eye (one or both) Signs & Symptoms:</p> <ul style="list-style-type: none"> • 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 <p>Interventions:</p> <ul style="list-style-type: none"> • Follow guidelines for visually impaired residents • Postoperative care <ul style="list-style-type: none"> ▪ 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 <p>Age-Related Macular Degeneration Loss of central vision Signs & Symptoms:</p>	<p style="text-align: center;">Box 39-6</p>	
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		<ul style="list-style-type: none"> • Gradual loss of vision • Progressive <p>Interventions:</p> <ul style="list-style-type: none"> • Guidelines for caring for a resident who is visually impaired. • Laser surgery <p>Diabetic Retinopathy Damage to the blood vessels in the retina. Complication of Diabetes Signs & Symptoms: (Both eyes usually)</p> <ul style="list-style-type: none"> • Blurred vision • Complaints of seeing spots floating • Blindness <p>Interventions:</p> <ul style="list-style-type: none"> • Control Diabetes • Control blood pressure. • Control cholesterol. • Laser surgery <p>Glaucoma Buildup of fluid in the eye causing pressure on the optic nerve Signs & Symptoms:</p> <ul style="list-style-type: none"> • Peripheral vision is lost. • Blurred vision • Objects are seen through a tunnel. • Halos around lights • Blindness <p>Interventions:</p> <ul style="list-style-type: none"> • No cure 		
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		<ul style="list-style-type: none"> • Damage is irreversible. • Medications • Surgery <p>Low Vision Vision loss that cannot be treated Signs & Symptoms:</p> <ul style="list-style-type: none"> • Difficulty reading • Difficulty recognizing faces. • Difficulty doing tasks such as cooking. • Difficulty reading signs anywhere. • Light seems dimmer. <p>Interventions:</p> <ul style="list-style-type: none"> • 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 		
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		<p style="text-align: center;">Medical Problems</p> <p>Cancer: Second leading cause of death</p> <p>Key terms:</p> <ul style="list-style-type: none"> ➤ Tumor <ul style="list-style-type: none"> ▪ Benign ▪ Malignant ➤ Metastasis <p>Risk Factors:</p> <ul style="list-style-type: none"> ✚ Age – most important ✚ Tobacco ✚ Radiation ✚ Infections ✚ Immuno-suppressive drugs ✚ Alcohol ✚ Diet ✚ Hormones ✚ Obesity ✚ Environment <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • 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 		
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		<p>Treatment:</p> <ul style="list-style-type: none"> • Goals <ul style="list-style-type: none"> ▪ Cure ▪ Control ▪ Reduce symptoms. • Surgery • Radiation • Chemotherapy • Immunotherapy • Report pain/discomfort. • Radiation site Skin Care • Dietary needs • Active listening <p style="text-align: center;">Musculo-Skeletal Disorders (Disorders affecting movement)</p> <p>Arthritis Joint inflammation</p> <p>Types:</p> <ul style="list-style-type: none"> ➤ Osteoarthritis (OA) – Cartilage wears away allowing bone to rub on bone. ➤ Rheumatoid (RA) – Autoimmune disorder attacks the lining of the joints. <p>Risk Factors:</p> <ul style="list-style-type: none"> ✚ Age ✚ Overweight ✚ Women ✚ Family history <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Joint Swelling 		
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		<ul style="list-style-type: none"> • Joint stiffness • Reduced range of motion of the joint <p>Interventions:</p> <ul style="list-style-type: none"> • Pain control • Heat & Cold • Exercise • Rest & joint care. • Assistive devices • Weight control • Assistance with ADLS as needed. • Surgery – Joint replacement (Arthroplasty) <ul style="list-style-type: none"> ✚ Care after Surgery <ul style="list-style-type: none"> ▪ Prevent pressure injury. ▪ Hip precautions: <ul style="list-style-type: none"> ❖ Do not cross legs. ❖ Do not sit in low chairs. ❖ Avoid flexing hips past 90 degrees. ❖ Use grabbers. ❖ Use elevated toilet seats. ❖ Abductor pillow 		
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Fracture

A break in a bone

Types:

- Open – Bone is through the skin (compound)
- Closed – Skin is intact (simple)

		<p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Pain • Swelling • Loss of function • Deformity • Bruising • Bleeding <p>Interventions:</p> <ul style="list-style-type: none"> • Reduction – realigns the bone. • Fixation – bone is held (fixed) in place. • Casting – Care guidelines • Traction <p>Osteoporosis Bones become porous and brittle.</p> <p>Risk Factors:</p> <ul style="list-style-type: none"> ○ Decreased estrogen. ○ Low levels of dietary calcium ○ Low levels of vitamin D ○ Family history ○ Lack of exercise ○ Immobility ○ Tobacco use ○ Eating disorders <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Back pain • Loss of height • Stooped posture • Fracture <p>Interventions:</p>		
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		<ul style="list-style-type: none"> • Prevention <ul style="list-style-type: none"> ○ Medications/Supplements <ul style="list-style-type: none"> ▪ Calcium ▪ Vitamin D ▪ Estrogen ○ Exercise Programs <ul style="list-style-type: none"> ▪ Walking ▪ Dancing ▪ Weightlifting ▪ Climbing stairs ○ Good body mechanics ○ Back supports/Corsets ○ Walking aids <p>Loss of a Limb (Amputation) Removal of all or part of an extremity. Causes:</p> <ul style="list-style-type: none"> ○ Severe injury ○ Tumors ○ Severe infection ○ Gangrene – death of tissue. ○ Vascular disorders <p>Interventions:</p> <ul style="list-style-type: none"> • Prosthesis <ul style="list-style-type: none"> ▪ Care of a prosthetic device <ul style="list-style-type: none"> ○ Wash stump shrinker. ○ Observe the skin on the stump. ○ Apply shrinker. ○ Assist the patient to put on the prosthesis. 		
