**November 2019**

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

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| **Class Day** | **Learning Outcomes (Goals)** | **Content Outline** | **Learning Activities** | **Time Allotted** |
| **Day 1** |  | Course Orientation Introductions:Students InstructorsThe role of Student ServicesReview:Textbook/WorkbookForms/Exams/Clinical Policies & Procedures  |  | 60 Minutes |
| **Unit 1****Health****Care****Settings** | 1.1. Describe healthcare settings.1.2A. Define the role of each member of the health care team.1.2B. State the role of the NA in the admission, discharge and transfer process of patients.1.3. Describe Nursing Care Patterns1.4. Identify health care payment sources.1.5. Define methods to ensure standards of care are met by health care facilities. | Heath care Settings Acute Care (Hospital) Subacute Care Outpatient Care Rehabilitation  Hospice Care Long-Term Care Centers Care Homes Assisted Living Residences Nursing CentersRoles of other Members of the Health Care Team Resident/Family Registered Nurse (RN) Licensed Practical Nurse  (LPN) Advanced Practice Nurse  (APRN) Certified Nursing Assistant (CNA/LNA) Physician Therapists – PT, OT, SLP Registered Dietitian (RDT) Social Worker Activity DirectorRole of the NA in admitting a patient to a facility:* Prepare the room
* Greet the patient by name
* Secure the patient’s belongings
* Orient the patient to the room and call system
* Orient the patient to activities, such as mealtime
* Communicate observations and resident patient response to the nurse

Role of the NA in discharging a patient from a facility:* Assist the patient to gather their belongings.
* Bring a wheelchair to the room
* Transport the patient to the vehicle
* Assist the patient to get into the vehicle
* Communicate observations and patient response to the nurse

Role of the NA in transferring a patient from one room to another room is the same facility:* Assist the patient to gather their belongings
* Place belongings in appropriate containers
* Bring a wheelchair to the patient’s room
* Transport the patient to the new room
* Assist the patient to secure their belongings
* Introduce the patient to the new staff person(S) who will be caring for the patient
* Assist the patient to get out of the wheelchair and get into bed or chair
* Communicate observations and patient response to the nurse

Nursing Care Patterns Functional Nursing Team Nursing Primary Nursing Case Management Patient-focused care Health Care Payment Sources Private Insurance Medicare Medicaid Patient Protection & Affordable Care Act Prospective Payment SystemMeeting Standards Survey Process Role Nursing Assistant Role  | Lecture & DiscussionChapter 1, Pages 1-3Skill: A Resident Care UnitChapter 17Box 17-1 Review the space Bed operation Equipment found in a  resident care areaLecture & DiscussionChapter 1, Pages 3-5Table 1-1Clinical PracticeLecture & DiscussionWorksheetLecture & DiscussionChapter 1, Pages 5 & 6Figure 1-3Lecture & DiscussionChapter 1, Pages 6 Lecture & DiscussionChapter 1, Page 7 |  |
| **Unit 2****Resident****Rights** | 2.1. List the components of *The Patient Care Partnership: Understanding Expectations, Rights, and Responsibilities.*2.2. Describe the *Omnibus Budget Reconciliation Act of 1987 (OBRA)*.  | Components of *The Patient Care Partnership* High-Quality Care Clean and Safe Setting Involvement in Care Protection of Privacy Preparing to Leave the Hospital Help with Bills and Insurance ClaimsResident Rights under OBRA Information Refusing Treatment Privacy & Confidentiality Personal Choice Grievances Work Resident Groups Personal Items Freedom from Abuse, Mistreatment &  Neglect Freedom form Restraints Quality of Life Activities Environment | Chapter 2 Page 10Lecture & DiscussionAppendix A Page 553Chapter 2 Pages 10-15Box 2-1Clinical Practice |  |
| **Unit 3****Nursing Assistant Regulations** | 3.1. Identify laws and policies regulating Nursing Assistant (NA) performance.3.2. Describe the nursing assistant *scope of practice.* | Federal and State laws  AZBN *Standards of Conduct for Nursing*  *Assistants* *The Omnibus Budget Reconciliation Act* *of 1987 (OBRA)* Training Programs Competency Evaluation Nursing Assistant Registry Certification Maintaining CompetenceNursing Assistant Standards Job Description Policy Procedure Manual Nursing Assistant Roles Bathing, & grooming Assisting with toileting Assisting with meals Maintaining Resident’s room Vital Signs Nursing Assistant Qualities Patient/Understanding/Unprejudiced Honest/Trustworthy Conscientious Enthusiastic Courteous Empathetic Dependable/Accountable | Lecture & DiscussionChapter 3, Pages 18-20Lecture & DiscussionChapter 3, Pages 21-24Boxes 3-2, 3-3 & 3-4  |  |
| **Unit 4****Safety &** **Body Mechanics** | 4.1. Explain the rules of body mechanics.4.2. Identify ways to prevent Work-Related injuries. | Rules of body mechanics: Good alignment  Wide base of support Bend at the knees Use larger muscle groups Keep objects close to the body General ways to prevent Work-Related injuries: Wear shoes with good traction Use equipment to assist Ask for help Plan and prepare for tasks Schedule harder tasks early Lock brakes on beds & wheelchairs  Give clear directions when working with  others Adjust the height of the bed | Lecture & DiscussionChapter 14, Pages 174-175Box 14-1Instructor DemonstrationSupervised PracticeLecture & DiscussionChapter 14, Page 176-177Box 14-2 |  |
| **Unit 5****Infection Prevention** | 5.1. Discuss the links in the ***Chain of Infection***.5.2. Define the purpose of medical asepsis.5.3. List the rules of hand hygiene.5.4. Demonstrate proper hand hygiene using soap and water and alcohol-based hand sanitizer.5.5. Explain the role of disposable gloves in the prevention of contamination.5.6. Demonstrate the proper procedure for donning and doffing (removing) disposable gloves. 5.7. Identify types of precautions | Links in the ***Chain of Infection***:  Source Reservoir Portal of Exit  Method of Transmission Portal of entry Susceptible host Purpose of medical asepsis Reduce the number of microbes Prevent the spread of microorganismsRules of hand hygiene: Use soap and water when hands are: Visibly dirty or soiled Before eating After using the restroom Exposure to *Clostridium Difficile* Use alcohol-based hand sanitizer: Before contact with a resident  After direct contact with a resident After contact with a resident’s items Steps for proper hand hygiene **(Soap & Water):** Wet hands and wrist Keep hands lower than the elbows Apply soap Lather hands, wrist & fingers -20 seconds  Clean under the fingernails Rinse well Dry hands and wrists starting at the fingernails Turn off the faucets with a dry paper  TowelSteps for proper hand hygiene **(Hand sanitizer):** Apply hand sanitizer Rub hands together Interlock fingers Continue rubbing until hands are dryRole of gloves in preventing the transmission of microbes: Protect the nursing assistant from direct  contact with blood /body fluids Protect the resident from microbes on the  nursing assistant’s handsProper Procedure for donning and doffingdisposable gloves Grasp the palm of the glove Pull the glove over the hand & hold glove Insert two fingers inside the other glove Pull the glove over the hand & glove  Dispose of the glovesTypes of precautions:* Standard
* Transmission-Based precautions
 | Lecture & DiscussionChapter 13, Pages 150-151 and page 158Box 13-3 Figure 13-1 & 13-2Clinical Practice Chapter 13, Page 152Chapter 13, Page 154Box 13-2Chapter 13, Pages 153-156Procedure Boxes: Hand-Washing &Figures: 13-5 thru 13-11VideoInstructor DemonstrationSupervised PracticeChapter 13, Page 156Procedure Boxes: Using Alcohol-Based SanitizerFigure 13-12Lecture & DiscussionChapter 13, Pages 163Chapter 13, Pages 165 & 168Figure 13-18Instructor DemonstrationSupervised PracticeChapter 13, Pages 159-161Boxes 13-4, 13-5, & 13-6 |  |
| **Unit 6****Delegation** | 6.1. State the four steps in the delegation process.6.2. Discuss the ***Five Rights od Delegation.***6.3. Discuss the Nursing Assistant’s possible responses to a delegated task. | Four steps in the delegation process as outlined by the *National Council of State Boards of Nursing* Assessment & Planning Communication Surveillance & Supervision Evaluation & Feedback***Five Rights of Delegation*** The Right Task The Right Circumstance The Right Person The Right Direction & Communication The Right Supervision & EvaluationThe nursing assistant possible responses to a delegated task:Accepting a taskRefusing a taskPolicy and Procedure Manuals | Lecture & DiscussionChapter 3, Pages 25-28Lecture & DiscussionChapter 3, Pages 27Box 3-5 Lecture & DiscussionChapter 3, Pages 27-28 |  |
| **Unit 7****Resident****Positioning**  | 7.1. Describe the benefits of positioning and re-positioning a resident in bed or other furniture. 7.2. Describe the various positions7.3. Describe procedures for moving a resident in bed.7.4. Demonstrate the proper procedure for positioning a resident on their side (Lateral position).  | Benefits of positioning and re-positioning (at least every two hours) Promote comfort Ease breathing Promote circulation Friction and Shearing Prevent pressure injuries Prevent contracturesPositions Fowler’s Positions - 45 degrees High-Fowler’s – 60 to 90 degrees Semi-Fowler’s – 30 degrees Supine Prone Lateral  Sim’s DanglingProcedures used to move a resident in bed (Bed mobility):196 Trapeze Assistive device (Lift sheet, board) The resident is moved in sections  LogrollingProper procedure for positioning a resident on their side (Lateral position). | Lecture & Discussion Chapter 14, Pages 178-182 Figures 14-5 – 14-13Chapter 17, Pages 224 -225Figures 17-2 thru 17-7Chapter 15, Pages 197-199Figures: 15-9 & 15-10Procedure Box: DanglingLecture & DiscussionChapter 15, Pages 185-200Figures 15-1 thru 15-12VideoInstructor DemonstrationSupervised PracticeClinical Practice |  |
| **Unit 8****Managing Pressure** **Ulcers** | 8.1. Identify selected terms associated with pressure injuries.8.2. Recognize common bony prominences when the resident is in various positions. 8.3. Identify risk factors associated with pressure injuries.8.4.Describe pressure injury stages.8.5.Identify ways to prevent pressure injuries.8.6. Identify common complications associated with pressure ulcers. | Selected terms associated with pressure injuries:**Bony prominence…***bone sticks out or projects from a flat surface of the body (pressure point).***Eschar…***thick, leathery dead tissue. It is often black or brown in color.***Shear…***layers of skin rub against each other; skin remains place and the underlying tissues move and stretch, tearing the underlying capillaries and blood vessels causing tissue damage.***Slough…***dead tissue shed from the skin; light in color, soft and moist. It may be stringy at times.* Bony prominences in various positions:* Supine
* Sacrum
* Heels
* Lateral (side lying)
* Hip
* Ankle
* Heel
* Semi Fowler’s position
* Sacrum
* Hip
* Heels
* Upright
* Shoulders
* Hip
* Sacrum

Risk factors associated with pressure injuries:* Age
* Dry skin
* Thinning skin
* Decreased sensation
* Decreased mobility
* Poor nutrition
* Poor hydration
* Incontinence
* Edema

Pressure Injury stages:* Stage 1 – non-blanchable erythema (red) of intact skin
* Stage 2 – Partial-thickness skin loss with exposed dermis (blister)
* Stage 3 – Full-thickness skin loss
* Stage 4 – Full-thickness skin & tissue loss (muscle, tendon, ligament, cartilage, or bone is exposed)
* Unstageable – Obscured full-thickness skin loss
* Deep tissue injury – Persistent non-blanchable deep red, maroon, or purple discoloration

Measures to prevent pressure injuries:* Identifying residents at increased risk for the development of pressures.
* Manage moisture for incontinence
* Provide good nutrition and fluid balance
* Follow the re-positioning schedule

(at least every 2 hours)* Float heels
* Use protective devices
* Bed cradle
* Heel/elbow protectors
* Heel/foot elevators
* Gel/fluid-filled cushions
* Special beds
* Other

