TOPIC 1: HEALTH CARE DELIVERY

1. **The Health Care System is composed of different parts designed to work together to make health care accessible to everyone**. The health care system includes:
   a. Hospitals – provide acute care (treatment for illnesses which come on suddenly and are usually of short duration) and either general or specialized care (children's, cancer, psychiatric, AIDS).
   b. Doctor's offices and Clinics – provide maintenance and preventative care.
   c. Rehabilitation/Convalescent Care Facilities – provide subacute care (treatment for illnesses after acute phase).
   d. Long Term Care Facilities – provide long term care (treatment for chronic illnesses that may develop slowly and continue for long periods of time). Many residents are elderly but an increasing number of residents are younger.
   e. Home Health Agencies – provide care within the person's home.
   f. Hospices – provide terminal care (treatment for the dying person to improve comfort and quality of life).

2. **Long Term Care is provided in nursing facilities, psychiatric facilities and facilities for persons with special needs**. Long term care facilities:
   a. Provide a home-like and safe living environment with daily routines designed to meet the resident's specific needs.
   b. Coordinate resident care through the efforts of the health care team.
   c. Provide health care, restorative care, and maintenance care.
   d. Provide activities and entertainment for the residents.
   e. Are subject to inspections by the federal government, the state department of health, and local health and fire departments.

3. **The Health Care Team is a group of professionals and non-professionals with special skills who work together to meet a resident's needs**. The team approach creates the highest quality of care because information is shared, care is coordinated, and a comprehensive care plan is developed for each resident. Team members may include some or all of the following depending on each resident's needs:
   a. Resident – efforts made to meet needs and maintain quality of life.
   b. Resident's Family – provides information about resident to staff; may make decisions if resident is unable with durable power of attorney.
   c. Physician – responsible for treatment of disease and illness.
   d. Nursing Staff – monitors and promotes health of the resident, identifies needs, assists with activities of daily living (ADL's). Staff includes registered nurses, licensed practical nurses, certified nurse aides (CNAs) and qualified medication aides (QMAs).
   e. Ombudsman – resident advocate who investigates complaints and helps achieve agreement between parties.
   f. Social Worker – counsels resident, family and staff and obtains needed services.
   g. Activity Coordinator – plans and carries out appropriate activities for the resident.
   h. Physical Therapist – works with muscle groups to maintain and increase the resident's physical abilities.
   i. Occupational Therapist – works with fine motor skills to improve the resident's use of hands for all activities and communication.
   j. Speech Therapist – works with resident who has difficulty with speech, communication and swallowing.
   k. Dietician – plans menus, special diets, and monitors nutritional needs of the resident.
   l. Spiritual Counselor – provides guidance and coordinates religious services for the resident.
   m. **Administrator – manages all departments within the facility and sets policies**.
   n. Building Maintenance – keeps buildings and grounds in good repair.
   o. Laundry – cleans resident's clothing and maintains linens.
   p. Dentist – provides routine and emergency dental care for the resident.

q. Podiatrist – provides foot care for the resident.
r. Optometrist – provides eye care for the resident.
s. Respiratory Therapist – provides breathing treatment and special equipment for respiratory conditions.
t. Housekeeping – keeps the facility clean and sanitary.
u. Qualified Mental Retardation Professional (QMRP) – person who is trained and experienced in treating the mentally retarded.
v. Power of Attorney/Health Care Representative or Guardian – makes decisions regarding care if resident is unable.

4. Observations made by all members of the health care team provide the nurse with the information necessary to complete the **Minimum Data Set (MDS) which is a form used to identify the physical, mental, and psychological status of each resident**. The MDS provides the guidelines that help develop the comprehensive care plan.

5. **The Comprehensive Care Plan (care plan) is a written plan of action developed by the Health Care Team to meet each resident's highest functional, medical, nursing, mental and psychosocial needs**. The plan includes the identification of the cause and nature of a resident's needs, the short term and long term goals for the resident, the individualized approaches to reach those goals, and the disciplines responsible for monitoring those goals. The comprehensive care plan fosters Continuity of Care.

6. **CNA's role**:
   a. Provide care according to the resident's comprehensive care plan.
   b. Actively listen and communicate with the resident, the family and the health care team.
   c. Observe and report any changes in the resident's appearance, behavior or mood to the nurse.
   d. Participate in care planning when asked.