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		<ul style="list-style-type: none"> ○ Manage Phantom pain. ● Physical Therapy <p style="text-align: center;">Nervous System Disorders</p> <p style="text-align: center;">Stroke – Brain Attack or Cerebrovascular accident (CVA)</p> <p>Causes:</p> <ul style="list-style-type: none"> ○ 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) <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Hemiplegia ● Redness of the face ● Noisy breathing ● Unconsciousness ● High blood pressure ● Slow pulse ● Seizures ● Incontinent ● Changing emotions ● Aphasia ● Behavior changes <p>Interventions:</p> <ul style="list-style-type: none"> ● Medications (Thrombolytics) ● Prevent aspiration. ● Anti-embolic stockings ● Safety precautions 		
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		<ul style="list-style-type: none"> • Establish communication methods. • Therapy – Physical, Occupational, Speech <p>Parkinson’s Disease Progressive disorder affecting movement. Signs & Symptoms:</p> <ul style="list-style-type: none"> • Tremors <ul style="list-style-type: none"> ▪ Pill-rolling. ▪ Trembling • Rigid, stiff muscles • Stooped posture • Impaired balance • Shuffling gait • Mask-like expression. <ul style="list-style-type: none"> ▪ Fixed stare ▪ Cannot blink or smile. • Swallowing & Chewing problems • Memory loss • Fear, insecurity. • Slow, monotone, & soft speech <p>Interventions: No cure</p> <ul style="list-style-type: none"> • Medications • Exercise • Therapy – physical, occupational, & speech • Safety measures <p>Multiple Sclerosis (MS) Destruction of the myelin (cover nerve fibers) in the brain and spinal cord – functions are impaired or lost</p>		
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		<p>Risk Factors:</p> <ul style="list-style-type: none"> ○ Age (15 to 60) ○ Gender (women) ○ Caucasian ○ Family history <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Blurred or double vision ● Muscle weakness ● Balance/Coordination problems ● Partial /complete paralysis ● Remission/Relapse <p>Interventions: No cure</p> <ul style="list-style-type: none"> ● Medications ● Safety precautions ● Care as needed ● Range of motion <p>Amyotrophic Lateral Sclerosis (ALS) <i>Lou Gehrig's Disease</i> Attacks the nerve cells that control voluntary muscles. Life expectance is 2-5 years</p> <p>Risk Factors:</p> <ul style="list-style-type: none"> ○ Age (40-60) <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Progressive muscle weakness <p>Interventions: No Cure</p> <ul style="list-style-type: none"> ● Medications ● Respiratory support ● Care as needed 		
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		<ul style="list-style-type: none"> • Safety Precautions <p>Head Injuries (TBI) - Causes:</p> <ul style="list-style-type: none"> ○ Falls ○ Traffic accidents ○ Assaults ○ Fire arms ○ Sport injuries ○ Combat injuries <p>Signs & Symptoms: Based on the area of the brain injured</p> <ul style="list-style-type: none"> • Change in level of consciousness. <ul style="list-style-type: none"> ✚ 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. <p>Interventions:</p> <ul style="list-style-type: none"> • Rehabilitation • Care as needed. • Safety precautions <p>Spinal Cord Injury - Causes:</p> <ul style="list-style-type: none"> ○ Traffic accidents ○ Falls ○ Violence 		
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		<ul style="list-style-type: none"> ○ Sport injuries ○ Cancer <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Paralysis <ul style="list-style-type: none"> ✚ 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 <p>Interventions:</p> <ul style="list-style-type: none"> ● Care as needed. ● Prevent pressure injuries. ● Safety precautions <p style="text-align: center;">Cardiovascular Disorders</p> <p>Hypertension – high blood pressure Systolic blood pressure is 140 mm Hg or higher. Diastolic blood pressure is 90 mm Hg or higher. Causes:</p> <ul style="list-style-type: none"> ○ Narrow blood vessels ○ Kidney disorders ○ Head injuries. ○ Pregnancy ○ Adrenal tumors <p>Risk Factors:</p> <ul style="list-style-type: none"> ○ Age – men 45 & women 55 ○ Gender – men ○ Race – African American 	<p>Procedure Box: <i>Applying Elastic (Anti-embolic) Stockings</i> Chapter 35, Page 451 Figure 35-5</p>	
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		<ul style="list-style-type: none"> ○ Family history ○ Obesity ○ Stress ○ Smoking ○ High cholesterol ○ Diabetes <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Headache ● Blurred vision ● Dizziness ● Nose bleeds <p>Interventions:</p> <ul style="list-style-type: none"> ● Medications ● Lifestyle modifications <p>Coronary Artery Disease (CAD) Coronary arteries become hardened and narrow causing the heart muscle to get decrease blood and oxygen.</p> <p>Causes:</p> <ul style="list-style-type: none"> ○ Atherosclerosis <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Angina – Chest pain ● Irregular heart rate <p>Complications:</p> <ul style="list-style-type: none"> ● Myocardial Infarction - <ul style="list-style-type: none"> ✚ Heart Failure <ol style="list-style-type: none"> 1. Right-sided symptoms. 2. Left-sided symptoms. ● Sudden death ● 		
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		<p>Interventions:</p> <ul style="list-style-type: none"> • Medications <ul style="list-style-type: none"> ✚ Nitroglycerin ✚ Diuretics ✚ Antihypertension • Lifestyle modifications • Surgery (CABG) <p style="text-align: center;">Respiratory Disorders</p> <p>Chronic Obstructive Pulmonary Disease (COPD) – Involves Chronic Bronchitis & Emphysema</p> <p>Obstruction of air flow (oxygen and carbon dioxide exchange). Lung function is gradually lost.</p> <p>Risk Factor – cigarette smoking.</p> <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Cough • Mucus production • Difficulty breathing (SOB) • Tires easily • Low oxygen levels • Barrel chest. • SOB on exertion and at rest. • Fatigue <p>Interventions:</p> <ul style="list-style-type: none"> • Medications • Breathing exercises – pursed lip 		