Common complications associated with pressure ulcers:* Infection (Most Common)
* Osteomyelitis
* Pain
 | Lecture & DiscussionChapter 29, Pages 429-439Chapter 29, Page 430Figures 29-2Chapter 29, Page 431Box 20-1Figure 29-4Chapter 29, Pages 432-435Box 29-2Figures 29-5 through 29-17Chapter 29, Page 436-437Box 29-3Chapter 29, Pages 438-439Figures 29-20 – 29-23 |  |
| **Unit 9****Ethical** **&****Legal** **Issues** | 9.1. Reviewethical andprofessional behaviors.9.2. Define theterm “ethics”.9.3. Discuss the terms of *prejudice* and *biased.* 9.4. The role of a *code of conduct.*9.5. Define *Professional**boundaries.*9.6. Identify the effects of under-involvement.9.7. Identify theeffects of over-involvement.9.8. Define theterms associated with the legal aspects of care. | Examples of ethical and professional/legal behaviors Competent Confidentiality Honesty Trustworthy Reporting errors Report abuse/neglect  Team Player Definition of the term “ethics”:…*is knowledge of what is right and wrong conduct.* Concepts of prejudice and bias: … *making judgements and having views before knowing the facts.*Reasons for prejudice and biasinclude one’s culture, religion, education, & experience.Role of a *code of conduct*: Rules or standards of conductDefinition of *professional boundaries:*…*a separation of helpful behaviors from behaviors that are not helpful*Effects of under-involvement: Disinterest Avoidance NeglectEffects of over-involvement: Boundary crossing Boundary violation Professional sexual misconductDefine legal terms: Law Criminal laws Civil laws Unintentional Torts Negligence Malpractice Intentional Torts Defamation Libel Slander False Imprisonment Invasion of privacy Fraud Assault & Battery   | Lecture & DiscussionReview Chapter 3Chapter 4, Page31Box 4-1Lecture & DiscussionChapter 4, Page 31Lecture & DiscussionChapter 4, Page 31Chapter 4, Page 31Box 4-1Lecture & DiscussionChapter 4, Pages 31-32Figure 4-1Boxes 4-2 and 4-3Lecture & DiscussionChapter 4, Page 33 |  |
|  | 9.9. Explain the *Health Insurance* *Portability and* *Accountability Act* *(HIPAA).* 9.10. Explain Informed Consent.9.11. Identify ways Informed Consent can be given.9.12.Define abuse.9.13. Describe types of elder abuse.9.14. Recognize signs of Elder Abuse. | The purpose of HIPAA is to protect health information regardless of the source (oral, paper or electronic)Informed Consent:…*process* *by which a person receives and understands information about a treatment or procedure and is able to decide if he or she will receive it.*Ways Informed Consent can be given: Written Verbal ImpliedDefinition of abuse:…*willfull infliction of injury, unreasonable confin*ement*, intimidation, or punishment that results in physical harm, pain, or mental anguish and or depriving a person of the goods or services needed to attain or maintain well-being.*Types of abuse  Physical Abuse Verbal Abuse Involuntary seclusion Emotional or mental Abuse Sexual abuse Financial Abuse Abandonment ***CNAs are legally bound to report suspected or actual abuse/neglect (Mandated Reporters)***Signs of Elder Abuse: Self-report Lacking personal hygiene Frequent injuries Missing assistive devices Bleeding or bruising around breasts or genital/rectal area Burns Individual is withdrawn Individual is restrained Personal conversations are allowed  | Lecture & DiscussionChapter 4, Pages 33-35Boxes 4-4 & 4-5Lecture & DiscussionChapter 4, Page 35Chapter 4, Page 35“Focus on Communication” Lecture & DiscussionChapter 4, Pages 36-39Lecture & DiscussionChapter 4, Pages 37Boxes 4-6Lecture & DiscussionChapter 4, Pages 37-39Box 4-7 & 4-8Figure 4-3 |  |
| **Unit 10****Bed Safety****&** **Comfort** **Needs** | 10.1. Define the term entrapment.10.2. Identify residents at greatest risk of entrapment.10.3. The benefits associated with proper bedmaking.10.4. Identify the various ways to make a bed based on the needs of the resident.10.5. Demonstrate the proper procedure for making an occupied bed | Definition of the term ***entrapment***:…*getting caught, trapped, or entangled in spaces created by the bed rails, the mattress, the bed frame, the head-board and /or the foot-board.*Risk factors associated with entrapment: Age Frail Disoriented or confused Restless Uncontrolled movements Poor muscle control Small size Restrained residents Benefits of making a bed: Promote comfort Prevent skin breakdown Prevent pressure injuriesTypes of beds: Closed bed Open bed Occupied bed Surgical/procedure bedProper procedure for making an occupied bed: | Lecture & DiscussionChapter 17Page 224 & 226Figure 17-8Lecture & DiscussionChapter 17, Pages 224Lecture & DiscussionChapter 17, Page 230Lecture & DiscussionChapter 17, Page 230Figures 17-14 – 17-17Chapter 17, Pages 230-240Figure 17-18, 17-19, 17-26, 17-28Procedure Box Pages 237-239Instructor DemonstrationSupervised PracticeClinical Practice |  |
| **Unit 11****Accident****Prevention** | 11.1. Describe risk factors associated with accidents.11.2. Describe the steps to properly identify a resident before providing care. 11.3. List types of possible accidents.11.4. Identify ways to prevent burns.11.5. Identify ways to prevent poisoning.11.6. Identify ways to prevent suffocation.11.7. Identify ways to prevent equipment accidents.11.8. Identify ways to prevent accidents from hazardous chemicals. 11.9. Identify types of disasters. 11.10. Identify actions to take in the event of a bomb threat.11.11 Identify ways to prevent a fire.11.12. Identify actions to take in the event of a fire.11.13. Identify ways to prevent elopement of a resident.11.14. Identify ways to prevent/control workplace violence.11.15Identify the role of a Risk Management Department.11.16 Discuss the reason an incident report would be completed. | Risk factors associated with accidents: Age Awareness of surroundings Agitated/Aggressive behavior Hearing loss Impaired senses (vision, hearing, smell,  or touch) Impaired mobility MedicationsSteps 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 systemTypes of accidents: Burns Poisoning Suffocation including Choking Equipment related Hazardous chemicals Disasters Bomb threats Fire Elopement Workplace violenceWays 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 smokeWays to prevent poisoning: Keep hazardous materials out of reach Keep harmful products in the original  Container Store personal care items safely Read labels before useWays to prevent suffocation: Choking is the primary cause of  SuffocationWays to prevent Choking Cut food into small bite-size pieces Make sure dentures fit properly Note loose teeth Follow the dietary care plan Follow aspiration precautions***If a resident is choking perform abdominal thrusts (Heimlich maneuver) to dislodge the foreign body and relieve airway obstruction.******Chest thrusts are used for obese residents.***Additional care measures to prevent suffocation: Do not leave a resident unattended in a  bathtub/shower Prevent entrapment  Remove residents from the area if there  is a smoke smellWays to prevent equipment accidents: Do not use unfamiliar items Do not use broken/damaged items Avoid using extension cords Do not cover electrical cords Have maintenance staff check resident  personal electrical items Check electrical cords for damage Make sure brakes work properly Ways to prevent hazardous chemical accidents: Keep original labels intact and readable***If the label is damaged or removed do not use the substance. Show the container to the nurse.*** Do not leave containers unattended Know the location of the *Safety Data*  *Sheets (SDS)* Types of disasters: Bomb Threats Fire ElopementActions during a real or potential bomb threat: Report all suspicious individuals  Report all suspicious items or packagesWays to prevent a fire: Follow oxygen use policy of the center Follow the smoking policy of the center Secure all smoking materials Do not leave cooking unattended Actions to take in the event of a fire: Know the center’s emergency and  evacuation policy Know the location of extinguishers,  alarms and emergency exits Attend fire drills Remember *RACE* and *PASS*Ways to prevent elopement of a resident: Identify residents at risk for elopement Monitor/supervise the resident Address elopement in the care plan Have a plan for finding the resident Ways to prevent/control workplace violence: If the individual is agitated/aggressive: Stay close to the door Move away from the person Stay calm, speak in a calm manner Do not touch the individual Leave the room as quick as possible Potential weapons in the environment: Do not wear jewelry or scarves Keep long hair up and off the collar Keep keys, scissor, pen in pockets Staff safety measure: * Use the “buddy system” in elevators or caring for persons with agitated or aggressive behaviors
* Wear well fitted uniforms and shoes with good soles
* Use security escorts

Role of Risk Management:* Protect all people in the agency
* Protect all property
* Prevent accidents/injuries
* Investigate safety issues
* Accidents
* Fire
* Negligence
* Malpractice
* Abuse
* Workplace violence
* Federal/State requirements

Risk managers look for patterns & trends in incident investigations. Corrections are made, procedures are changed, and training is done to prevent further incidents.Examples of safety procedures:* Color-coded wristbands
* Red = Allergy
* Yellow = Fall Risk
* Purple = DNR/AND
* Pink = Limb Alert
* Resident belongings
* Complete a belongings list
* Itemize all jewelry items
* Label clothing
* Have the resident/family co-sign the belongings list/envelope

Purpose of an incident reports:* Accidents
* Errors in care
* Broken or lost items
* Hazardous chemical incidents
* Workplace violence incidents

***Complete an incident report as soon as possible.***  | Lecture & DiscussionChapter 10, Page 107-120Lecture & DiscussionChapter 10, Page 109 & 110Figures 10-1 & 10-2Supervised PracticeClinical PracticeLecture & DiscussionChapter 10, Pages 110-118Chapter 10, Page 110Box 10-1Chapter 10, Pages 111-113BLS Training class Box 10-2Figures 10-4 thru 10-8Chapter 10, Page 114Box 10-4Figure 10-10Chapter 10, Page 115Figure 10-11Chapter 10, Pages 115-116Chapter 10 Page 116Chapter 10, Page117Box 10-5Figure 10-12 & 10-13Chapter 10, Page 116-117Figures 10-12 & 10-13Procedure Box: Using a Fire ExtinguisherChapter 10, Page 118Box 10-6Chapter 10, Page 119Figure 10-14Chapter 10, Page 120 |  |
| **Unit 12****Health Team****Communication** | 12.1. Define the term communication. 12.2. Identify components of “good” communication.12.3. Define the term medical record.12.4. List the parts of a medical record.12.5. Describe the difference between objective and subjective data.12.6. List the observations the nursing assistant needs to report immediately to the charge nurse.12.7. Identify the role of the nursing assistant in the completion of the Minimum Data Set (MDS).12.8. Identify the role of the Comprehensive care plan.12.9. Explain the terms reporting and recording.12.10. Convert conventional time to military /international time.12.11. Explain proper telephoneEtiquette.12.12. Recognize common medical and nursing terminology. | Definition of the term communication:…*exchange of information-a message sent is received and correctly interpreted by the intended person.*Components of “good” communication: Avoid words with more than one meaning Avoid terms the resident/family does not  understand Be brief and concise Give information in a logical way Give the facts Be specificDefinition of the term medical record:…*legal account of a person’s condition and responses to treatment and care.*Parts of a medical record: Admission information Health history Flow sheets/graphic sheets Progress notes **Objective data:** Observations or signs that can be seen,  heard, felt, or smelled by an observer;  such as a pulse, color of urine. **Subjective data:** Refers to information the resident shares  with the observer. These data are referred to as symptoms. Pain, nausea, or fear are examples of subjective data. Observations to be **reported immediately**: Change in a resident’s ability to respond Changes in a resident’s mobility Complaints of sudden, severe pain A reddened area, bruise, or open area Complaints of vision changes Vital signs out of the resident’s range Role of the nursing assistant in completing the MDS: The observations the nursing assistant documents are used to complete the MDS. The MDS nurse may interview the nursing assistants care for a resident.Role of the Comprehensive care plan (CCP): The nurse uses data from the MDS to create a CCP. It outlines all the interventions required to meet a resident’s needs. It is updated periodically through medical record review and care conferences. The interventions to be completed by the direct care provider is entered onto an assignment sheet.Reporting: …*oral account of care and observations*Recording: …*written account of care and observations*Reporting and recording are done as needed throughout the shift and at the end of the shift. If a caregiver leaves before their shift is scheduled to end the caregiver is obligated to report and record care and observations occurring during the time the caregiver was assisting a resident.Military time has four (4) digits. The first two represent the hour and the last two represent the minutes. In this system the colons and AM and PM are not used.Example: 9:00 AM = 0900Military time used a 24-hour clockExample: 9:00 PM = 2100Proper telephone etiquette: Answer the call after the first ring Give a courteous greeting including  facility, location, your name and  position Do not give confidential informationMedical and nursing terminology: Common prefixes and suffixes are listed in the textbook.***Only use the facility list of approved abbreviations*** | Lecture & DiscussionChapter 6, Pages 53-66Supervised PracticeClinical PracticeChapter 6, Page 55Box 6-2Chapter 6, Page 54Box 6-1Chapter 6, Pages 54-57Chapter 6, Page 59-60Box 6-5Box 6-6Box 6-7Chapter 6, Page 58Box 6-4Figure 6-4Chapter 6, Page 63Box 6-8Chapter 6, Pages 62-66Boxes 6-9 |  |
| **Unit 13****Communicating****with****Residents** | 13.1. Define the term *Holism*.13.2. Identify the proper way to address a resident.13.3. Define the term *need.*13.4. Discuss Maslow’s basic needs.13.5. Define the term *culture.*13.6. Define the term *religion.*13.7. Discuss types of communication.13.8. Explain various communication methods.13.9. Describe barriers to communication.13.10. Recognize methods to communicate with residents with special needs13.11. Discuss communication strategies when a person exhibits behavior issues. | Definition of the term *holism:**…concept that considers the whole person. The person has physical, social, psychological, and spiritual parts. These parts are woven together and cannot be separated.*Proper way to address a resident: Greet the resident by title –  Miss, Mr., Mrs.  Do not call a resident by their first name Do not call them by other names, such as sweetheart, honey, popsDefinition of the term *need*:…*something necessary or desired for maintaining life and mental well-being.*Maslow’s basic needs: Physical Safety and security Love and belonging Self-esteem Self-actualizationDefinition of the term *culture*: …*characteristics of a group of people-language, values, beliefs, likes, dislikes, and customs. They are passed from 1 generation to the next*.Definition of the term *religion*:…*relates to spiritual beliefs, needs, and practices.*Types of communication: **Verbal** communication – uses written or spoken words.When speaking to another person consider the following rules: Look directly at the person Position yourself at eye level with the person Do not speak loudly Speak clearly & slowly Do not use slang words Repeat information as needed Ask one question at a time  Wait for the person to answer Be kind and courteousWhen writing a message follow these guidelines: Keep the note simply Use black ink on white paper Print the message in large letters Use a large Font if using a computer**Nonverbal** Communication – no words are used Gestures, facial expressions, posture, body movements, touch, and smell are used.These messages more accurately reflect a person’s feelings. They are usually involuntary and hard to control.Tools such as Magic slates and Picture boards may be helpful when the person does not speakCommunication methods: Listening Paraphrasing Direct questions Pen-ended questions Clarifying Focusing SilenceBarriers to communication: Unfamiliar language Cultural differences Changing the subject Giving opinion Talking a lot Failure to listen “Pat” answers Illness including coma AgeMethods to communicate with residents with special needs:* Residents with disabilities
* Speak directly to the resident
* Speak with the resident at eye level
* Ask if help is needed before acting
* Let the resident set the pace for activities
* Comatose resident
* Knock before entering the resident’s room
* Introduce yourself
* Tell the resident the date and time
* Explain procedures to the resident
* Tell the resident when you are leaving the room and when you will be back