QUESTIONS:

What is the difference between an acute care facility and a long-term care facility?
What is the purpose of the Comprehensive Care Plan?
How does the CNA contribute to the Comprehensive Care Plan?

ADDITIONAL DEFINITIONS:

Maintenance Care – care that preserves function
Preventative Care – care that stops disease or injury from happening
Restorative Care – care aimed at regaining health and strength
Activities of Daily Living (ADL) – physical activities of everyday life (bathing, grooming, dressing, positioning, toileting, eating)
Advocate – one who defends the rights of another
Spiritual – the search for meaning in life usually through religion
Psychosocial Needs – need for independence, a supportive environment, recognition as an individual, spiritual fulfillment, and social interaction
Continuity of Care – getting everyone from every department on all shifts working towards the same goals using compatible methods
Actively Listen – paying attention to what is said in a conversation
Communicate – exchange information

TOPIC 2: ROLE OF THE NURSE AIDE

1. **The role of the Certified Nurse Aide is to provide for the daily care, comfort, safety and health needs of the residents. The CNA is an important member of the health care team and the nursing team**.
   a. To provide for the resident's **daily care**, the CNA assists the resident with:
      1) Bathing, dressing and grooming (Topics 17, 18, 19, 20, 21).
      2) Eating (Topic 24).
      3) Elimination (Topic 25).
      4) Transferring and ambulating (Topics 6, 15, 22, 23).
      5) Communication (Topic 4).
   b. To provide for the **resident's comfort**, the CNA should:
      1) Create a positive home-like <u>environment</u> (Topic 14).
      2) Help the resident develop <u>trust</u> (Topic 9).
      3) Offer emotional support and work with the family (Topic 13).
      4) Communicate and actively listen.
   c. To provide for the **resident's safety**, the CNA must:
      1) Follow infection control practices (Topic 5).
      2) Maintain a clean, safe environment and report safety problems immediately (Topic 7).
      3) Perform procedures correctly (as taught and mandated by ISDH).
   d. To provide for the **resident's health needs**, the CNA should:
      1) Observe and report any changes in the resident's appearance, behavior, or mood to the nurse (Topics 3, 10, 11, 12, 26).
      2) Determine measurements accurately (temperature, pulse, respirations, blood pressure, weight, intake, output and food consumption) (Topic 16).
      3) Assist the nurse during treatments, medical procedures and emergencies (Topic 8).
      4) **Respond to any <u>call light</u> immediately**.

2. A person who chooses to become a CNA must:
   a. Understand that, by law, a criminal history check will be done.
   b. Have Mantoux testing or chest X-ray and a physical examination.
   c. Complete an Indiana State Department of Health (ISDH) approved training program that includes at least 30 hours of classroom training, at least 75 hours of clinical experience, and successfully pass both a written and skills competency evaluation.

3. **The CNA must exhibit <u>ethical behavior</u>**. All health care employees are expected to behave ethically.
   a. Perform to the best of your ability.
   b. Be loyal to your employer, co-workers, residents, and their families.
   c. Be <u>accountable</u> for your actions.
   d. Carry out your supervisor's instructions.
   e. Perform only duties legally permitted.
   f. <u>Respect</u> the people and environment around you.
   g. Maintain <u>confidentiality</u>.
   h. Safeguard the resident's right to <u>privacy</u>.
   i. Keep residents free from <u>abuse</u> or <u>neglect</u>. **Report suspected abuse or neglect to the nurse immediately**.
   j. Safeguard the resident's property.
   k. Report <u>incidents</u> or errors to the nurse immediately.

4. **The CNA must be aware of and abide by the legal considerations or <u>rules of conduct</u> enacted by a governmental body**. All facilities have standards of care based on federal, state and local laws and

rules, facility policies, and current nursing practices.

5. CNA's must understand their job description. **The job description should list the tasks that a CNA is expected to perform**.

6. The CNA is expected to present a **positive personal image**. Take care of yourself before you care for others. Because of the physical and emotional demands of the job, the CNA must maintain:
   a. **Personal Health** – eat a balanced diet, get adequate rest, use good body mechanics.
   b. **Personal Hygiene** – bathe daily, use deodorant, practice good oral hygiene.
   c. **Personal Appearance** – dress professionally including clean uniform and shoes, limited jewelry, ID tag, moderate makeup, simple hair style, little or no perfume, nails that are smooth, clean and trimmed.
   d. **Personal State of Mind** - since the job is stressful, talk about feelings and emotions, identify what is stressful, feel sad when appropriate, set priorities. Personal behavior on personal time is still a reflection on the employer.