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		<ul style="list-style-type: none"> • Positioning – Upright • Meeting Oxygen needs <ul style="list-style-type: none"> ▪ Positioning ▪ Deep Breathing & Coughing ▪ Supplemental Oxygen <ul style="list-style-type: none"> ✚ Delivery systems <p>Asthma Inflammation and narrowing of the airways. Risk Factors:</p> <ul style="list-style-type: none"> ○ Allergies ○ Air pollutants/irritants ○ Smoking ○ Respiratory infections ○ Cold air <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Shortness of breath (SOB) • Wheezing • Coughing • Increased pulse rate • Fear • Sweating • Cyanosis (Blue color to the skin) <p>Interventions:</p> <ul style="list-style-type: none"> • Medications • Meeting Oxygen needs <p>Influenza Respiratory infection Cause is a virus</p>		
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		<p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • High fever for several days • Headache • Cough • Cold symptoms <p>Interventions:</p> <ul style="list-style-type: none"> • Medications • Fluids & rest <p>Pneumonia Inflammation and infection of lung tissue causing impaired gas exchange.</p> <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Fever • Chills • Cough • Shortness of breath (SOB) • Thick sputum (Mucous) • Tiredness <p>Interventions:</p> <ul style="list-style-type: none"> • Medications • Oxygen • Position – (semi-Fowler’s) • Increased fluids • Rest <p>Tuberculosis Bacterial infection of the lungs</p> <p>Risk Factors:</p> <ul style="list-style-type: none"> ○ Contact with an infected person ○ Age 		
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		<ul style="list-style-type: none"> ○ Poor nutrition ○ HIV <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Cough (blood) ● Tiredness ● Weight loss ● Fever ● Night sweats <p>Interventions:</p> <ul style="list-style-type: none"> ● Medications ● Care as needed. ● Airborne precautions <p style="text-align: center;">Digestive Disorders</p> <p>Vomiting</p> <p>Diverticular Disease</p> <p>Inflammatory Bowel Diseases (IBD)</p> <ul style="list-style-type: none"> ● Crohn's Disease & Ulcerative colitis <ul style="list-style-type: none"> ▪ Signs & Symptoms <ul style="list-style-type: none"> ✚ Diarrhea - blood ✚ Abdominal pain ✚ Cramping ✚ Fever ✚ Weight loss ▪ Interventions: <ul style="list-style-type: none"> ✚ Medications ✚ Diet modifications. ✚ Surgery – <ul style="list-style-type: none"> ➤ Ileostomy ➤ Colostomy 		
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		<p>Constipation Fecal Impaction Diarrhea Fecal Incontinence Flatulence</p> <p>Bowel Training:</p> <ul style="list-style-type: none"> ▪ Goals of bowel training <ul style="list-style-type: none"> ○ To gain control of bowel movements (BM) ○ To develop a regular pattern of elimination ▪ Interventions <ul style="list-style-type: none"> ○ 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. <p style="text-align: center;">Liver Diseases</p> <ul style="list-style-type: none"> • Hepatitis – Inflammation and infection of the liver caused by a virus. <ul style="list-style-type: none"> ○ Types <ul style="list-style-type: none"> ✚ Hepatitis A – contaminated food and water ✚ Hepatitis B – infected blood and body fluids 		
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		<ul style="list-style-type: none"> ✚ Hepatitis C – infected blood ✚ Hepatitis D – HBV ✚ Hepatitis E – contaminated food and water <ul style="list-style-type: none"> • Cirrhosis – scar tissue blocks blood flow through the liver; function is affected. <ul style="list-style-type: none"> ▪ Causes: <ul style="list-style-type: none"> ✚ Chronic alcohol abuse ✚ Chronic Hepatitis B & C ✚ Fatty liver ✚ Obesity ▪ Signs & Symptoms <ul style="list-style-type: none"> ✚ Weakness ✚ Loss of appetite ✚ Itching ✚ Edema ✚ Ascites ✚ Jaundice <p style="text-align: center;">Urinary System Disorders</p> <p>Urinary Tract infections – Lower tract, Cystitis, Pyelonephritis Microbes enter the urinary tract through the urethra. Causes:</p> <ul style="list-style-type: none"> • Poor perineal hygiene • Immobility • Poor fluid intake • Urinary catheters 		
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	<p>19.2 Demonstrate the proper procedure for catheter care and emptying a urinary drainage bag.</p>	<ul style="list-style-type: none"> • GU examinations • Intercourse <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Frequency • Urgency • Dysuria - pain • Cloudy urine - pyuria (pus) • Foul-smelling urine • Hematuria – blood • High fever - <p>Interventions:</p> <ul style="list-style-type: none"> • Medications - antibiotics • Fluids – 2000 mL/day <p>Proper procedure for catheter care and emptying a urinary drainage bag.</p> <p>Prostate Enlargement – Benign Prostatic Hyperplasia (BPH) Cause is age.</p> <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Weak urine stream • Trouble starting to urinate. • Frequent voids of small amounts 	<p>Chapter 26 Pages 334-339</p>	
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		<ul style="list-style-type: none"> • Leakage of urine, dribbling of urine • Nocturia – Nighttime • Urinary retention • Pain <p>Interventions:</p> <ul style="list-style-type: none"> • Medications • Urinary Catheters • Surgery <p>Kidney Stones – Calculi</p> <p>Risk Factors:</p> <ul style="list-style-type: none"> ○ Bedrest ○ Immobility ○ Poor fluid intake <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> • Pain – back below the ribs • Fever • Chills • Dysuria • Hematuria • Cloudy urine <p>Interventions:</p> <ul style="list-style-type: none"> • Medications – pain • Increase fluid intake – 2000 to 3000mL/day. • Strain all urine. • Diet modifications. • Surgery 		