Communication strategies for persons exhibiting behavior issues: Recognize the behavior and the possible  Cause Maintain dignity and respect Answer questions thoroughly Keep the person informed Answer call lights quickly Stay calm Use distraction Do not argue with the person Listen  Use silence Encourage family participation | Lecture & DiscussionChapter 7, Pages 68-77 Chapter 7, Page 69Figure 7-2 Chapter 7, Page 71Box 7-1Chapter 7, Page 72Figure 7-3Chapter 7, Page 73Boxes titled Caring about CultureChapter 7, Page 75Box 7-2Chapter 7, Page 77Box 7-3 |  |
| **Unit 14** **Measuring** **Vital Signs** | I4.1. Identify factors that may affect vital signs.14.2. Identify sites used to take a resident’s temperature. 14.3. State the normal range for body temperature by site used.14.3. Demonstrate competency with the procedure of measuring temperature.14.4. Define selected terms associated with taking a pulse.14.5. List pulse sites.14.6. Demonstrate competency with the procedure for counting a pulse.14.7 A.Define the term respiration.14.7 B.Identify the respiratory range for a healthy adult.14.8 A.State the normal qualities of respirations.14.8 B. Recognize abnormal respirations.14.9. Demonstrate competency with the procedure for counting respirations.14.10.Define selected terms associated with measuring a person’s oxygen levels.14.11.State the normal range of oxygen saturation.14.12.Identify types of probes used to measure a person’s oxygen saturation.14.13.Recognize factors that affect the accurate measurement of oxygen saturation>14.13.Demonstrate competency with the procedure for measuring a person’s oxygen saturation.14.14.Define selected terms associated with blood pressure measurement.14.15.Identify types of sphygmo-manometers.14.16.State which artery is usually used to measure blood pressure.14.17.List guidelines for measuring blood pressure.14.18. Demonstrate competency with the procedure for measuring blood pressure.14.19.Identify selected terms associated with pain.14.20.Discuss types of pain.14.21.List signs and symptoms of pain.14.22. State factors that affect pain.14.23. Recognize comfort and pain-relief measures | Factors that may affect vital signs: Activity Age Anger Medications Eating Gender Pain IllnessSites used to take a resident’s temperature: Oral Rectal Tympanic Temporal AxillaryNormal body temperature ranges by site: Oral 97.6 to 99.6 degrees F Rectal 98.6 to100.6 degrees F Axillary 96.6 to 98.6 degrees F Tympanic 98.6 degrees F Temporal artery 99.6 degrees FProcedure of measuring temperature: Definition of the term pulse:**Pulse**…*the beat of the heart felt at an artery as a wave of blood passes through the artery.***Pulse rate**…*the of heartbeats or pulses in 1 minutes.***Pulse rhythm**…*refers to the pattern of the heartbeats – regular or irregular.***Pulse force** – *relates to the pulse strength – strong, full, bounding or weak, thread, or feeble.***Stethoscope**… *instrument used to listen to the sounds produced by the heart, lungs, and other body organs.*Pulse sites:* Temporal
* Carotid
* Apical
* Brachial
* Radial
* Femoral
* Popliteal
* Posterior tibial pulse
* Dorsalis pedis pulse

***All pulses are present on both sides for the body except the Apical pulse.******The radial pulse is the most often used to count a pulse.******Normal pulse range for an adult resident is 60 to 100 beats per minutes (bpm).***Procedure for counting a pulse:Definition of the term **respiration**:…*breathing air into (inhalation) and out of (exhalation) the lungs.*Respiratory range for a healthy adult: **12 to 20 respirations per minute** Normal qualities of respirations:* Quiet
* Effortless
* Regular

Abnormal respirations:* Tachypnea
* Bradypnea
* Apnea
* Hypoventilation
* Hyperventilation
* Dyspnea
* Cheyne-Stokes respirations
* Orthopnea
* Kussmaul respirations

Procedure for counting respirations:Definition of selected terms associate with measuring a person’s oxygen level:**Pulse oximetry…***measures the oxygen concentration in arterial blood.***Oxygen concentration…***amount (%) of hemoglobin containing oxygen.*Normal oxygen saturation: **95 – 100 %**Types of probes used to measure oxygen saturation:* Finger (most common method)
* Toe
* Ear
* Forehead

Factors that affect the accurate measurement of oxygen saturation:* Avoid areas with edema
* Avoid sites with skin breakdown
* Avoid bright lights
* Remove nail polish
* Remove “fake” finger nails
* Keep the site still as possible
* Do not take the blood pressure on the arm if a finger on that side is used for continuous oxygen saturation measurement

Procedure for measuring oxygen saturation:Selected terms associated with blood pressure:**Blood pressure** - …*amount of force exerted against the walls of an artery by the blood.***Systolic pressure** *- …pressure in the arteries when the heart contracts.***Diastolic pressure** *- …pressure in the arteries when the heart is at rest.***Hypertension** - …*Systolic pressure is 130 mm Hg or higher or the diastolic pressure is 80 m Hg or higher***Hypotension** *-…Systolic pressure is below 90 mm Hg or the diastolic pressure is below 60 mm Hg.***Normal blood pressure is considered 120/80 mm Hg****Sphygmomanometer** - …*a cuff and a measuring device used to measure blood pressure.*Types of sphygmomanometer:* Aneroid
* Mercury
* Electronic

Artery usually used to measure blood pressure: **Brachial artery****The brachial artery is found by palpating the inner aspect of the antecubital fossa.**Guidelines for measuring blood pressure:* Do not take the blood pressure on an arm with:
* An IV infusing
* An arm cast/injury
* A dialysis access site
* Breast surgery
* Person should rest for 10 to 20 minutes
* Measuring blood pressure when sitting or standing
* Apply the cuff to bare arm
* Use the correct size cuff
* The entire diaphragm should have contact with the skin over the brachial artery
* Pump the cuff to 30 mm Hg over the resident’s usual systolic pressure
* The first sound heard is the systolic pressure
* The last sound heard is the diastolic pressure
* Wait 30-60 seconds before repeating the blood pressure
* If you cannot hear the blood pressure tell the nurse

Procedure for taking blood pressure:Selected terms associated with pain:**Pain or Discomfort**… *to ache, hurt, or be sore*Types of pain:* Acute pain – suddenly felt from injury, disease, trauma, or surgery. There is tissue damage.
* Chronic pain – continues for a long time
* Radiating pain – felt at the site of tissue damage and in nearby areas
* Phantom pain – felt in a body part no longer there

Signs & symptoms of pain:* Location
* Onset & Duration
* Intensity
* Rating scales
* Numeric scale
* Wang-Baker FACES scale
* Description
* Precipitating factors
* Factors affecting the pain
* Vital signs – increasing
* Other signs & symptoms
* Body responses
* Behaviors

***Pain is what the resident says it is.***Factors affecting pain:* Past experience with pain
* Anxiety
* Rest and Sleep
* Attention
* Responsibilities
* The value of pain
* Support
* Culture
* Illness

Comfort and pain-relief measures:* Position
* Adjust the room temperature
* Give back massage
* Avoid sudden or jarring movements
* Provide distraction (music)
* Apply warm or cold measures, if ordered
 | Lecture & DiscussionChapter 25, Page 360-382Box 25-1Chapter 25, Page 361-368Box 25-2Figures 25-1 through 25-5Figures 25-6 through 25-9Chapter 25, Page 31Box 25-1VideoChapter 25, Page 363Box – *Taking a Temperature with an Electronic Thermometer*Supervised PracticeClinical PracticeChapter 25, Page 369Figure 25-13, 25-14, 25-15Box 25-4 Chapter 25, Page 368Figure 25-12Chapter 25, Pages 371-372Box – *Taking a radial pulse*Figure 25-17 & 25-18VideoInstructor DemonstrationSupervised PracticeClinical PracticeChapter 25, Page 372Chapter 30, Page 442Chapter 25, Page 373Box – *Counting Respirations*VideoInstructor DemonstrationSupervised PracticeClinical PracticeChapter 30, Pages 443-444Figure 30-2Chapter 30, Page 444Procedure Box: Using a Pulse OximeterChapter 25, Page 373Figures 25-19 & 25-20Chapter 25, Page 374Figures 25-19 & 25-20Chapter 25, Page 375Box 25-5Chapter 25, Pages 376-377Box - *Measuring Blood Pressure*Figures 25-22 & 25-23VideoInstructor DemonstrationSupervised PracticeClinical PracticeChapter 25, Page 378-379Box 25-6Chapter 25, Page 378-379Box 25-6Figures 25-25 & 25-26Chapter 17, Page 241Box 17-3Chapter 17, Pages 242-243Figures 17-33 & 17-34Procedure Box: Giving a Back Massage |  |
| **Unit 15****Body Structure and**  **Function** | 15.1. Explain the relationship between cells, tissues and organs.15.2Describe the components and function(s) of the Integumentary System. 15.3Describe the components and function(s) of the Musculoskeletal System.15.4Describe the components and function(s) of the Nervous System.15.5. Describe the components and function(s) of the Circulatory System.15.6. Describe the components and function(s) of the Lymphatic System.15.7.Describe the components and function(s) of the Respiratory System.15.8.Describe the components and function(s) of the Digestive System.15.9.Describe the components and function(s) of the Urinary System.15.10.Describe the components and function(s) of the male and female Reproductive Systems.15.11.Describe the components and function(s) of the Endocrine System.15.12.Describe the components and function(s) of the Immune System. | Relationship between cells, tissues, and organs:**Cells:** The cell is the basic unit of body structure All cells have the same structure Components of the cell include: Membrane Nucleus Chromosomes - 46  Genes Cell division - mitosis**Tissues:** Groups of cells with similar function combine to form tissues. Types of Tissues: Epithelial Connective Muscle Nerve**Organs:** Groups of tissue with the same function  form organs. **Systems** are formed by organs working together to perform a special function. An example would the cardiovascular system.Components and functions of the Integumentary System (Skin). Largest organ in the body. **Components:** Two layers:1. Epidermis – outer, pigment
2. Dermis – inner

 Blood vessels Nerves, Sweat glands Oil glands Hair roots Nails **Functions:** Protective covering Regulates water Regulates body temperature Sensations Stores fat and waterComponents and function of the musculoskeletal system: **Components:** 1. Bones - 206
2. Joints – allow movement
3. Muscles - 500