7. **To maintain certification**, the CNA must:
   a. Be offered at least 12 hours of inservice education per year.
   b. Work for a health care provider at least one eight hour shift every twenty-four months.
   c. **Never have a verified complaint against them on the registry. If a complaint of abuse or misappropriation of resident's property or funds is found to be valid, the CNA will loose their certification in all 50 states permanently**. If found guilty of neglect the CNA will not be allowed to work as a CNA for two to five years.
   d. Be evaluated yearly and offered inservice education on their weaknesses.

QUESTIONS:

How does a CNA provide for a resident's comfort?
What must a person do to become a CNA and maintain certification?
Explain ethical behavior.
Explain accountability.
What is confidentiality?
What must a CNA do to present a "positive personal image"?
List the reasons why a CNA would have a complaint on the Nurse Aide Registry.

ADDITIONAL DEFINITIONS:

Environment – surroundings
Trust – to have confidence and faith in, to rely on
Call Light – a means of communicating with staff to get help
Ethical Behavior – doing what is right according to the rules of conduct of a particular group
Accountable – being responsible for your own choices (words and actions)
Respect – to treat with courtesy and consideration
Confidentiality – keeping information secret
Privacy – freedom from outsiders entering and watching without your consent
Abuse – an act that causes harm
Neglect – failure to act in a reasonable and caring manner.
Incident – any unusual event (falls, theft, errors) that occurs in the health care facility
Current Nursing Practices – up-to-date, proven and accepted ways of providing nursing care
Stress - pressure or strain that disturbs a person's mental or physical well being
Inservice Education – opportunities for learning offered by an employer
Verified Complaint – wrong doing that has been proven

TOPIC 3: OBSERVING AND REPORTING

1. **Observing and reporting is the most important way the CNA assists the nurse and other members of the health care team to identify the needs of the residents**.
   a. **Observing is the gathering of bits of information about a resident through the use of the senses and feelings**. The information provides knowledge about the resident's condition and response to care. Methods of observation include:
      1) **Objective observation** includes data available through the senses.
         Sight - rash, swelling, diarrhea, skin color change, unconsciousness.
         Sound - cough, irregular heartbeat, moans of pain.
         Smell - foul odor from a wound, bad breath, unusual odors from urination or defecation.
         Touch - fever, change in pulse, swelling or lump under the skin.
      2) **Subjective observation** includes information reported by a resident about how he or she is feeling. Statements such as "I'm tired," "I'm dizzy," "I can't see," "My ears are ringing".
      3) Accurate observations include detailed information and improve the quality of care.
      4) Observations that **indicate an acute condition requiring immediate attention** from the nurse include but are not limited to :

severe pain	anxiety	mood swings	any sudden change in condition
fall or accident	confusion	depression	skin tears or bruises
signs of shock	odor	loss of control	loss of consciousness
seizures	swelling	hemorrhage	difficulty breathing

   b. **Reporting means verbally informing the person in authority (the nurse) about resident care and what has been observed**. Telling another CNA or a QMA about an observation is not reporting.
      1) Report should include the resident's name, room and bed number and detailed descriptions of the observation. Reporting may be:
         (a) **Objective**-stating what is seen, smelled, heard or felt including exactly what the resident says.
         (b) **Subjective** – stating what cannot be observed by the senses but rather a feeling about something that doesn't seem right ("Mrs. Jones seems uncomfortable.").
      2) **Routine reporting** is usually done at the end of the shift. Routine information is not of immediate importance. Include information about the resident and the care given. Before reporting, ask:
         (a) Did I meet each resident's needs?
         (b) Was there anything new or changed?
         (c) What did I see, hear, smell, or touch?
      3) **Immediate reporting** must be done at the time the observation is made and includes:
         (a) Dangerous situations (i. e., frayed cord, loose handrails, broken equipment).
         (b) Unusual observations (i. e., high temperature, skin changes especially any red or open areas).
         (c) Unusual incidents (i. e., falls, signs or suspicions of abuse).
         (d) Resident complaints of ill health (i. e., dizziness pain).