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		<p>Kidney Failure Kidneys do not function properly if at all. Waste products build up in the body. Fluid is retained. Interventions:</p> <ul style="list-style-type: none"> • Fluid restrictions • Diet modifications – decreased protein, potassium, and sodium. • Daily weights • Postural blood pressure readings • Care as needed. • Dialysis <p>Bladder Training</p> <ul style="list-style-type: none"> • The goal is to control urinary elimination. • Often need after a urinary catheter is removed. <ul style="list-style-type: none"> ○ Methods <ul style="list-style-type: none"> ✚ Bladder re-training <ul style="list-style-type: none"> ➤ Urinate at scheduled times ✚ Prompted voiding. <ul style="list-style-type: none"> ➤ Recognizes when the bladder is full.. ✚ Habit training <ul style="list-style-type: none"> ➤ Every 2-4 hours while awake. ✚ Catheter clamping 		
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		<p style="text-align: center;">Endocrine Disorders</p> <p>Diabetes - Glucose intolerance Risk factor is family history. Types:</p> <ul style="list-style-type: none"> ○ 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. <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● Thirst ● Frequent urination ● Hungry ● Weight loss ● Dry, itchy skin ● Slow healing ● Tingling in the feet ● Blurred vision <p>Complications:</p> <ul style="list-style-type: none"> ○ Hypoglycemia ○ Hyperglycemia <p>Interventions:</p> <ul style="list-style-type: none"> ● Diet modifications. ● Exercise programs. ● Medications ● Foot care 		
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		<p style="text-align: center;">Immune System Disorders</p> <p>HIV/AIDS A virus spreads through direct contact with infected blood or body fluids from a person who has the HIV virus.</p> <p>Causes:</p> <ul style="list-style-type: none"> ○ Sex with an infected person ○ Sharing equipment used to prepare injection drugs. <p>Signs & Symptoms:</p> <ul style="list-style-type: none"> ● 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 <p>Interventions:</p> <ul style="list-style-type: none"> ● Care as needed. ● Medications ● Blood borne precautions. 		
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		<p style="text-align: center;">jjjjSkin Disorders</p> <p>Shingles (herpes zoster) Caused by the virus that caused chicken pox. Signs & Symptoms:</p> <ul style="list-style-type: none">• Rash• Fluid-filled blisters• Burning, tingling pain• Numbness• Itching <p>Interventions:</p> <ul style="list-style-type: none">• Medications• Care of the lesions• Contact precautions.		
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	<p>20.3 Identify selected measures to incorporate in the care for residents who are confused.</p> <p>20.4 List causes of delirium.</p> <p>20.5 State possible signs and symptoms of delirium.</p>	<ul style="list-style-type: none"> • Hearing & vision loss • Medication side effects <p>Selected care measures:</p> <ul style="list-style-type: none"> • 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. <p>Causes of delirium:</p> <ul style="list-style-type: none"> • Surgery • Substance abuse • Medication side effects • Infections <p>Signs & symptoms of delirium:</p> <ul style="list-style-type: none"> • More alert in the AM • Drowsiness • Confusion about time or place • Concentration changes • Incontinence • Emotional changes • Speech is not clear. <p>Delirium is usually temporary and reversible. Delirium signals disease. Delirium is an emergency.</p>		
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	<p>20.6 List the early warning signs of dementia.</p> <p>20.7 List the risk factors associated with AD.</p> <p>20.8 Identify warning signs of AD.</p> <p>20.9 Identify signs of AD.</p>	<p>Early warning signs of dementia:</p> <ul style="list-style-type: none"> • Memory loss • Common tasks problems • Forgetting simple words • Poor judgment • Personality changes <p>Alzheimer’s dementia (AD) is the most common form of dementia</p> <p>Risk factors:</p> <ul style="list-style-type: none"> ○ Age – after age 65 ○ Gender – women ○ Family history <p>Warning signs of AD:</p> <ul style="list-style-type: none"> • Asking the same question • Repeats the same story • Gets lost in known places • Problems with budget • Neglects hygiene • Forgets how to do tasks <p>Signs of AD:</p> <ul style="list-style-type: none"> • Forgetting • Speaks native language. • Wanders • Distrusts others 		
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	<p>20.10 Discuss the Three Stages of AD.</p>	<ul style="list-style-type: none"> • Conversation problems • Slow, steady decline in mental function <p>Stages of AD:</p> <ul style="list-style-type: none"> • Mild <ul style="list-style-type: none"> ▪ Memory problems ▪ Tasks take longer. ▪ Behavior changes ▪ Wandering ▪ Getting lost • Moderate <ul style="list-style-type: none"> ▪ Problem with routine tasks ▪ Difficulty recognizing family/friends ▪ Cannot learn new things. ▪ Sundowning ▪ Hallucinations ▪ Delusions ▪ Paranoia ▪ Impulsive behavior • Severe <ul style="list-style-type: none"> ▪ Cared for by others. ▪ Cannot communicate. ▪ Difficulty swallowing ▪ Incontinence 		
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	<p>20.11 Identify communication techniques to use when interacting with a resident with AD or other types of dementia.</p> <p>20.11. Discuss selected care measures.</p>	<p>Communication techniques:</p> <ul style="list-style-type: none"> • 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. <p>Care measures:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▪ 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. 		