 Voluntary Involuntary Cardiac Sphincters – esophageal, anal, urethral, pyloric **Functions:**1. Movement
2. Maintain posture and tone
3. Production of body heat

Components and functions of the nervous system: **Components:** Central Nervous System –  Brain  Spinal cord Peripheral Nervous System -  Nerves 12 cranial nerves 31 spinal nerves Sense organs 5 Senses – Sight, Smell, Hearing,  Taste & Touch **Functions:**Controls, directs, & coordinates all  body functionsComponents and functions of the circulatory system: **Components:** Blood Red Cells & Hemoglobin (RBC) White Cells (Leukocytes WBC) Platelets  Heart – 4 chambers Blood Vessels – Arteries & Veins **Functions:** Carries food to the cells Transports oxygen to the cells Removes waste products from the cells Maintains fluid balance Regulates body temperature Work with the immune systemComponents 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 intestinesComponents and functions of the respiratory system: **Components:** Nose Pharynx Throat) Larynx Trachea Lung Bronchi Bronchioles Alveoli Diaphragm **Functions:** Supplies the cells with oxygen Removes carbon dioxideComponents and functions of the digestive system: **Components:** Alimentary canal (GI Tract) Mouth, teeth, tongue, taste buds, &  Saliva Pharynx (Throat) Esophagus Stomach Small Intestine – 20 feet Gallbladder Pancreas Large Intestine  Rectum & Anus **Functions:** Breaks down food physically &  chemically Removes solid waste from the bodyComponents and functions of the urinary system: **Components:** Kidneys - 2 Nephron Convoluted Tubule - Urine Bowman’s Capsule -  Glomerulus - filter Renal pelvis Ureter Bladder Urethra Meatus  **Functions:** Removes waste products from blood Maintains electrolyte balance Maintains acid-base balanceComponents of the male reproductive system: Components: Testes – Sperm, Testosterone Scrotum Seminal vesicle – Sperm & Semen Prostate Gland Penis – Urethra Components of the female reproductive system: Components: Ovary – Estrogen & Progesterone Ovum (Egg) – One release monthly  Fallopian tube Uterus Fundus Cervix Endometrium - Menstruation Vagina Labia Mammary glands **Function of the male and female reproductive systems is to reproduce.**  Components and functions of the endocrine system: **Components:** Pituitary Gland Growth Hormone Thyroid-stimulating Hormone Adrenocorticotropic (ATCH) Antidiuretic Hormone (ADH) Oxytocin – childbirth Thyroid Gland - Metabolism Parathyroid Glands – Calcium Thymus Pancreas Adrenal Gland  **Functions:** Secrete hormones into the blood stream to regulate the activities of other organs of the body. Components and functions of the immune system: **Components:** Antibodies Antigens Phagocytes Lymphocytes – (B cells & T cells) **Function:** Protects the body from disease and infection.  | Lecture & DiscussionChapter 8, Pages 80-95Figure 8-1Chapter 9, Pages 101 - 103 Boxes 9-1Table 9-1Chapter 8, Page 80Figure 8-2Chapter 8, Page 80Figure 8-3Chapter 8, Page 81Figure 8-4Chapter 8, Pages 82 & 83Figures 8-5, 8-6, 8-7, & 8-8Chapter 8, Pages 84 & 85Figures 8-10, 8-11, 8-12Chapter 8, Pages87-88Figures 8-15, 8-16, & 8-17Chapter 8, Pages 88-89Figure 8-18Chapter 8, Pages 89-90Figure 8-19Chapter 8, Page 90Figure 8-20Chapter 8, Page 91Figure 8-21Chapter 8, Page 92-93Figures 8-23 thru 8-26Chapter 8, Page 94Figure 8-27Chapter 8, Page 95Figure 8-28 |  |
| **Unit 16** **Personal Care** | 16.1. Explain the importance of personal hygiene.16.2. Describe adaptive devices available to promote resident independence with hygiene needs.16.3. Identify routine hygiene tasks to be completed through the day. 16.4. State the purpose of providing oral hygiene.16.5. State observations during oral hygiene to report immediately.16.6. Demonstrate the proper procedure for oral care, including; brushing teeth for an alert resident and an unconscious resident. 16.6. Demonstrate the proper procedure for denture care. 16.7. State the benefits of bathing. 16.8. Discuss the rules for bathing.16.9. Demonstrate the proper procedure for completing a bed bath.16.10. List other types of baths.16.11. Demonstrate the proper procedure for completing perineal care for the male and the female resident.16.12. Define selected terms associated with skin and scalp conditions.16.13. Describe the proper procedure for brushing, combing, and shampooing hair.16.14. State the rules for shaving a resident.16.15. Demonstrate the proper procedure for providing nail and foot care for residents.16.16. Discuss the rules for dressing and undressing a resident.16.17. Demonstrate the proper procedure for dressing and undressing a resident. | Importance of personal hygiene: Maintaining intact skin Prevent body odor Prevent breath odor Provide relaxation Promote circulation Adaptive (assistive) devices: Toothpaste tube squeezer Wash mitt with a pocket for a bar of soap Faucet adapter/extender Long-handle sponge Routine hygiene tasks: Assist with elimination Assist with face & hand washing Assist with dressing/undressing Assist with hair care Assist with sensory devices, such as  Eyeglasses, hearing aidsThese activities are done before breakfast (AM care), after breakfast, early afternoon and in the evening (PM care). Purpose of oral hygiene: Keeps the mouth& teeth clean Prevents odors and infection Increases comfort Reduces the risk for cavities & other  diseasesObservations 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  denturesProper procedure for oral care for the alert and unconscious resident:Proper procedure for denture care:Benefits of bathing: Cleans the skin and mucous membranes Removes microbes, dead skin,  perspiration, & excess oils Promotes relaxation Stimulates circulation Exercises body parts Rules for bathing: Allow personal choice  Follow standard precautions Remove hearing aids Provide privacy Assist with elimination before bathing Know the water temperature Wash from the cleanest to the dirtiest  areas Encourage the resident to help Rinse skin thoroughly Pat the skin dry Dry well under breasts and skin folds &  Between toes Proper procedure for completing a bed bath:Other types of baths: The partial bath Tub bath Shower bath Using a shower chair Using a shower trolleyProper procedure for perineal care for the male and the female resident: Terms associated with hair care: Alopecia Dandruff Pediculosis Scabies Proper procedure for brushing and combing hair:***Have the resident use a long-handled comb or brush to promote independence.***Rules for shaving a resident: Use electric razors for residents taking  Anticoagulant medications Soften facial hair before shaving Lather the area Hold the skin taut Shave in the direction of hair growth- Face & axilla Shave against the direction of hair growth Legs & when using an electric razorProper procedure for providing nail and foot care:Rules for dressing and undressing a resident: Provide privacy Let the resident select clothing Put clothing on the weak side first Remove clothing from the strong side  first Support the limb during dressing or  Undressing ***Have the resident use assistive devices for independence with dressing such as a sock assist.***Proper procedure for dressing and undressing a resident:  | Lecture & DiscussionChapter 18, Page 247-271Chapter 18, Page 248Figure 18-1Chapter 18, Page 249Box 18-1Clinical PracticeChapter 18, Pages 249-256Chapter 18, Page 249Box titled: Delegation GuidelinesChapter 18, Pages 250-253Figure 18-5Video & DiscussionInstructor demonstration Supervised practiceClinical PerformanceChapter 18, Pages 254-256Figure 18-9Video & DiscussionInstructor demonstration Supervised practiceClinical PracticeChapter 18, Page 256Box 18-2Chapter 18, Pages 258-261Figures 18-10 - 18-17Video & DiscussionInstructor demonstration Supervised practiceClinical PerformanceLecture & DiscussionChapter 18, Pages 262-266Figures 18-21-18-23Clinical PracticeLecture & DiscussionChapter 18, Pages 266-271Figures 18-24 – 18-29VideoInstructor DemonstrationSupervised PracticeClinical PracticeLecture & DiscussionChapter 19, Page 274Figures 19-2 & 19-3Lecture & DiscussionChapter 19, Pages 274-279Figures 19-1, 19-4 & 19-5Clinical practiceLecture & DiscussionChapter 19, Pages 279-281Box 19-1 Figure 19-9Clinical practiceLecture & DiscussionChapter 19, Pages 282-284Figures 19-10 – 19-12Clinical PracticeLecture & DiscussionChapter 19, Pages 284-289Figures 19-13 – 19-22Chapter 19, Page 273Figure 19-1Chapter 19, Pages 285-287Figures 19-13 – 19-20VideoInstructor DemonstrationSupervised PracticeClinical Practice |  |
| **Unit 17****Fall Prevention** | 17.1. Define the meaning of a fall according to the Centers for Medicare & Medicaid Services (CMS).17.2. Identify the potential impact of a fall on a resident.17.3. Discuss risk factors associated with falls.17.4. Identify components of fall prevention measures.17.5. Explain the proper procedure to assist a person who starts to fall to the floor.17.6. Identify situations when a restraint may be used.17.7. Describe types of restraints.17.8. Identify alternatives to the use of a restraint.17.9. Identify examples of physical restraints.17.10. Differentiate enablers from restraints.17.11. List possible risks associated with restraint use.17.12. Describe laws, rules, & guidelines associated with restraint use.17.12. Explain safety guidelines associated with restraint use. 17.13. Define the term transfer.17.14. List devices and equipment used to transfer a resident.17.15. Define the term transfer/gait belt.17.16. Demonstrate the proper procedure for using a transfer/gait belt.17.17. Identify safety guidelines for using wheelchairs and stretchers.17.18-A. Demonstrate the proper procedure to pivot transfer a resident to and from the wheel chair. 17.18-B.Discuss the purpose and types of mechanical lifts to transfer a resident.17.19.Demonstrate the proper procedure to ambulate a resident using a gait belt and a walker.17.20.Demonstrate the proper procedure to assist a resident with range of motion (ROM) of their joints | Definition of a fall:* Unintentionally coming to rest on a lower level
* A person loses his/her balance and would have fallen if staff did not prevent the fall
* When a person is found on the floor

Fall are the most common accident in nursing centers.Impact of a fall on a resident: Main cause of injury Main cause of death Serious injuries increase risk of death Hip Fractures Head trauma  Disability Functional decline Decrease quality of lifeRisk factors for falls:* The person
* Over age 65 years
* Balance problems
* Blood pressure alterations
* Confusion, Disorientation
* Dizziness
* Drug side effects
* Incontinence
* Nocturia
* Unsteady gait
* Pain
* Poor judgement
* Slow reaction time
* Poor fitting shoes
* Vision problems
* Weakness
* Care setting
* Bed height
* Care equipment – drainage tube
* Floor – clutter, wet, uneven
* Furniture out pf place
* No hand rails or grab bars
* Lighting - -poor or glare
* Restraints
* Throw rugs
* Improper use or fit

Fall prevention measures:* Meeting basic needs
* Bathrooms and shower rooms
* Floors and hallways
* Furniture
* Bed and other equipment
* Lighting
* Shoes and clothing
* Call lights, alarms and barriers, mats
* Observations

Proper procedure to assist a person to the floor:* Stand behind the person
* Bring the person close to your body
* Move your leg so the person’s buttocks rest on it
* Lower the person to the floor
* Stay calm and talk to the person
* If the person id bariatric move objects out of the way and protect the person’s head
* Call the nurse

Situations in which a restraint may be used:* To treat a medical symptom
* For immediate physical safety of the person or others
* Failure of less restrictive measures fail to protect the person/others

Types of restraints:* Physical – *any manual method or physical device, material, or equipment attached to or near the person’s body that he or she cannot remove easily and that restricts freedom of movement or normal access to one’s body. (CMS)*
* Chemical *– any drug used for discipline or convenience and not required to treat medical symptoms. (CMS)*

Alternatives to restraint use:* Meeting physical needs
* Consider life-long habits
* Food, fluid, hygiene, & eliminations needs are met
* Personal items are in easy reach
* Comfort measures such as back massages
* Outdoor time is scheduled
* Visit every 15 minutes
* Staff assignments are consistent
* Meeting safety & security needs
* Call light in reach
* Wander alerts are present
* Bed, chair, & Door alarms are used
* Frequent explanations are given
* Meeting love, belonging, & self-esteem Needs
* Diversional activities are provided
* Frequent visits or sitters
* Reminiscing with the person

Examples of physical restraints:* Trays, bars, belts attached to a chair
* Wrist restrains or mitts
* Locked chairs
* Bed or chair close to a wall
* Bed rails
* Tucking sheets too tight