2. **Documentation is the written account of a resident's condition**. Documentation can include charts, worksheets and facility records. Documentation is considered a permanent legal record of the resident's condition and the care given. **The CNA is legally responsible for recording complete and accurate details of the care given**. If it isn't documented, legally it wasn't done.
   a. Guidelines for Documentation:
      1) Resident's name must be on each page before anything else is written.
      2) Write all entries in ink - not pencil or felt tip - neatly and legibly.
      3) Make sure all entries are accurate. Use quotation marks when reporting what the resident said. Document only what you observe and perform.
      4) Documentation must be in chronological order.
      5) Never document before a procedure is completed.

6) Do not leave spaces or skip lines between entries to prevent altering of document.
7) Use standard medical terminology and standard abbreviations - no ditto marks.
8) Time and date all entries, and sign with your name and title.
9) Never document for someone else.

b. Guidelines for Correcting Documentation.
   1) Draw a single line through error. What was written should remain readable. Never use correction fluid.
   2) Print word "error". Initial and date the correction.

3. **CNA's Role**:
   a. Use your senses to observe physical changes.
   b. Use your active listening skills to observe any changes the resident may say they are experiencing.
   c. Report any unusual findings to the nurse immediately.
   d. Always document according to current nursing practices.

QUESTIONS:

How does a CNA assist the health care team to identify the needs of the resident?
What is the difference between an objective and subjective observation?
To whom does the CNA report?
Give examples of observations that should be reported immediately.
What is the procedure for correcting an error in documentation?

ADDITIONAL DEFINITIONS:

Accurate – correct, exact
Legally Responsible – accountable by law for one's actions
Chronological Order – the sequence in which events occur
Medical Terminology – the specific language of medicine
Abbreviation – a shortened form of a word

TOPIC 4: COMMUNICATION AND INTERPERSONAL SKILLS

1. **Communication is the exchange of information and messages**. Communicating with residents, families and co-workers is the responsibility of every member of the health care team. Effective communication completes a cycle between two people. Four elements necessary for successful communication include:
   a. Sending the message through:
      1) **Verbal communication** - written or spoken words.
      2) **Nonverbal communication** – facial expressions, tone of voice, posture, gestures, touch (body language) or call light.
   b. Formulating the message – must be organized, complete and understandable.
   c. Receiving the message – listener must prepare to receive the message, concentrate on the content and actively listen.
   d. Observing the feedback – sender must interpret the verbal and nonverbal response of the listener. **What is observed may be more important than what is heard.**

2. To make it easier for others to understand what is being communicated:
   a. Speak clearly and slowly using a gentle tone.
   b. Be at eye level looking directly at the person with whom you are speaking.
   c. Use appropriate nonverbal communication.
   d. Use language with which the listener is familiar. Use words with only one meaning. Allow time for the listener to process the information.
   e. Give facts, not opinions, unless specifically requested.
   f. Make messages logical and brief.
   g. Repeat a message, using exactly the same words, if necessary.

3. **Good listening skills** allow you to learn more about the people around you. **Active listening promotes good relationships**. To actively listen:
   a. Use body language that shows interest and concern (eye contact, lean forward).
   b. Avoid interrupting the speaker. Let the person finish his thought.
   c. Give the speaker feedback, both verbal and nonverbal, to show that you are actively listening.
   d. Avoid judging the other person based on your own personal opinions and beliefs.

4. **Barriers to communication** include:
   a. **Cultural differences** - beliefs, values, habits, diet and health practices that relate to a person's culture or religion.
   b. **Age** - people of different ages and eras with different values and communication styles.
   c. **Impairments** – physical and/or mental limitations requiring special considerations when communicating.
      1) **A person who is blind relies on verbal cues, including words and tone of voice**.
         (a) State your name before beginning a conversation.
         (b) Describe persons, things and environment.
         (c) Tell the resident when you are entering or leaving the room.
         (d) Explain in detail what you are doing and ask the resident what he would like to do for himself.
         (e) Touch the resident if appropriate.
         (f) Read resident's mail or personal documents if asked.
         (g) Sit where resident can easily see you if resident has partial vision.

2) **A person who is hearing impaired relies on nonverbal cues including body language, sign language, and writing**.
   (a) Speak slowly and distinctly.
   (b) Use short sentences.
   (c) Face the resident.
   (d) Be certain that the light source is on you and behind the resident.
   (e) Use facial expressions and gestures.
   (f) Reduce outside distractions.
   (g) Use sign language and message boards if appropriate.
   (h) Be certain that the resident's hearing aid is in and working properly, if applicable.
3) A person who is cognitively impaired relies on both verbal and nonverbal cues and may need messages repeated frequently, using short sentences and simple words.