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	<p>20.12 Describe <i>Validation Therapy</i>.</p>	<p><i>Validation therapy</i> 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 <i>validation therapy</i>:</p> <ul style="list-style-type: none">• 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.		
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<p>Unit 21</p> <p>Mental Health Disorders</p>	<p>21.1 Identify selected terms associate with mental health and mental health disorders.</p> <p>21.2 List the possible causes of mental health disorders.</p> <p>21.3 Describe selected defense mechanisms.</p>	<p>Selected terms:</p> <p>Mental – <i>relates to the mind.</i></p> <p>Stress - <i>...response or change in the body caused by any emotional, physical, social, or economic factor.</i></p> <p>Mental health - <i>...involves a person’s emotional, psychological, and social well-being.</i></p> <p>Mental health disorder - <i>...disturbance in the ability to cope with or adjust to stress. Behavior and function are impaired.</i></p> <p>Defense mechanism - <i>...unconscious reaction that blocks unpleasant or threatening feelings.</i></p> <p>Causes of mental health disorders:</p> <ul style="list-style-type: none"> • Chemical imbalances • Genetics • Physical, biological, or psychological factors • Substance abuse • Social & cultural factors • Abuse <p>Selected defense mechanisms:</p> <ul style="list-style-type: none"> • Compensation • Conversion • Denial • Displacement • Identification • Projection • Rationalization 	<p>Lecture & Discussion</p> <p>Chapter 41</p> <p>Pages 529-538</p>	
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	<p>21.4 List types of Mental health disorders.</p>	<ul style="list-style-type: none"> • Reaction formation • Regression • Repression <p>Types of mental health disorders:</p> <ul style="list-style-type: none"> • Anxiety Disorders • Panic Disorders • Phobias <ul style="list-style-type: none"> ▪ Agoraphobia ▪ Aquaphobia ▪ Claustrophobia ▪ Mysophobia ▪ Nyctophobia • Obsessive-Compulsive disorder • Post-traumatic stress disorder <ul style="list-style-type: none"> ▪ Flashbacks • Schizophrenia • Bipolar Disorder • Depression <ul style="list-style-type: none"> ▪ Older adults • Personality Disorders <ul style="list-style-type: none"> ▪ Antisocial Personality ▪ Borderline Personality • Substance abuse Disorder <ul style="list-style-type: none"> ▪ Addiction <ul style="list-style-type: none"> ✚ Withdrawal Syndrome • Eating Disorders <ul style="list-style-type: none"> ▪ Anorexia Nervosa ▪ Bulimia Nervosa 		
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		<ul style="list-style-type: none">▪ Binge eating disorder.• Suicide...<i>to ends one's life on purpose.</i> Risk factors:<ul style="list-style-type: none">Prior suicide attemptDepressionChronic painFamily history	Box 41-10	
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<p style="text-align: center;">22 Emergency Care</p>	<p>22.1 Define selected terms associated with emergency care.</p>	<p>Selected terms associated with emergency care:</p> <p>First aid...<i>emergency care given to an ill or injured person before medical help arrives.</i></p> <p>Sudden cardiac arrest (SCA)...<i>the heart stops suddenly and without warning.</i></p> <p>Respiratory arrest...<i>breathing stops but heart action continues for several minutes.</i></p> <p>Rescue Breathing...<i>breaths given when there is a pulse but no breathing only agonal gasps.</i></p> <p>Agonal respirations...<i>struggling to breath; agonal gasps do not bring enough oxygen into the lungs.</i></p> <p>Resuscitate...<i>to revive from apparent death or unconsciousness using emergency measures.</i></p> <p>Recovery position...<i>used when the person is breathing and has a pulse but is not responding. This position keeps the airway open and prevents aspiration.</i></p> <p>Defibrillation...<i>shock the heart into a regular rhythm.</i></p> <p>Anaphylaxis...<i>life-threatening sensitivity to an antigen</i></p>	<p>Lecture & Discussion</p> <p>Chapter 43 Pages 555-568 BLS Class</p>	
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	<p>22.5 State the rate of compressions during CPR.</p> <p>22.6 State the rate of providing rescue breaths.</p> <p>22.7 State the rate for providing breaths during CPR.</p> <p>22.8 Describe the role of the Automated External Defibrillator (AED).</p> <p>22.8 Define respiratory arrest.</p> <p>22.9 Discuss emergency care measures for a resident experiencing respiratory arrest.</p>	<ul style="list-style-type: none"> • Provide post -arrest care. <p>Rate of compressions during CPR:</p> <ul style="list-style-type: none"> • Compressions rate = 100-120 per minute <p>Rate of providing rescue breaths:</p> <ul style="list-style-type: none"> • Rescue breaths = 1 breath every 5-6 seconds <p>Rate for providing breaths during CPR:</p> <ul style="list-style-type: none"> • Each breath should take 1 second. • The chest should rise with each breath. • Two breaths are given after 30 chest compressions. <p>Role of an AED to deliver a shock to the heart. The shock stops ventricular fibrillation. The heart may resume a regular rhythm.</p> <p>Definition of respiratory arrest...<i>breathing stops, however, the heart actions continue for several minutes.</i></p> <p>Emergency care measures for a resident experiencing respiratory arrest: Initiate rescue breathing.</p>		