Differentiate enablers from restraints:Definition of ***enablers*** – *a device that limits freedom of movement but is used to promote independence, comfort, or safety.* In addition, the device can be removed easily by the person.Definition of ***restraints -*** *any manual method or physical device, material, or equipment attached to or near the person’s body that he or she cannot remove easily and that restricts freedom of movement or normal access to one’s body.*Possible risks associated with restraint use:* Constipation
* Contractures
* Physical function decline
* Incontinence
* Infections - pneumonia
* Pressure injuries
* Withdrawal
* Strangulation

Laws, rules, & guidelines associated with restraint use:* Restraints must protect the person
* A doctor’s order is required
* The least restricted method is used
* Restraints are used only after other measures fail to protect the person
* Unnecessary restraint is false imprisonment
* Informed consent is required

Safety guidelines associated with restraint use:* Observe for increased confusion
* Protect the person’s quality of life
* Apply restraints with enough help to prevent the person and staff injury
* Observe the person every 15 minutes or as often as directed by the nurse and the care plan
* Remove or release the restraint, re-position the person, and meet basic needs at least ever two (2) hours.
* Report & Record restraint use

Definition of the term transfer:*…how a person moves to and from a surface.*Devices and equipment used to transfer a resident:* Bed attachments
* Slide boards
* Transfer belts
* Mechanical lift (full-sling)
* Mechanical lift (stand-assist)

The care plan will include information about the proper technique to safely transfer a resident.Definition of the term transfer/gait belt:…*a device applied around the waist and used to support a person who is unsteady or disabled.*Proper procedure for using a transfer/gait belt:* Assist the resident to a sitting position
* Wrap the belt around the resident
* **Always place the belt over clothing**
* Insert the metal tip into the buckle through the side with the teeth
* Tighten the belt – should be able to fit two finger under the belt

Safety guidelines for using wheelchairs and stretchers:* Maintenance – ensure all parts work correctly
* Transfers
* Lock brakes
* Remove leg lifts/footplates
* Position feet on the footplates
* Transport
* Push the wheelchair forward
* Pull the wheelchair backward when going through a doorway
* Pull the wheelchair backward when going down a ramp
* Stretcher
* Use at least two staff to transfer a resident to and from a stretcher
* Locks the breaks
* Fasten the safety straps
* Raise the side rails
* Move the stretcher feet first
* Do not leave the resident alone on the stretcher

Proper procedure for a pivot transfer:Purpose of the mechanical lift:* Resident cannot assist/participate with the transfer
* Resident is too heavy to be moved by staff

Types of mechanical lifts:* Stand-assist mechanical lift
* Full-sling mechanical lift

Proper procedure to use to ambulate a resident using a gait belt and/or walker:Proper procedure for assisting a resident with ROM of the shoulder, hip and knee. | Lecture & DiscussionChapter 11, Pages 122Box: Focus on SurveysChapter 11, Page 123Box 11-1Chapter 11, Pages 123-127Box 11-2Figures 11-1 – 11-7Chapter 11, Pages 130 – 131Figure 11-12Supervised Practice Lecture & DiscussionChapter 12, Page 133Clinical PracticeChapter 12, Pages 134-135Box 12-1Figures 12-1, 12-2, & 12-3Clinical PracticeChapter 12, Page 136Clinical PracticeLecture & DiscussionChapter 12, Page 136Box 12-2Lecture & DiscussionChapter 12, Page 137Lecture & DiscussionChapter 12, Page 137-146Box 12-3Figures 12-4 - 12-19Clinical PracticeChapter 16, Page 203Lecture & DiscussionChapter 16, Pages 204-217Figures 16-1, 16-2, 16-12, 16-13, 16-14Clinical PracticeLecture & DiscussionChapter 11, Page 127 Lecture & DiscussionChapter 11, Pages 127-129Figures 11-9, 11-10, 11-11Instructor DemonstrationSupervised PracticeClinical PracticeLecture & DiscussionChapter 16, Page 205Box 16-1Instructor DemonstrationSupervised PracticeClinical PracticeLecture & DiscussionChapter 16, Pages 206-212Figures 16-5 through 16-11Instructor DemonstrationSupervised PracticeClinical PracticeChapter 16, Pages 212-217Figures 16-12 – 16-14Lecture & DiscussionChapter 27, Pages 399-403Figures 27-24, 27-25, and  27-26Instructor Demonstration Supervised PracticeClinical PracticeLecture & DiscussionChapter 27, Pages 404-408Figures 27-10 thru 27-21Instructor Demonstration Supervised PracticeClinical Practice |  |
| **Unit 18****Nutrition****&****Fluid Needs** | 18.1. State the effects of poordiet and poor eating habits. 18.2. Define the term *Nutrition.* 18.3. Define the term *nutrient*.18.4. Define the term *calorie.*18.5. Explain thepurpose of the *MyPlate* symbol.18.6. List weeklyphysical activity recommended byUSDA. 18.7 Describe the fivefood groups andgive examples of each.18.8. Identify each nutrient and its function.18.9. Recognizefactors affectingeating and nutrition.18.10. Discuss the OBRAdietary requirements.18.11.Explain thepurpose of special diets.18.12. Define various special diets.18.13. Identify sign and symptoms of dysphagia.18.14.Explain aspiration precautions.18.15.Demonstrate the proper procedurefor feeding a dependentresident.18.16.Identify ways to assist a visuallyimpaired resident. 18.17.Identify the nursing assistant role in providing care for a resident who receives enteral nutrition.18.18.Define selected terms associated with fluid balance.18.19.Identify normal fluid requirements.18.20Explain special considerations associated with older adults.18.21.List special fluid orders.18.22.List common intake and output measurements.18.23.Demonstrate proper procedure for measuring intake and output.18.24.Identify the role of the nursing assistant in caring for a resident receiving intravenous (IV) therapy.18.25.Identify guidelines for measuring height and weight. | Effects of poor diet and eating habits:* Increased risk of disease and infection
* Causes chronic illnesses to become worse
* Difficulty healing
* Increase in accidents and injuries

Definition of the term *nutrition*:…*process involved in the ingestion, digestion, absorption, and the use of food and fluids by the body.*Definition of the term *nutrient*:*…substance that is ingested, digested, absorbed, and used by the body.*Definition of the term *calorie:**…fuel or energy value of food*Examples:1 gram of fat = 9 calories1 gram of protein = 4 calories1 gram of carbohydrate = 4 caloriesPurpose of the MyPlate symbol:* Balance calories
* Increasing certain foods
* Half the plate should be fruits and vegetables
* At least half of the grains should be whole grains
* Fat-free or low-fat milk
* Reducing certain foods
* Choosing low-sodium foods
* Drinking water

Weekly physical activity:* At least three days a week
* Two hours & 30 minutes of moderate physical activity such as:
* Walking rate of 3 & a half mph
* Water aerobics
* 75 minutes of vigorous physical activity such as:
* Running at a rate of 5 mph
* Swimming laps

The five food groups:* Grains – Bread, Pasta, Oatmeal
* Vegetables – Broccoli, Kale, Beans
* Fruits – Any fruit or juice
* Dairy – Milk, Yogurt, Cheese
* Proteins – Beef, Chicken, Seafood, Eggs, Soy, Beans, Peas, and Nuts

Note: Oils are not a food group. Butter is included in the oil category.Basic nutrients and their function:* Protein – Tissue growth & repair
* Carbohydrates – Provides energy & fiber
* Fats – Provide energy and flavor. They also help the body to utilize certain vitamins
* Vitamins – Needed for certain body functions. Vitamins A, D, E, & K are stored. Vitamins C & B are not stored.
* Minerals – Necessary for bone & teeth formation, nerve and muscle function, & fluid balance
* Water – Necessary for all body function

Factors affecting eating and nutrition:* Culture
* Religion
* Finance
* Appetite
* Personal choice
* Body reaction & Age
* Illness
* Medication (Drugs)
* Chewing problems
* Swallowing problems
* Disability
* Impaired cognitive function

OBRA dietary requirements:* Each resident’s dietary needs are

 met* The resident’s diet is well-balanced
* Food is appetizing
* Hot foods are served hot
* Cold foods are served cold
* Food is served promptly
* Substitutions are similar in

nutritional value* Each resident receives at least 3

meals each day* A bedtime snack is offered
* Adaptive equipment/utensils are

providedPurpose of special diets:Special diets are ordered by the physician for one of the following reasons:* A nutritional deficiency
* An illness
* To help with weight gain/loss
* To remove/decrease certain substances in the diet

Define special diets:* Regular Diet – no limitations
* Sodium-controlled –
* Diabetic meal plan
* Dysphagia Diet – Prevents choking

Signs & symptoms of dysphagia:* “Pockets” food
* Complains the food will not go down
* Coughs or chokes when swallowing
* Tires during the meal
* Regurgitates food after eating

In a dysphagia diet food and fluids consistency is changed to meet the resident’s needs. The change in consistency helps to prevent aspiration. Aspiration precautions:* Follow the dietary care plan
* Position the resident in high- Flower’s
* Maintain the upright position for 30 to 60 minutes after eating
* Question the use of straws
* Check the resident’s mouth after eating

*Dysphagia means difficulty swallowing**Aspiration means breathing fluid, food, vomitus, or an object into the lungs.*Proper procedure for feeding a dependent resident including calculating the amount of food and fluid consumed:***To promote independence with eating use*** ***provide the resident with assistive devices , such as, built-up flat wear, eating device attached to a splint, plate guard, or special handle cups.***Ways to assist a visually impaired resident:* Describe the food on the tray
* Ask the resident what to eat first
* If the resident can feed themselves tell them where each food item is located on the plate/tray – use the numbers face of a clock

In most nursing centers the nursing assistant does not administer enteral nutrition. It is important for the nursing assistant to know about the tubes used to administer enteral nutrition as they will need to ensure the tubes are not removed.The nursing assistant may have the responsibility for cleaning around the tube.Enteral feeding tubes:* Naso-gastric
* Gastrostomy
* Jejunostomy

Preventing aspiration:* Position the resident in a Fowler’s or semi-Fowler’s position

Definition of selected terms:Intake = *the amount of fluid taken in*Output = *the amount of fluid loss*Hydration = *having an adequate amount of*  *water in body tissues*Edema = *swelling of body tissues with water*Dehydration = *decrease in the amount of*  *water in body tissues*Dehydration will be discussed in detail in the Unit titled ***Health Problems***Normal fluid requirements:* Adults need 1500 mL for survival
* Fluid balance require approximately 2000 to 2500 mL/day
* Water requirements increase with hot weather, exercise, fever, illness, and at times of fluid losses

Special considerations associated with older adults;* Body water decreases with age
* Older adults have a decreased thirst sensation

Special fluid orders:* Encourage fluids
* Restrict fluids – no water pitcher at the resident’s bedside
* Nothing by mouth (NPO)
* Thickened liquids

Common measurements:* 1 cubic centimeter = 1 mL
* 1 ounce = 30 mL
* 1 cup = 240 mL
* 1 quart = 1000 mL
* 1 liter = 1000 mL

Proper procedure for measuring intake and output:* All fluids taken in and all fluids put out are measured and recorded.
* All fluids are measured on a flat surface at eye level
* All fluids are measured in milliliters (mL)
* Fluids levels are totaled at the end of every shift and every 24 hours

***To promote resident independence provide a lidded mug for sipping or a straw if ordered.***Nursing assistant (NA) role in caring for a resident receiving IV therapy:* Report signs and symptoms of local complications
* Bleeding
* Blood backing up into the tubing
* Swelling at the site
* Pale or redness at site
* Complaints of pain
* Hot or cold skin near the site
* Report signs or symptoms of systemic complications
* Fever
* Itching
* Drop in blood pressure
* Increased pulse rate (> 100)
* Change in mental status
* Decreasing or no urine output
* Chest pain

Guidelines for measuring height and weight:* Resident wears a gown
* Resident voids before weighing
* Complete weight at the same time of day
* Use the same scale
* Balance the scale at zero
 | Lecture & DiscussionChapter 23, Pages 331-346Chapter 23, Page 332Figure 23-1Chapter 23, Page 332Box 23-1Chapter 23, Pages 333-334Table 23-1 Chapter 23, Page 336Figure 23-2Chapter 23, Pages 336-339Boxes 23-2, 23-3, 23-4Chapter 23, Page 339Box 23-3Chapter 23, Page 339Box 23-4Chapter 23, Pages 339-345Chapter 31, Page 452Figures 23-2, 23-3, 23-4, & 23-7Figure 31-1VideoInstructor DemonstrationSupervised PracticeClinical PracticeChapter 23, Page 343Figure 23-6Clinical PracticeChapter 23, Page 345Figures 23-8, 23-9 & 23-10Chapter 23, Page344Chapter 24, Pages 349-356Chapter 24, Page 350Box 24-2Chapter 24, Page 253Figure 24-4Chapter 23, Pages 355 & 356Chapter 25, Pages 379-382Box – *Measuring Weight and Height*Instructor DemonstrationSupervised Practice Clinical Practice |  |
| **Unit 19****Common****Health** **Problems**Hearing: Meniere’s LossVisual disorders: Cataracts Glaucoma Low Vision BlindnessCancerArthritisFracturesStroke AphasiaParkinson’sMSALSHead InjurySpinal cord InjuryHeart DiseaseRespiratory  COPD Asthma Influenza Pneumonia TuberculosisDigestive Vomiting Diverticulosis IBD  Hepatitis CirrhosisUrinary UTI BPH Kidney Stones Kidney FailureDiabetesAutoimmune HIV/AIDSShingles  | 19.1.Discuss commonhealth problems and common interventions associated with the health problem  | Common health problem and associated interventions:**Hearing Problems****Meniere’s Disease** – Involves the inner earSigns & Symptoms: * Vertigo
* Tinnitus
* Hearing loss
* Pressure in the ear

Interventions: * Assist the resident to lie down
* Tell the resident to keep their head still
* Stand in front of them when speaking
* Avoid sudden movements
* Dim the lights in the room
* Keep the blinds closed

**Hearing Loss –**Limited to total deafnessSigns & Symptoms:* Straining to understand conversation
* Answers to questions are inappropriate
* Ask others to repeat themselves
* Leaning forward to hear
* Turning up devices (TV, Radio, etc.)