5. **Interpersonal skills needed to form positive relationships between people include**:
   a. **Patience -** the capacity to be even-tempered and calm.
   b. **Courtesy -** the capacity to have respect and consideration for others.
   c. **Tact –** a sense of what to do or say in order to maintain good relations with others and avoid offense.
   d. **Empathy -** the ability to understand another's point of view and share in another's feelings or emotions.

6. **CNA's role**:
   a. Always use tact.
   b. Use gestures and posture to show you care.
   c. Use touch to communicate comfort, caring, and understanding.
   d. Practice active listening.
   e. Be patient with residents who have difficulty communicating.
   f. Develop positive relationships with residents and coworkers.
   g. Never say, "I know how you feel" because you don't!
   h. Always include the resident in conversation if more that one CNA is assisting in care.
   i. Verbally communicate with an unconscious resident.
   j. Always offer choices.
   k. Be supportive when a resident is transferred or discharged.

QUESTIONS:

What are the four elements necessary for successful communication?
Explain verbal and nonverbal communication.
Define active listening.
What are three barriers to good communication?
List factors affecting communication with residents who are impaired.
Explain interpersonal skills.

ADDITIONAL DEFINITIONS:

Barrier – anything that hinders or blocks
Culture – values, beliefs and customs passed on from generation to generation by a group of people
Impairment – diminished function
Sign language – a method of communication using hand signals usually used to communicate with the deaf
Cognitively Impaired – diminished mental capacity for awareness and ability to make correct judgements

TOPIC 5: INFECTION CONTROL

1. **Infection Control means preventing the spread of microorganisms by following certain practices and procedures**. Microorganisms:
   a. Compose the largest population of life forms on earth.
   b. Are everywhere – water, air, soil, plants, animals, minerals, humans.
   c. Cannot be seen with the naked eye.
   d. May be harmful – harmful microorganisms that may cause infection are called pathogens (germs) and include bacteria, viruses, fungi, protozoa.

2. **The "infection chain" explains how pathogens move from one place to another**. The six links which make up the chain include the:
   a. **Pathogen** – the causative agent: bacteria, viruses, fungi, and protozoa.
   b. **Reservoir** – the place where pathogens live and multiply (**especially places that are warm, dark and moist**): on linen, medical equipment, surfaces, animals and humans.
   c. **Portal of exit** – the way pathogens leave the body: in urine, feces, saliva, tears, drainage from wounds, sores, blood, excretion from respiratory tract or genitals.
   d. **Route of transmission** – how pathogens travel: through the air, in contaminated soil and water, on objects (dirty linen, your uniform, equipment), by insects (flies, mosquitoes, maggots), and on people, especially on hands.
   e. **Portal of entry** – the way pathogens get into the body: mouth, nose, skin breaks, urinary tract and anus.
   f. **Susceptible host** – the person who can be infected: the very young, the elderly, persons who are not in good health, people who are exposed to large numbers of pathogens, and people who do not follow proper infection control practices.

3. Breaking the chain of infection controls the spread of infection. To prevent the spread of infection at work:
   a. Use good handwashing technique. **Handwashing is the best way to prevent the spread of infection**.
   b. Follow employee health policies - stay home when ill, take advantage of vaccines such as flu and Hepatitis Vaccine, have a Mantoux test or chest X- ray as indicated, know the facility's exposure plan.
   c. Take care of yourself - good personal hygiene, good nutrition, adequate fluid, rest and exercise.
   d. Practice medical asepsis - keep clean away from dirty, handle linen properly, remove and clean dirty articles and equipment quickly, handle food and food tray properly.
   e. Follow rules for disposal of medical waste - handle and dispose of sharps safely according to current nursing practices and local and state laws.
   f. Separate persons with infections from others, which helps prevent nosocomial infection.
   g. Kill germs - disinfect or sterilize equipment, surfaces, dishes and utensils.
   h. Use Standard Precautions.