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	<p>22.10 Discuss emergency care measures for a resident experiencing poisoning.</p> <p>22.11 Identify emergency care measures for a resident experiencing a heart attack.</p> <p>22.12 Identify signs and symptoms of an internal hemorrhage.</p> <p>22.13 Discuss emergency care measures for a resident experiencing internal hemorrhage.</p> <p>22.14 Identify signs and symptoms of an external hemorrhage.</p> <p>22.13 Discuss emergency care measures for a resident experiencing</p>	<p>Emergency care measures for a resident experiencing poisoning: Call the Poison Control Center.</p> <p>Emergency care measures for a person experiencing a heart attack: Activate EMS. Start CPR</p> <p>Sign and symptoms of an internal hemorrhage: Pain, shock, vomiting blood, coughing up blood, cool and pale skin and loss of consciousness</p> <p>Emergency care measures for a resident experiencing an internal hemorrhage: Activate EMS Keep the person warm. Do not give fluids.</p> <p>Signs and symptoms of an external hemorrhage: Bleeding from a vein is a steady flow of blood. Bleeding from an artery occurs in spurts.</p> <p>Emergency care measures for a resident experiencing an external hemorrhage: Activate EMS Do not remove any objects if one pierces the</p>		
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	<p>external hemorrhage.</p> <p>22.14 Define Fainting.</p> <p>22.15 Identify signs and symptoms of fainting.</p> <p>22.16 Discuss emergency care measures for a resident experiencing fainting.</p> <p>22.17 Define shock.</p> <p>22.18 Identify the signs and symptoms associated with shock.</p>	<p>skin. Cover the wound. Apply pressure to the wound until the bleeding stops.</p> <p>Fainting (syncope)...<i>sudden loss of consciousness from inadequate blood flow to the brain.</i></p> <p>Signs and symptoms of fainting: Dizziness, perspiration, weakness, vision changes, skin is pale, weak pulse</p> <p>Emergency care measures for a resident experiencing fainting: If the person feels they might faint: Assist the person to sit or lie down. If sitting position, the head between the leg. If lying down, raise the legs. Loosen tight clothing. If fainting occurs: Activate EMS Raise the feet about 12 inches. Initiate CPR for cardiac arrest.</p> <p>Shock...<i>tissues and organs do not get enough blood.</i></p> <p>Signs and symptoms of shock: Low blood pressure Rapid/weak pulse Rapid respirations</p>		
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	<p>22.19 Identify emergency care measures for a resident experiencing shock.</p> <p>22.20 Define Anaphylactic Shock.</p> <p>22.21 Identify the signs and symptoms associated with anaphylactic shock.</p> <p>22.22 Identify emergency care measures for a resident experiencing anaphylactic shock.</p>	<p>Cold, moist, and pale skin Thirst Nausea/vomiting Restlessness Confusion leading to loss of consciousness.</p> <p>Emergency care measures for a resident experiencing shock: Raise legs 6-12 inches. Maintain an open airway. Control bleeding, if necessary. Initiate CPR.</p> <p><i>Anaphylactic Shock...life-threatening sensitivity to an antigen.</i></p> <p>Sign and symptoms of anaphylactic shock: Itchy rash, Swelling of the face, eye, or lips, feeling warm, fast and weak pulse, or feeling dread or doom.</p> <p>Emergency care measures for a resident experiencing anaphylactic shock: Activate EMS Maintain an open airway. Initiate CPR for cardiac arrest. Start rescue breathing for respiratory arrest. Administer epinephrine, if available.</p>		
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	<p>22.23 Define Stroke.</p> <p>22.24 Identify signs and symptoms of stroke.</p> <p>22.25 Identify emergency care measures for a resident experiencing a stroke.</p> <p>22.26 Define seizure.</p> <p>22.27 Identify types of seizures.</p>	<p>Stroke...<i>brain is suddenly deprived of its blood supply. Usually, only part of the brain is affected. Causes include thrombus, embolus, or hemorrhage.</i></p> <p>Signs and symptoms of stroke: Sudden numbness or weakness of the face, arm, or leg. Sudden confusion or trouble speaking or understanding speech. Sudden trouble seeing. Sudden trouble walking. Sudden severe headache.</p> <p>Emergency care measures for a resident experiencing a stroke: Check the time symptoms started. (Best outcome if treatment is started within 3 hours of symptom onset) Initiate EMS</p> <p>Seizure...<i>violent and sudden contractions or tremors of muscle groups caused by abnormal activity in the brain.</i></p> <p>Signs and symptoms of seizure: Generalized seizure – Absence seizure Tonic-clonic (grand mal) seizure Focal seizure</p>		
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	<p>22.28 Identify emergency care measures for a resident experiencing a seizure.</p> <p>22.29 Define concussion.</p> <p>22.30 Identify emergency care measures for a resident experiencing a concussion.</p> <p>22.31 30 Identify emergency care measures for a resident experiencing a burn.</p>	<p>Emergency care measures for a resident having a seizure: You cannot stop a seizure.</p> <p>During the seizure the goal is to protect the resident from injury.</p> <p>Note the time seizure activity begins and the time seizure ends.</p> <p><i>Concussion...a head injury resulting from a bump or blow to the head or a jolt to the head or body. The head and the brain move quickly back and forth.</i></p> <p>Emergency care measures for a resident experiencing a concussion:</p> <ul style="list-style-type: none"> Activate EMS. Place hands on both sides of the head. Do not apply direct pressure to the skull. Logroll if repositioning is needed. Apply ice to swollen areas. <p>Emergency care for a resident experiencing a burn:</p> <ul style="list-style-type: none"> Activate EMS Do not touch the resident if the source is electrical. Do not remove clothing/jewelry. Cover the area with a sterile/clean cloth. Do not put anything on the burned area. 		