Interventions:* Hearing aids
* Watch facial expression, gestures, and body language
* Sign language
* Story boards
* Hearing dogs
* Face the person when speaking

**Visual Problems****Cataracts-**Clouding of the lens of the eye (one or both) Signs & Symptoms:* Cloudy, blurry, or dim vision
* Colors seem faded or brownish
* Blues and purples are hard to see
* Sensitivity to light & glares
* Poor vision at night
* Halos around objects
* Double vision

Interventions:* Follow guidelines for visually impaired residents
* Postoperative care
* Glasses or eye shield
* Eye shield to be worn for sleeping
* Remind the resident not to rub or press on the affected eye
* Report pain or drainage
* Remind the resident not to bend, stoop, cough or lift things

**Age-Related Macular Degeneration**Loss of central visionSigns & Symptoms:* Gradual loss of vision
* Progressive

Interventions:* Guidelines for caring for a resident who is visually impaired
* Laser surgery

**Diabetic Retinopathy**Damage to the blood vessels in the retinaComplication of DiabetesSigns & Symptoms: (Both eyes usually)* Blurred vision
* Complaints of seeing spots floating
* Blindness

Interventions:* Control Diabetes
* Control blood pressure
* Control cholesterol
* Laser surgery

**Glaucoma**Build up of fluid in the eye causing pressure on the optic nerveSigns & Symptoms:* Peripheral vision is lost
* Blurred vision
* Objects are seen through a tunnel
* Halos around lights
* Blindness

Interventions:* No cure
* Damage is irreversible
* Medications
* Surgery

**Low Vision**Vision loss that cannot be treatedSigns & Symptoms:* Difficulty reading
* Difficulty recognizing faces
* Difficulty doing tasks such as cooking
* Difficulty reading signs any where
* Light seems dimmer

Interventions:* Make reading glasses available
* Offer large-print books
* Hand-held magnifiers
* Audio tapes
* Computers with large fonts & sound
* Adjustable lights
* Large numbers on things like phones, clocks & watches

***General guidelines when caring for residents with impaired vision & blindness*****Medical Problems****Cancer:** Second leading cause of deathKey terms:* Tumor
* Benign
* Malignant
* Metastasis

Risk Factors:* Age – most important
* Tobacco
* Radiation
* Infections
* Immuno-suppressive drugs
* Alcohol
* Diet
* Hormones
* Obesity
* Environment

Signs & Symptoms:* Unexplained weight loss
* Skin changes
* Change in bowel habits
* Sores that do not heal
* White patches in the mouth
* Unusual bleeding or discharge
* Thickening or lump
* Indigestion
* Difficulty swallowing
* Nagging cough
* Hoarse

Treatment:* Goals
* Cure
* Control
* Reduce symptoms
* Surgery
* Radiation
* Chemotherapy
* Immunotherapy
* Report pain/discomfort
* Radiation site Skin Care
* Dietary needs
* Active listening

**Musculo-Skeletal Disorders**(Disorders affecting movement)**Arthritis**Joint inflammationTypes:* Osteoarthritis (OA) – Cartilage wears away allowing bone to rub on bone
* Rheumatoid (RA) – Autoimmune disorder attacking the lining of the joints

Risk Factors:* Age
* Overweight
* Women
* Family history

Signs & Symptoms:* Joint Swelling
* Joint stiffness
* Reduced range of motion of the joint

Interventions:* Pain control
* Heat & Cold
* Exercise
* Rest & joint care
* Assistive devices
* Weight control
* Assistance with ADLS as needed
* Surgery – Joint replacement (Arthroplasty
* Care after Surgery
* Prevent pressure injury
* Hip precautions
* Do not cross legs
* Do not sit in low chairs
* Avoid flexing hips past 90 degrees
* Use grabbers
* Use elevated toilet seat
* Abductor pillow

**Fracture**A break in a boneTypes:* Open – Bone is through the skin (compound)
* Closed – Skin is intact (simple)

Signs & Symptoms:* Pain
* Swelling
* Loss of function
* Deformity
* Bruising
* Bleeding

Interventions:* Reduction – realigns the bone
* Fixation – bone is held (fixed) in place
* Casting – Care guidelines
* Traction

**Osteoporosis**Bones become porous and brittleRisk Factors:* Decreased estrogen
* Low levels of dietary calcium
* Low levels of vitamin D
* Family history
* Lack of exercise
* Immobility
* Tobacco use
* Eating disorders

Signs & Symptoms:* Back pain
* Loss of height
* Stooped posture
* Fracture

Interventions:* Prevention
* Medications/Supplements
* Calcium
* Vitamin D
* Estrogen
* Exercise Programs
* Walking
* Dancing
* Weight lifting
* Climbing stairs
* Good body mechanics
* Back supports/Corsets
* Walking aids

**Loss of a Limb (Amputation)**Removal of all or part of an extremity.Causes:* Severe injury
* Tumors
* Severe infection
* Gangrene – death of tissue
* Vascular disorders

Interventions:* Prosthesis
* Care of a prosthetic device
* Wash stump shrinker
* Observe the skin on the stump
* Apply shrinker
* Assist the patient to put on the prosthesis
* Manage Phantom pain
* Physical Therapy

**Nervous System Disorders****Stroke –** Brain Attack or Cerebrovascular accident (CVA)Causes:* Ruptured blood vessel in the brain (hemorrhage)
* Blood flow to an area of the brain stops due to a blood clot
* Transient ischemic attack (TIA)

Signs & Symptoms:* Hemiplegia
* Redness of the face
* Noisy breathing
* Unconsciousness
* High blood pressure
* Slow pulse
* Seizures
* Incontinent
* Changing emotions
* Aphasia
* Behavior changes

Interventions:* Medications (Thrombolytics)
* Prevent aspiration
* Anti-embolic stockings
* Safety precautions
* Establish communication methods
* Therapy – Physical, Occupational, Speech

**Parkinson’s Disease**Progressive disorder affecting movementSigns & Symptoms:* Tremors
* Pill-rolling
* Trembling
* Rigid, stiff muscles
* Stooped posture
* Impaired balance
* Shuffling gait
* Mask-like expression
* Fixed stare
* Cannot blink or smile
* Swallowing & Chewing problems
* Memory loss
* Fear, insecurity
* Slow, monotone, & soft speech

Interventions: No cure* Medications
* Exercise
* Therapy – physical, occupational, & speech
* Safety measures

**Multiple Sclerosis (MS)**Destruction of the myelin (cover nerve fibers) in the brain and spinal cord – functions are impaired or lostRisk Factors:* Age (15 to 60)
* Gender (women)
* Caucasian
* Family history

Signs & Symptoms:* Blurred or double vision
* Muscle weakness
* Balance/Coordination problems
* Partial /complete paralysis
* Remission/Relapse

Interventions: No cure* Medications
* Safety precautions
* Care as needed
* Range of motion

**Amyotrophic Lateral Sclerosis (ALS)*****Lou Gehrig’s Disease***Attacks the nerve cells that control voluntary muscles.Life expectance is 2-5 yearsRisk Factors:* Age (40-60)

Signs & Symptoms:* Progressive muscle weakness

Interventions: No Cure* Medications
* Respiratory support
* Care as needed
* Safety Precautions

**Head Injuries (TBI) –**Causes:* Falls
* Traffic accidents
* Assaults
* Fire arms
* Sport injuries
* Combat injuries

Signs & Symptoms:Based on the area of the brain injured* Change in level of consciousness
* Coma - unaware
* Vegetative state – Sleep-wake cycles, open eyes, make sounds, may move cannot speak or follow commands
* Brain death – complete loss of brain function, spontaneous respirations are absent

Interventions:* Rehabilitation
* Care as needed
* Safety precautions

**Spinal Cord Injury -** Causes:* Traffic accidents
* Falls
* Violence
* Sport injuries
* Cancer

Signs & Symptoms:* Paralysis
* Paraplegia – paralysis of the legs, lower trunk and pelvic organs
* Quadriplegia – arms, legs, trunk, and pelvic organs
* Lumbar and thoracic injuries cause paraplegia
* Cervical Injuries cause quadriplegia

Interventions:* Care as needed
* Prevent pressure injuries
* Safety precautions

**Cardiovascular Disorders****Hypertension –** high blood pressure  (130/80)Causes:* Narrow blood vessels
* Kidney disorders
* Head injuries
* Pregnancy
* Adrenal tumors

Risk Factors: * Age – men 45 & women 55
* Gender – men
* Race – African-American
* Family history
* Obesity
* Stress
* Smoking
* High cholesterol
* Diabetes

Signs & Symptoms:* Headache
* Blurred vision
* Dizziness
* Nose bleeds

Interventions:* Medications
* Life style modifications

**Coronary Artery Disease** **(CAD)**Coronary arteries become hardened and narrow causing the heart muscle to get decrease blood and oxygen.Causes:* Atherosclerosis

Signs & Symptoms:* Angina – Chest pain
* Irregular heart rate

Complications:* Myocardial Infarction -
* Heart Failure
1. Right-sided symptoms
2. Left-sided symptoms
* Sudden death

Interventions:* Medications
* Nitroglycerin
* Diuretics
* Antihypertension
* Life style modifications
* Surgery (CABG)

**Respiratory Disorders****Chronic Obstructive Pulmonary Disease****(COPD) –** Involves **Chronic Bronchitis & Emphysema**Obstruction of air flow (oxygen and carbon dioxide exchange. Lung function is gradually lost.Risk Factor – cigarette smokingSigns & Symptoms:* Cough
* Mucus production
* Difficulty breathing (SOB)
* Tires easily
* Low oxygen levels
* Barrel chest
* SOB on exertion then at rest
* Fatigue

Interventions:* Medications
* Breathing exercises – pursed lip
* Positioning – Upright
* Meeting Oxygen needs
* Positioning
* Deep Breathing & Coughing
* Supplemental Oxygen
* Delivery systems

**Asthma** Inflammation and narrowing of the airwayRisk Factors:* Allergies
* Air pollutants/irritants
* Smoking
* Respiratory infections
* Cold air

Signs & Symptoms:* Shortness of breath (SOB)
* Wheezing
* Coughing
* Increased pulse rate
* Fear
* Sweating
* Cyanosis (Blue color to the skin)

Interventions:* Medications
* Meeting Oxygen needs

**Influenza**Respiratory infectionCause is a virusSigns & Symptoms:* High fever for several days
* Headache
* Cough
* Cold symptoms

Interventions:* Medications
* Fluids & rest

**Pneumonia**Inflammation and infection of lung tissue causing impaired gas exchange.Signs & Symptoms:* Fever
* Chills
* Cough
* Shortness of breath (SOB)
* Thick sputum (Mucous)
* Tiredness

Interventions:* Medications
* Oxygen
* Position – (semi-Fowler’s)
* Increased fluids
* Rest

**Tuberculosis**Bacterial infection of the lungsRisk Factors:* Contact with an infected person
* Age
* Poor nutrition
* HIV

Signs & Symptoms:* Cough (blood)
* Tiredness
* Weight loss
* Fever
* Night sweats

Interventions:* Medications
* Care as needed
* Airborne precautions

**Digestive Disorders****Vomiting****Diverticular Disease****Inflammatory Bowel Diseases (IBD)*** Crohn’s Disease & Ulcerative colitis
* Signs & Symptoms
* Diarrhea - blood
* Abdominal pain
* Cramping
* Fever
* Weight loss
* Interventions:
* Medications
* Diet modifications
* Surgery –
* Ileostomy
* Colostomy