4. **Standard Precautions are guidelines developed by the Center for Disease Control (CDC) to reduce the risk of transmission of pathogens from both known and unknown sources of infection in a health care setting**. Every person is treated as potentially infectious. Sources of infection include: blood, all body fluids, secretions and excretions (except sweat) regardless of whether or not they contain visible blood, non-intact skin, and mucous membranes. Standard Precautions include:
   a. Wearing gloves when indicated for resident care.
   b. Wearing a gown, apron, mask and protective eyewear in situations or during procedures where indicated.
   c. Washing your hands at appropriate times.
   d. Transporting infected residents using indicated safeguards.
   e. Cleaning common use equipment between residents.

5. **Isolation (Transmission Based) precautions** may be ordered to prevent the transmission of pathogens.
   a. **Airborne precautions** – pathogens are transmitted on dust particles in air currents. Examples include tuberculosis, chickenpox and measles.
   b. **Droplet precautions** – pathogens are transmitted in droplets when a person coughs, sneezes or talks. Examples include pneumonia, influenza and scarlet fever.
   c. **Contact precautions** – pathogens are transmitted by direct contact (skin to skin) with the resident or indirect contact with surfaces or care items in the resident's environment. Examples include conjunctivitis, scabies, and impetigo.

6. Some infections of concern in Long Term Care include:
   a. **Hepatitis** - contagious disease of the liver caused by a virus and spread by exposure to infected blood, sexual contact and fecal/oral contact. Symptoms are flu-like. Severe infection can cause permanent liver damage and death.
   b. **Scabies** – skin infection caused by a mite and spread by direct contact. Symptoms include itching, skin irritation in the form of a rash. All contacts, bedding and clothing must be treated to prevent spread and re-infestation.
   c. **Tuberculosis (TB)** – chronic bacterial infection that usually affects the lungs but may affect other parts of the body such as the kidneys, bones and brain. TB is spread through air in droplets from sputum of persons with active disease. Symptoms include fever, loss of appetite, fatigue, productive cough and night sweats.
   d. **Acquired Immune Deficiency Syndrome (AIDS)** – results from infection with Human Immunodeficiency Virus (HIV) which destroys the body's ability to fight infection. The virus is spread through infected blood and body fluid. Early symptoms are flu-like followed by a symptom free period which can last many years (one to ten or more). No cure is known, however new drugs and treatments show promise.
   e. **Methicillin Resistant Staphlococcus Aureus (MRSA)** – bacteria that no longer responds to antibiotics normally used to treat staphlococcal infections. It is spread on the hands of health care workers. To prevent the spread follow Standard Precautions.

7. **CNA's role**:
   a. Wash your hands before and after performing procedures, using the bathroom, eating, serving food or feeding a resident.
   b. Clean spills quickly.
   c. Follow standard precautions.
   d. Remove gloves immediately after completing a procedure and wash your hands.
   e. Never wear gloves in the hallway unless you have a rash, open sore, or are transporting an infected person.
   f. Keep the environment clean.
   g. Use isolation techniques when ordered and follow directions on posted signs.
   h. Keep linen away from uniform.
   i. Consider all blood, body fluids and excrement contaminated.

QUESTIONS:

Define pathogens and give examples.
Explain infection control.
What is the best and easiest way to prevent the spread of infection?
What is a nosocomial infection?
What are Standard Precautions?
When should gloves be worn during resident care?
What is the purpose of isolation precautions?

ADDITIONAL DEFININTIONS:

Microorganism –a tiny living thing which can only be seen with a microscope
Pathogen – microorganism capable of producing disease
Vaccine – weakened or killed disease-producing organism taken orally or by injection to protect against disease
Mantoux Test – skin test to determine past or present exposure to Tuberculosis
Personal Hygiene – cleanliness including bathing, using deodorant, mouth care and wearing clean clothing
Sharps – any piece of medical equipment that has the potential to cut or puncture the skin
Nosocomial Infection – an infection acquired during a stay at a health care facility
Disinfect – using chemicals or boiling water to reduce the number of microorganisms
Sterilize – process of killing all microorganisms (done by steam or chemical solutions)

RELATED PROCEDURES:

PROCEDURE 1: HANDWASHING

STEP	RATIONALE
1. Turn on faucet with a clean paper towel	1. Faucet may be used by residents/visitors and should be kept as clean as possible
2. **ADJUST WATER TO ACCEPTABLE TEMPERATURE**	2. Hot water opens pores which may cause irritation
3. Angle arms down holding hands lower than elbows. Wet hands and wrists	3. The hands are most contaminated. Water should run from cleanest to dirtiest
4. Put soap in hands	
5. **LATHER ALL AREAS OF HANDS AND WRISTS, RUBBING VIGOROUSLY FOR AT LEAST 10 SECONDS**	5. Lather and friction loosen skin oils and allow pathogens to be rinsed away
6. **CLEAN NAILS BY RUBBING THEM IN PALM OF OTHER HAND**	6. Most pathogens on hands come from beneath the nails (McGinley et al, 1988)
7. **RINSE THOROUGHLY, RUNNING WATER DOWN FROM WRISTS TO FINGERTIPS**	7. Wrists are cleanest, fingertips dirtiest. Soap left on skin may cause irritation and rashes
8. Pat dry with paper towel	8. Skin may chap if left damp
9. **TURN OFF FAUCET WITH PAPER TOWEL AND DISCARD TOWEL IMMEDIATELY**	9. Hands will be recontaminated if you touch the dirty faucet with clean hands or if the towel is used after turning off the faucet

PROCEDURE 2: GLOVES

STEP	RATIONALE
1. Wash hands (according to procedure 1)	
2. Put on gloves	
3. Check for tears	3. Damaged gloves do not protect you or the resident
4. Perform procedure	
5. **REMOVE ONE GLOVE BY GRASPING OUTER SURFACE JUST BELOW CUFF**	5. Both gloves are contaminated and should not touch unprotected skin
6. **PULL GLOVE OFF SO THAT IT IS INSIDE OUT**	6. The dirtiest part of glove is concealed
7. **HOLD THE REMOVED GLOVE IN YOUR GLOVED HAND**	
8. **PLACE TWO FINGERS OF UNGLOVED HAND UNDER CUFF OF OTHER GLOVE AND PULL DOWN SO FIRST GLOVE IS INSIDE SECOND GLOVE**	8. Touching the outside of the glove with an ungloved hand causes contamination
9. **DISPOSE OF GLOVES WITHOUT CONTAMINATING HANDS**	9. Hands may be contaminated if gloves are rolled or moved from hand to hand
10. **WASH HANDS** (according to procedure 1)	

TOPIC 6: BODY MECHANICS

1. **Body mechanics means using the body properly to coordinate balance and movement**. Using proper body mechanics:
   a. Maximizes strength and minimizes stress allowing the CNA's body to be used efficiently.
   b. Prevents injury to the CNA when bending, moving and lifting.
   c. Reduces fatigue for the CNA at the end of the workday.
   d. Promotes safety for the CNA and the resident during moves.

2. **Mechanisms that affect** moving include:
   a. **Center of gravity** - the pelvis is the center of gravity and maintains balance and stability.
   b. **Base of support** - the feet are the base of support and should be approximately 18 inches or shoulder width apart to support the body during the move.
   c. **Friction** - affects the amount of effort needed to move something. More friction under the feet increases stability. Less friction under what is being moved decreases the effort needed to move it. Avoid lifting objects. Push, pull, or slide objects if possible.

3. **General principles** include:
   a. Bend the knees, keep the back straight.
   b. Keep the load close to you.
   c. Lift smoothly using leg muscles. Don't jerk.
   d. Never lift and twist at the same time.

4. What to consider before lifting and moving:
   a. **Survey the area**: remove clutter to reduce the chance of accident and injury. Adjust height of bed up for care, down for transfer. Lock wheelchair and bed brakes for safety.
   b. **Assess the load** to be lifted: assess both weight and height. If unsure of your ability or resident's ability talk with the nurse and review the plan of care.
   c. **Plan and think through the move**: prepare the move. Bring the resident close to you by moving the resident to edge of the bed with feet on the floor.
   d. **Communicate**: explain what you are going to do and always move on a count of one, two, three.

5. **What to consider during the lift**:
   a. Take a deep breath before lifting and exhale during the lift which helps pump blood to the lungs and oxygen to the muscles.
   b. Tighten the abdominal muscles. Pull in the stomach to support the spine.
   c. Move smoothly. Counting to three allows the CNA and the resident to move at the same time. Jerking could injure both the CNA and the resident. Stop if any team member is not ready for the lift.
   d. Don't lift and twist at the same time. Once you straighten your knees, pivot around by repositioning your feet as you turn.

6. **CNA's role**:
   a. Always tell the resident what you are doing.
   b. Always move the resident on the count of three.
   c. If in doubt, get help. Offer to help others.
   d. Report injuries to the nurse immediately.