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		<p>Keep blisters intact. When possible, elevate the burned area above the heart Cover the resident to prevent heat loss.</p>		
<p>23 End-of-life Care</p>	<p>23.1 Identify selected terms associated with End-of-Life care.</p>	<p>Selected terms associated with End-of-Life Care:</p> <p>End-of-Life Care...<i>support and care given during the time surrounding death.</i></p> <p>Terminal illness...<i>an illness or injury from which the person will not likely recover.</i></p> <p>Palliative care...<i>relieving or reducing the intensity of uncomfortable symptoms without producing a cure.</i></p> <p>Hospice care...<i>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.</i></p> <p>Reincarnation...<i>belief that the spirit or soul is reborn in another human body or in another form of life.</i></p> <p>Grief...<i>person's response to loss</i></p> <p>Advanced Directives...<i>a document stating a person's wishes about health care when that person</i></p>	<p>Lecture & Discussion</p> <p>Chapter 44 Pages 569-577</p>	

	<p>23.2 Discuss how various age groups understand death.</p> <p>23.3 Identify the 5 stages of dying/grief.</p>	<p><i>cannot make his or her own decisions.</i></p> <p>Post-mortem care...<i>care of the body after death has occurred.</i></p> <p>Rigor mortis...<i>stiffness or rigidity of the skeletal muscles that occurs after death. (2-4 hours after death)</i></p> <p>Autopsy...<i>the examination of the body after death</i></p> <p>Understanding death by various age groups:</p> <ul style="list-style-type: none"> • 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. <p>Five stages of dying/grief:</p> <ul style="list-style-type: none"> • Denial – “No, not me” • Anger – “Why me” • Bargaining – “Yes, me but...” 		
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	<p>23.4 Discuss the comfort needs of the person who is dying.</p>	<ul style="list-style-type: none"> • Depression – “Yes me” and is very sad • Acceptance – Calm and peaceful <p><i>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.</i></p> <p>Comfort needs of the dying person:</p> <ul style="list-style-type: none"> • Listening • Touch • Silence • Physical Needs <ul style="list-style-type: none"> ▪ Pain ▪ Breathing problems <ul style="list-style-type: none"> ✚ Noisy breathing (death rattle) ▪ Sensory changes <ul style="list-style-type: none"> ✚ Blurred vision – lights on ✚ Speech – difficult ✚ Hearing – last to leave. ▪ Mouth, Nose, Skin <ul style="list-style-type: none"> ✚ 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 – 		
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	<p>23.5 Identify the needs of the family/friends of the person who is dying.</p> <p>23.6 Discuss the legal documents associated with end-of-life.</p>	<p>pale and mottled (blotchy)</p> <ul style="list-style-type: none"> ▪ Nutrition ▪ Elimination ▪ The person’s room. <p>Needs of the Family:</p> <ul style="list-style-type: none"> • Be available to listen. • Be courteous and considerate. • Respect privacy. • Provide food/beverages. • Provide care. <p>Legal documents associated with end-of-life:</p> <ul style="list-style-type: none"> • 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 (<i>health care proxy</i>) • “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. 		
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		<ul style="list-style-type: none"> • 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 		
<p>Unit 24</p> <p>Collecting Specimens</p>	<p>24.1. State the purpose of collecting/testing specimens (Samples).</p> <p>24.2. State the rules for specimen collection.</p>	<p>Purpose of collecting/testing specimens:</p> <ul style="list-style-type: none"> • To prevent disease • To detect disease • To treat disease <p>Rules for collecting specimens:</p> <ul style="list-style-type: none"> • 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. <p>Each agency will have specific guidelines for specimen collection.</p>	<p>Lecture & Discussion</p> <p>Chapter 34</p> <p>Pages 434-445</p>	

	24.3. List the types of specimens to be collected.	Types of specimens to be collected: <ul style="list-style-type: none"> • Random urine specimen • Midstream urine specimen • Urinary catheter specimen • 24-Hour urine specimen • Testing urine using a reagent strip. • Stool specimens • Sputum specimens • Blood Glucose testing 		
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.	Definition of selected terms associated with wound care: Wound ... <i>a break in the skin or mucous membrane.</i> Skin tear ... <i>a break or rip in the outer layers of the skin</i> Ulcer ... <i>shallow or deep crater-like sore of the skin or mucous membrane</i> Dilate ... <i>to expand or open wider.</i> Common causes of wounds: <ul style="list-style-type: none"> • Trauma • Pressure • Decrease blood flow. • Nerve damage The most common complication associated with wounds is infection .	Lecture & Discussion Chapter 35 Pages 446-463	

	<p>25.3. List the possible causes of skin tears.</p> <p>25.4. List ways to prevent circulatory ulcers.</p> <p>25.5. Discuss the role of the NA in applying dressings.</p>	<p>Common causes of skin tears:</p> <ul style="list-style-type: none"> • Friction • Shearing • Holding limbs too tight • Parts of wheelchair or other equipment • Clothing • Jewelry • Fingernails <p>Interventions focus on prevention.</p> <p>Ways to prevent circulatory ulcers:</p> <ul style="list-style-type: none"> • Remind the resident not to cross their legs. • Do not dress the resident in tight clothes. • Apply anti-embolic stocking, when ordered. • Provide good skin care. • Pat skin dry after bathing. • Keep pressure off the heels. • Re-position residents at least every 2 hours • Check residents' skin and report wounds. • Do not massage over boney prominences. <p>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.</p>		