**Constipation****Fecal Impaction****Diarrhea****Fecal Incontinence****Flatulence****Bowel Training:*** Goals of bowel training
* To gain control of bowel movements (BM)
* To develop a regular pattern of elimination
* Interventions
* Identify the resident’s usual time for BM
* Assist the resident to the bathroom at these times
* Provide privacy
* Increase fluids (warm)
* Provide a high-fiber diet
* Encourage activity

**Liver Diseases*** Hepatitis – Inflammation and infection of the liver caused by a virus
* Types
* Hepatitis A – contaminated food and water
* Hepatitis B – infected blood and body fluids
* Hepatitis C – infected blood
* Hepatitis D – HBV
* Hepatitis E – contaminated food and water
* Cirrhosis – scar tissue blocks blood flow through the liver; function is affected
* Causes:
* Chronic alcohol abuse
* Chronic Hepatitis B & C
* Fatty liver
* Obesity
* Signs & Symptoms
* Weakness
* Loss of appetite
* Itching
* Edema
* Ascites
* Jaundice

**Urinary System Disorders****Urinary Tract infections – Lower tract, Cystitis, Pyelonephritis**Microbes enter the urinary tract through the urethra.Causes:* Poor perineal hygiene
* Immobility
* Poor fluid intake
* Urinary catheters
* GU examinations
* Intercourse

Signs & Symptoms:* Frequency
* Urgency
* Dysuria - pain
* Cloudy urine - pyuria (pus)
* Foul-smelling urine
* Hematuria – blood
* High fever -

Interventions:* Medications - antibiotics
* Fluids – 2000 mL/day

**Prostate Enlargement – Benign Prostatic Hyperplasia (BPH)**Cause is age.Signs & Symptoms:* Weak urine stream
* Trouble starting to urinate
* Frequent voids of small amounts
* Leakage of urine, dribbling of urine
* Nocturia – Nighttime
* Urinary retention
* Pain

Interventions:* Medications
* Urinary Catheters
* Surgery

**Kidney Stones – Calculi**Risk Factors:* Bedrest
* Immobility
* Poor fluid intake

Signs & Symptoms:* Pain – back below the ribs
* Fever
* Chills
* Dysuria
* Hematuria
* Cloudy urine

Interventions:* Medications – pain
* Increase fluid intake – 2000 to 3000mL/day
* Strain all urine
* Diet modifications
* Surgery

**Kidney Failure**Kidneys do not function properly if at all. Waste products build up in the body. Fluid is retained.Interventions:* Fluid restrictions
* Diet modifications – decreased protein, potassium, and sodium
* Daily weights
* Postural blood pressure readings
* Care as needed
* Dialysis

**Bladder Training*** The goal is to control urinary elimination
* Often need after a urinary catheter is removed
* Methods
* Bladder re-training
* Urinate at scheduled times
* Prompted voiding
* Recognizes when the bladder is full
* Habit training
* Every 2-4 hours while awake
* Catheter clamping

**Endocrine Disorders****Diabetes –** Glucose intoleranceRisk factor is family history.Types:* Type 1 – little or no production of Insulin
* Type 2 – Insulin production is normal, however the body does not utilize the Insulin well
* Gestational Diabetes – develops during pregnancy

Signs & Symptoms:* Thirst
* Frequent urination
* Hungry
* Weight loss
* Dry, itchy skin
* Slow healing
* Tingling in the feet
* Blurred vision

Complications:* Hypoglycemia
* Hyperglycemia

Interventions:* Diet modifications
* Exercise programs
* Medications
* Foot care

**Immune System Disorders** HIV/AIDSA virus spread through direct contact with infected blood or body fluids from a person who has the HIV virus.Causes:* Sex with an infected person
* Sharing equipment used to prepare injection drugs

Signs & Symptoms:* Weight loss
* Recurring fever
* Night Sweats
* Fatigue
* Swollen lymph nodes
* Diarrhea lasting more than 1 week
* Sore throat
* Sores in the mouth and elsewhere
* Blotches under the skin

Interventions:* Care as needed
* Medications
* Blood borne precautions

**Skin Disorders****Shingles (herpes zoster)**Caused by the virus that caused chicken pox.Signs & Symptoms:* Rash
* Fluid-filled blisters
* Burning, tingling pain
* Numbness
* Itching

Interventions:* Medications
* Care of the lesions
* Contact precautions

  | Lecture & DiscussionChapter 32, Pages 458-467Chapter 32, Page 459Box 32-1, 32-2, 32-3, 32-4Figures 32-1 & 32-2Chapter 32, Pages 462Boxes 32-3Chapter 32. Page 463Box 32-4Chapter 32, Pages 463-467Box 32-6Figures 32-5, 32-6, 32-7Lecture & Discussion Chapter 33, Pages 469-491Chapter 33, Page 471Box 33-1Chapter 33, Page 472Figure 33-3Chapter 33, Pages 472-473Box 33-2Figure 33-5Chapter 33, Page 473Figure 33-6Chapter 33, Page 474Boxes 33-3, 33-4, 33-5Figures 33-7, 33-8, 33-9, 33-10, 33-11Chapter 33, Page 476Figures 33-12 & 33-13Chapter 33, Page 477Boxes 33-6 & 33-7Figure 33-14Chapter 33, Page 478Figure 33-15Chapter 33, Page 479 - 480Figure 33-16Box 33-8Chapter 33, Page 480Box 33-9, Chapter 33, Page 481Figures 33-17, 33-18,  & 33-19Chapter 28, Pages 415-416Procedure Box: Applying Elastic (Anti-embolic) StockingsFigure 28-6Chapter 33, Page 483Figure 33-20Chapter 30, Pages 444-449Chapter 22, Pages 327-329Figures 22-5, 22-6, 22-7 & 22-8Chapter 22, Pages 323-324Chapter 33, Page 486Figure 33-22Chapter 33, Page 486Box 33-13Chapter 33, Page 487Figure 33-23Chapter 13, Pages 164-168Chapter 21, Pages 309-318Box 21-1Procedures Boxes: Giving Catheter Care Emptying a Urine Drainage BagFigure 21-5Chapter 33, Page 487Figures 33-24Chapter 33, Page 487Figures 33-25Chapter 33, Page 488Box 33-14Chapter 33, Page 489Table 33-1Chapter 28, Page 414Box 28-3Chapter 33, Page 490Boxes 33-15 & 33-16 |  |

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| **Unit 20****Confusion** **&** **Dementia****Unit 21****Mental****Health****Disorders** | 20.1. Define selected terms associated with confusion and dementia.20.2. Describe nervous system changes from aging.20.3. List causes of confusion.20.3. Identify selectedcare measures to incorporate in the care for residents who are confused.20.4. List causes of delirium.20.5. State possible signs and symptoms of delirium.20.6. List the early warningsigns of dementia.20.7. List the risk factors associated with AD.20.8. Identify warning signs ofAD.20.9. Identify signs of AD.20.10. Discuss the three stagesof AD.20.11. Identify communicationtechniques to use wheninteracting with aresident with AD or other types of dementia.20.11. Discuss selectedcare measures. 20.12.Describe *Validation**Therapy.*21.1. Identify selected termsassociate with mental health and mental healthdisorders.21.2. List the possible causes of mental healthdisorders.21.3. Describe selected defense mechanisms.21.4. List types of mentalhealth disorders. | Selected terms:**Cognitive function** – *involves memory, thinking, reasoning, ability to understand, judgement, and behavior.***Disoriented** – *to be apart from one’s awareness.***Confusion** - *…a state of being disoriented to person, time, place, situation, or identify.***Delirium** - *…a state of sudden, severe confusion and rapid changes in brain function.***Dementia** - *…the loss of cognitive function that interferes with routine personal, social, and occupational activities.*Age related nervous system changes:* Reflexes, responses, and reaction times are slower
* Senses decrease
* Sensitivity to pain decreases
* Sleep patterns change
* Memory is shorted; forgetfulness occurs
* Dizziness can occur

Causes of confusion:* Disease
* Brain injury
* Infection
* Hearing & vision loss
* Medication side effects

Selected care measures:* Give the date & time each morning
* Keep a calendar & clock in sight
* Break tasks into small steps
* Place familiar objects & photos in view
* Discuss current events
* Maintain day-night cycle
* Follow the resident’s routine

Causes of delirium:* Surgery
* Substance abuse
* Medication side effects
* Infections

Signs & symptoms of delirium:* More alert in the AM
* Drowsiness
* Confusion about time or place
* Concentration changes
* Incontinence
* Emotional changes
* Speech is not clear

Delirium is usually temporary and reversible. Delirium signals disease.Delirium is an emergency. Early warning signs of dementia:* Memory loss
* Common tasks problems
* Forgetting simple words
* Poor judgment
* Personality changes

*Some dementia is reversible when the cause can be treated.* **Alzheimer’s dementia (AD) is the most** **common form of dementia** Risk factors:* Age – after age 65
* Gender – women
* Family history

Warning signs of AD:* Asking the same question
* Repeats the same story
* Gets lost in known places
* Problems with budget
* Neglects hygiene
* Forgets how to do tasks

Signs of AD:* Forgetting
* Speaks native language
* Wanders
* Distrusts others
* Conversation problems
* Slow, steady decline in mental function

Stages of AD:* Mild
* Memory problems
* Tasks take longer
* Behavior changes
* Wandering
* Getting lost
* Moderate
* Problem with routine

tasks* Difficulty recognizing

family/friends* Cannot learn new things
* Sundowning
* Hallucinations
* Delusions
* Paranoia
* Impulsive behavior
* Severe
* Cared for by others
* Cannot communicate
* Difficulty swallowing
* Incontinence

 Communication techniques:* Make eye contact
* Control distractions
* Use a calm, gentle voice
* Avoid negative body language
* Give simple instructions
* Give the person time to respond
* Do not criticize or argue
* Do not try to reason

Care measures:* Follow set routines
* Use picture signs
* Place large clock/calendars in view
* Select tasks based on ability
* Remove harmful items
* Consider electrical safety
* Provide safe storage for:
* Personal items
* Cleaning products
* Car keys
* Smoking materials
* Lock doors
* Keep alarms on
* Respond to alarms quickly
* Meet personal needs for food and elimination
* Avoid caffeine
* Play soft music

*Validation therapy* is a communication technique used in dementia care.**Validate** - …*to show that a person’s feelings and needs are fair and have meaning.*Principles of *validation therapy*:* All behavior has meaning.
* A person may have unresolved issues from the past.
* A person’s mind may return to the past to resolve issues and emotions.
* Caregivers need to listen and provide empathy.

Selected terms:**Mental** – *relates to the mind* **Stress** - *…response or change in the body caused by any emotional, physical, social, or economic factor.***Mental health** - …person copes with and adjusts to everyday stresses in ways accepted by society.**Mental health disorder** - *…disturbance in the ability to cope with or adjust to stress. Behavior and function are impaired.***Defense mechanism** - *…unconscious reaction that blocks unpleasant or threatening feelings*Causes of mental health disorders:* Chemical imbalances
* Genetics
* Physical, biological, or psychological factors
* Substance abuse
* Social & cultural factors
* Abuse

Selected defense mechanisms:* Compensation
* Conversion
* Denial
* Displacement
* Identification
* Projection
* Rationalization
* Reaction formation
* Regression
* Repression

Types of mental health disorders:* Anxiety Disorders
* Panic Disorders
* Phobias
* Agoraphobia
* Aquaphobia
* Claustrophobia
* Mysophobia
* Nyctophobia
* Obsessive-Compulsive disorder
* Post-traumatic stress disorder
* Flashbacks
* Schizophrenia
* Bipolar Disorder
* Depression
* Older adults
* Personality Disorders
* Antisocial Personality
* Borderline Personality
* Substance abuse Disorder
* Addiction
* Withdrawal Syndrome
* Eating Disorders
* Anorexia Nervosa
* Bulimia Nervosa
* Binge eating disorder
* Suicide
 | Lecture & DiscussionChapter 35, Pages 504-517Chapter 35, Page 505Box 35-2Chapter 35, Page 505Box 35-3Chapter 35, Pages 507Box 35-5Chapter 35, Pages 507Box 35-5Chapter 35, Page 507Box 35-7Chapter 35, Page 511Box 35-8Focus on Communication BoxChapter 35Pages 513-515Box 35-9Lecture & DiscussionChapter 34Pages 494-502Chapter 34, Page 495Box 34-2Chapter 34, Page 498Box 34-5 |  |
| **22****Emergency** **Care** | 22.1.Define selected termsassociated with emergency care.22.2. State the emergencycare rules. 22.3.State the three major signs of sudden cardiac arrest (SCA).22.4. List the steps in the Chain of Survival forout-of-hospital situations.22.5.State the rate of compressions to be given during CPR.22.6.State the rate of providing rescue breaths.22.7.State the rate of providing breaths during CPR.  | Selected terms associated with emergency care:**First aid**…*emergency care given to an ill or injured person before medical help arrives.***Sudden cardiac arrest (SCA)…***the heart stops suddenly and without warning.***Respiratory arrest*…****breathing stops but heart action continues for several minutes.***Rescue Breathing…***breaths given when there is a pulse but no breathing only agonal gasps.***Agonal respirations…***struggling to breath; agonal gasps do not bring enough oxygen into the lungs.****Resuscitate…****to revive from apparent death or unconsciousness using emergency measures.***Recovery position…***used when the person is breathing and has a pulse but is not responding. This position keeps the airway open and prevents aspiration.***Defibrillation**…*shock the heart into a regular rhythm.***Anaphylaxis…***life-threatening sensitivity to an antigen*Emergency care rules:* Call for help
* Tell the operator the following:
* Location
* Phone number
* What seems to have happened
* How many people are involved
* Condition of the victims
* What aid is being given
* Assess the situation for safety
* Stay calm
* Know your limitations
* Follow standard/bloodborne precautions
* Do not move the person unless the situation is unsafe
* Do not remove clothing
* Do not given the person food or fluids