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	<p>25.6. State the purpose of binders/compression garments.</p> <p>25.7. State the benefits of heat application.</p> <p>25.8. List the types of heat applications.</p> <p>25.9. State the common complication associated with heat application.</p> <p>25.10. State the benefits of cold applications.</p>	<p>Purpose of binders/compression garments:</p> <ul style="list-style-type: none"> • Provide support. • Hold dressings in place. <p>Benefits of heat application:</p> <ul style="list-style-type: none"> • Relieve pain. • Relaxes muscles. • Promotes healing. • Reduces tissue swelling. • Decrease joint stiffness. <p>Types of heat applications:</p> <ul style="list-style-type: none"> • Moist heat applications <ul style="list-style-type: none"> ▪ Hot compress ▪ Sitz Bath ▪ Hot pack • Dry applications <ul style="list-style-type: none"> ▪ Aquathermia pad <p>Complication of heat application: Burns are the most common complication associated with heat application.</p> <p>Benefits of cold application:</p> <ul style="list-style-type: none"> • Reduce pain. • Prevent swelling. • Decrease circulation/bleeding. • Cool the body during a fever. 		
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	<p>25.11. List types of cold applications.</p> <p>25.12. Identify rules for applying heat and cold.</p>	<p>Types of cold applications:</p> <ul style="list-style-type: none"> • Cold compress • Cold packs <p>Rules for applying heat and cold:</p> <ul style="list-style-type: none"> • 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. 		
<p>Unit 26</p> <p>Care of the Peri-operative resident</p>	<p>26.1. Identify the roles of the NA in the care of a patient prior to having surgery (pre-operative care).</p>	<p>Role of the NA in pre-operative care:</p> <ul style="list-style-type: none"> • Psychological preparation <ul style="list-style-type: none"> ▪ Listen to the patient. ▪ Observe patient's body language. ▪ Report observations to the nurse. • Physical preparation <ul style="list-style-type: none"> ▪ 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 	<p>Lecture & Discussion</p> <p>Care of the Perioperative Patient Handout</p>	

	<p>26.2. Identify the roles of the NA in the care of a patient after surgery (post-operative care)</p>	<p>showering policies/orders</p> <ul style="list-style-type: none"> ▪ 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. <p>Role of the NA in post-operative care:</p> <ul style="list-style-type: none"> • Post Anesthesia Care Unit PACU) <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Make a surgical bed. ▪ Stock the room with necessary supplies. <ul style="list-style-type: none"> ✚ Vital Sign equipment ✚ Emesis basin ✚ Tissues ✚ IV Pole • Care of the patient returning from the PACU 		
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		<ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ 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). 		
<p>Unit 27</p> <p>Care of the resident with special needs</p>	<p>27.1. Describe the role of the Nursing Assistant in the care of Residents with special needs</p>	<p>Tasks delegated to the nursing assistant for the medically stable resident with special needs:</p> <p>A. Wound dressings and nursing assistant responsibilities.</p> <ol style="list-style-type: none"> 1. Know the purpose. 2. Wound care per facility policy & procedure as delegated. 3. Appropriate observations. 4. Report status, observations, and resident's response to nurse. <p>B. Gravity drains and nursing assistant responsibilities.</p> <ol style="list-style-type: none"> 1. Know the purpose. 	<p>Lecture & Discussion</p> <p>Care of a Resident with special needs Handout</p>	

		<p>2. Care of drains per facility policy & procedure as delegated.</p> <p>3. Appropriate observations.</p> <p>4. Report status, observations, and resident's response to nurse.</p> <p>C. Surgical evacuators and nursing assistant responsibilities.</p> <p>1. Know the purpose.</p> <p>2. Care of resident with surgical evacuators per facility policy & procedure as delegated.</p> <p>3. Appropriate observations.</p> <p>4. Report status, observations, and resident's response to nurse.</p> <p>D. Sump drain systems and nursing assistant responsibilities.</p> <p>1. Know the purpose.</p> <p>2. Care of residents with sump drains. per facility policy & procedure as delegated.</p> <p>3. Appropriate observations.</p> <p>4. Report status, observations, and resident's response to nurse.</p> <p>E. Various types of abdominal binders and nursing assistant responsibilities.</p> <p>1. Know the purposes.</p> <p>2. Applying binders per facility policy & procedure as delegated.</p> <p>3. Appropriate observations.</p> <p>4. Report status, observations, and resident's response to nurse.</p> <p>F. Various types of immobilization devices</p>		
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		<ol style="list-style-type: none"> 1. Know the purpose. 2. Care of resident with immobilizing devices per facility policy & procedure as delegated. 3. Appropriate observations. 4. Report status, observations and resident's response to <p>G. Ventilator therapy and nursing assistant responsibilities</p> <ol style="list-style-type: none"> 1. Know the purpose. 2. Care of resident on a ventilator per facility policy & procedure as delegated. 3. Appropriate observations. 4. Report status, observations, and resident's response to the nurse. 		
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