Three major signs of SCA:* No response
* No breathing or no normal breathing
* No pulse

Steps in the Chain of Survival:* Recognize cardiac arrest
* Activate EMS
* Perform CPR immediately
* Defibrillate quickly
* Provide BLS and ALS
* Provide post -arrest care

Rate of compressions during CPR:* Compressions rate = 100-120 per minute

Rate of providing rescue breaths:* Rescue breaths = 1 breath every 5-6 seconds

Rate of providing breaths during CPR:* Each breath should take 1 second
* The chest should rise with each breath
* Two breaths are given after 30 chest compressions
 | Lecture & DiscussionChapter 36Pages 519-531BLS ClassChapter 36, Page 520Box 36-1 |  |
| **23****End-of-life** **Care** | 23.1.Identify selected termsassociated with End-of-Life care.23.2.Discuss how various age groups understand death.23.3.Identify the 5 stages of dying/grief.23.4.Discuss the comfort needs of the person who is dying.23.5. Identify the needs of the family/friends of the person who is dying.23.6.Discuss the legal documents associated with end-of-life.23.7.Recognize the signs of death.23.8.Identify the steps in the care of the person’s body after death has occurred. | Selected terms associated with End-of-Life Care:**End-of-Life Care…***support and care given during the time surrounding death.***Terminal illness…***an illness or injury from which the person will not likely recover.***Palliative care…***relieving or reducing the intensity of uncomfortable symptoms without producing a cure.***Hospice care…***focuses on the physical, emotional, social, & spiritual needs of the dying person/family. Cure or life-saving measures are not concerns. Often the person has less than 6 months to live.***Reincarnation…***belief that the spirit or soul is reborn in another human body or in another form of life.***Grief…***person’s response to loss***Advanced Directives…***a document stating a person’s wishes about health care when that person cannot make his or her own decisions.***Post-mortem care…***care of the body after death has occurred.***Rigor mortis…***stiffness or rigidity of the skeletal muscles that occurs after death. (2-4 hours after death)***Autopsy…***the examination of the body after death*Understanding death by various age groups:* Infants and toddlers do not understand death. They sense the effects of the death of an individual.
* Children 2 to 6 years of age think death is temporary.
* Children 6 to 11 years of age learn death is final. They do not think they will die.
* Adults fear pain and suffering, dying alone, and invasion of privacy. They worry about those left behind.
* Older adults know death will occur. Some welcome death.

Five stages of dying/grief:* Denial – “No, not me”
* Anger – “Why me”
* Bargaining – “Yes, me but…”
* Depression – “Yes me” and is very sad
* Acceptance – Calm and peaceful

***The dying person does not always move through each stage and may move back and forth between the stages or stay in one stage for a long period of time.***Comfort needs of the dying person:* Listening
* Touch
* Silence
* Physical Needs
* Pain
* Breathing problems
* Noisy breathing (death rattle)
* Sensory changes
* Blurred vision – lights on
* Speech – difficult
* Hearing – last to leave
* Mouth, Nose, Skin
* Frequent oral care
* Clean the nose of secretions
* Skin is cool, sweating occurs Bathe the person and change linens
* Reposition the person frequently
* Note change in skin color – pale and mottled (blotchy)
* Nutrition
* Elimination
* The person’s room

Needs of the Family:* Be available to listen
* Be courteous and considerate
* Respect privacy
* Provide food/beverages
* Provide care

Legal documents associated with end-of-life:* Advanced Directives
* Living Will – relates to measures to support or maintain life when death is likely. Examples: resuscitation, ventilation, tube feeding
* Durable Power of Attorney for **Health Care** – gives the power to make health care decisions to another person (*health care proxy*)
* “Do Not Resuscitate” orders – DNR or No Code or AND means the person will not be resuscitated. The family and/or doctor make the decision if the person is not mentally able to do so.

Signs of death:* Movement, muscle tone, and sensation are lost
* GI functions slows – nausea/vomiting, fecal incontinence occur
* Body temperature rises
* Excessive sweating occurs
* Skin is cool, pale, and mottled
* Pulse is weak and irregular
* Blood pressure starts to fall
* Noisy respirations (death rattle)
* Pain decreases with loss of consciousness
* When death occurs there is no pulse, no respirations, and no blood pressure

***The doctor determines death has occurred.***Steps in the care of the person’s body after death:* Bath the person’s body
* Position the person’s body in good alignment
* Expect air to be expelled from the person’s body when moved
* Tubes and dressing may be removed
* Autopsy may be done
* Close the person’s eyes
* Close the person’s mouth
* Place a disposable bed protector under the person
* Brush/comb the person’s hair
* Gather all the person’s belongings
* Fill out the ID tags (ankle or toe)
* Place the person in the body bag & tag
 | Lecture & DiscussionChapter 37Pages 533-539Chapter 37Pages 538 & 539 |  |
| **Unit 24****Collecting****Specimens** | 24.1. State the purpose of collecting/testingspecimens (Samples). 24.2. State the rules forspecimen collection. 24.3. List the types ofSpecimens to be collected. | Purpose of collecting/testing specimens:* To prevent disease
* To detect disease
* To treat disease

Rules for collecting specimens:* Maintain medical asepsis
* Follow standard and bloodborne precautions
* Use the correct container
* Identify the resident using two identifiers
* Label the container at the time the specimen is collected in the presence of the resident
* Urine and stool specimen must not contain toilet tissue
* Secure the lid to the container
* Put the specimen in a biohazard bag
* Take the specimen & requisition to the lab

**Each agency will have specific guidelines for specimen collection.**Types of specimens to be collected:* Random urine specimens
* Midstream urine specimens
* Testing urine using a reagent strip
* Stool specimens
* Sputum specimens
 | Lecture & DiscussionChapter 26, Pages 385 -394 Chapter 26, Page 385Box 26-1 |  |
| **Unit 25****Wound Care** | 25.1. Define selected terms associated with wound care. 25.2. Identify common causes of wounds.25.3. State the most common complication associated with wounds.25.3. List the possible causes of skin tears.25.4. List ways to prevent circulatory ulcers.25.5. Discuss the role of the NA in applying dressings.25.6. State the purpose of binders/compression garments.25.7. State the benefits of heat application.25.8. List the types of heat applications.25.9. State the common complication associated with heat application.25.10. State the benefits of cold applications.25.11. List types of cold applications.25.12. Identify rules for applying heat and cold. | Definition of selected terms associated with wound care:Wound…a break in the skin or mucous membrane. Skin tear…a Break or rip in the outer layers of the skin Ulcer…shallow or deep crater-like sore of the skin or mucous membraneDilate…to expand or open widerCommon causes of wounds:* Trauma
* Pressure
* Decrease blood flow
* Nerve damage

The most common complication associated with wounds is infection.Common causes of skin tears:* Friction
* Shearing
* Holding limbs too tight
* Parts of wheel chair or other equipment
* Clothing
* Jewelry
* Fingernails

Interventions focus on prevention.Ways to prevent circulatory ulcers:* Remind the resident not to cross their legs
* Do not dress the resident in tight clothes
* Provide good skin care
* Pat skin dry after bathing
* Keep pressure of the heels
* Re-position residents at least every 2 hours
* Check residents’ skin and report wounds
* Do not massage over boney prominences

NA role in applying dressings:Follow nursing center policy for applying dressings. The most common role is to assist the license staff to apply dressings.Purpose of binders/compression garments:* Provide support
* Hold dressings in place

Benefits of heat application:* Relieve pain
* Relaxes muscles
* Promotes healing
* Reduces tissue swelling
* Decrease joint stiffness

Types of heat applications:* Moist heat applications
* Hot compress
* Sitz Bath
* Hot pack
* Dry applications
* Aquathermia pad

Complication of heat application:**Burns are the most common complication associated with heat application.**Benefits of cold application:* Reduce pain
* Prevent swelling
* Decrease circulation/bleeding
* Cool the body during a fever

Types of cold applications:* Cold compress
* Cold packs

 Rules for applying heat and cold:* Follow agency policy for temperature ranges
* Cover dry heat & cold applications
* Observe the skin every 5 minutes during the application
* Leave the application in place for no more than 15 to 20 minutes
 | Lecture & DiscussionChapter 28, Pages 411-427 Chapter 28, Page 412Box 28-1Figure 28-1Chapter 28, Page 413Box 28-2Figures 28-2 & 28-3Chapter 28, page 419Box 28-4Chapter 28Pages 421 & 422Box 28-5Figures 28-11 & 28-13Chapter 28, Page 423Figure 28-15Chapter 28, Page 424Figures 28-16 & 28-17Chapter 28, Page 424Box 28-6  |  |
| **Unit 26****Care of the** **Peri-****operative** **resident**  | 26.1. Identify the roles of the NA in the care of a patient prior to having surgery (pre-operative care).26.2. Identify the roles of the NA in the care of a patient after surgery (post-operative care) | Role of the NA in pre-operative care:* Psychological preparation
* Listen to the patient
* Observe patient’s body language
* Report observations to the nurse
* Physical preparation
* Place an identification band on the patient
* Follow nutrition orders. Patients are often NPO for 8-12 hours prior to surgery.
* Assist with completing the surgical checklist: Complete set of vital signs, documenting the last voiding time
* Complete special bathing or showering policies/orders
* Remove and secure dentures
* Remove nail polish
* Remove and secure jewelry
* Remove and secure prostheses including eyeglasses, artificial limbs

Hearing aids maybe left in during the surgery* Bowel and urinary elimination orders are followed

Role of the NA in post-operative care:* Post Anesthesia Care Unit PACU)
* The patient usually stays 1-2 hours
* Vitals signs are monitored frequently
* The patient leaves the PACU when vital signs are stable, Respiratory function is good and the patient is responsive and can call for help
* Preparation of the patient’s room
* Make a surgical bed
* Stock the room with necessary supplies
* Vital Sign equipment
* Emesis basin
* Tissues
* IV Pole
* Care of the patient returning from the PACU
* Assist with transferring the patient to the bed from the stretcher
* Frequent vital signs
* Measure and record first post-operative void
* Maintain standard and body fluid precautions
* Preventing complications
* Assist the patient with turning, coughing, and deep breathing exercises. Assist the patient to use the incentive spirometer.
* Encourage leg exercises (ROM)
* Apply Anti-embolic stockings
* Apply sequential compression devices (SCD)
* Report observations to the nurse
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| **Unit 27****Care of the** **resident with** **special needs** | 27.1. Describe the role of a NA in the care of stable residents with special needs. | Describe care of stable residents with special needs:* Care of residents with non-sterile dressings and/or elastic bandages (ACE wraps):
* Know the reason for the dressing or ACE bandage
* Follow agency policy for applying non-sterile dressings/ACE bandages
* Observe the resident’s skin
* Report observations and the resident’s response to the nurse
* Care of residents with surgical drains:

*A surgical drain is a tube used to remove pus, blood or other fluids from a wound or cavity. Drains may be attached to a suction machine or they may drain by self suction or gravity.** Know the purpose of the drain
* Record the amount of drainage
* Clean the drain insertion site
* Monitor temperature
* Check insertion site at the beginning of shift and after repositioning the resident
* Report observations and resident response to the nurse
* Care of residents with immobilizing devices:
* Know the purpose for the device
* Monitor the resident’s skin under the device
* Report observations and resident response to the nurse
* Care of residents on a ventilator:
* Know the purpose of the ventilator therapy
* Ask for assistance when repositioning the resident
* Report observations and resident response to the nurse
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