QUESTIONS:

What should be considered before lifting or moving a resident?
Define the general principles of good body mechanics.
Why is the count of three important when moving a resident?
What two movements should not be done at the same time?
Why are proper body mechanics so important for the CNA?
What are the alternatives to lifting an object or person?
What should a CNA consider before lifting a resident?
What should be done if an injury occurs during a lift?

ADDITIONAL DEFINITIONS:

Efficient – using the least amount of effort to accomplish a task
Pelvis – the hip area
Balance – a state of being stable
Friction – rubbing one surface against another
Assess – to evaluate or check

TOPIC 7: SAFETY

1. **Providing an environment in which the resident feels safe and secure is an important goal of every member of the health care team**.

2. **To promote safety**:
   a. **Be aware of the environment**:
      1) Keep the traffic patterns clear in residents' rooms and hallways.
      2) Walk. Never run. Stay to the right.
      3) Clean up spills immediately. Use "Wet Floor" signs if necessary.
      4) Check for frayed electrical cords but **do not attempt repairs**.
      5) Check that equipment is working properly before using.
      6) Use equipment safely and according to manufacturer's guidelines.
      7) **Never use electrical equipment near water or oxygen**.
      8) Approach swinging doors with care.
      9) Report potentially hazardous conditions to the nurse immediately.
   b. **Visit all residents frequently**:
      1) Be certain the call light is on resident's unaffected side and within reach.
      2) **Answer any call light immediately**.
   c. **Follow good infection control practices**:
      1) Wash hands properly.
      2) Use Standard Precautions at all times during the workday.
      3) Handle linen and equipment according to proper infection control practices.
   d. **Be aware of your body and the resident's body when moving a resident**:
      1) **Use good body mechanics**.
      2) Never turn a resident toward the side of the bed with the side rail down. Raise the side rail, walk to the other side of the bed and assist the resident to turn toward the raised side rail.
      3) Never lean over a resident in bed to do any procedure. Discomfort and injury to both the CNA and the resident can result. The linen and your uniform can cross contaminate.
      4) Be certain the resident is wearing shoes or slippers with rubber soles when getting out of bed.
      5) Have resident sit on the side of the bed with feet flat on the floor 10-15 seconds and check for dizziness before moving.
      6) Never move a resident by grabbing him under the arm.
      7) Place pillow against headboard when moving a resident up in bed.
      8) Ask resident to help as much as possible.
      9) Move resident on a count of "one, two, three".
   e. **Understand that side rails can be considered**:
      1) **A safety aid** and must be up if bed is elevated to working height.
      2) **A self help device** to assist the resident to move independently.
      3) **A restraint** if used for the sole purpose of confining the resident in bed and requires a doctor's order.
   f. **Use protective devices (restraints, safety devices) only under the following rules**:
      1) A specific doctor's order is required.
      2) A protective device must be used according to the manufacturer's guidelines including a quick release knot.
      3) A restraint must be checked for proper fit and comfort by placing the open hand flat between the resident and the restraint.
      4) Residents in restraint must be visited at least every hour and the restraint released at least every two hours with some type of activity provided.

g. **Use extreme caution when oxygen is in use**.
   1) Oxygen is highly flammable. Never use electrical appliances near oxygen.
   2) Keep open flames (matches, lighter, cigarettes) away from oxygen.
   3) "No Smoking, Oxygen In Use" signs must be posted on the inside and outside of the resident's door.

h. Before beginning any procedure, **check the resident's identity.**
   1) Call resident by name and observe for a response.
   2) Check identification bracelet, and/or photo ID, if applicable.

3. **CNA's Role**:

a. Be aware of safety at all times.
b. Observe and report unsafe situations to the nurse immediately.
c. Always practice proper infection control.
d. Use proper body mechanics.
e. Use side rails as directed by the nurse.
f. Identify each resident before beginning a procedure.
g. Understand that safety is an important consideration for the CNA and the resident.
h. Document the release and activity of resident in restraint according to current nursing practices.

QUESTIONS:

How does the CNA promote safety in the resident's environment?
Why is it important to avoid leaning over a resident?
What is a side rail considered to be?
When can a protective device be used?

DEFINITIONS:

Traffic Pattern – usual path taken in a room or hallway
Side Rail (guard rail) – metal or plastic rails on the sides of hospital beds
Cross Contamination – spread of different pathogens between two surfaces
Restraint – device or method including chemical means used to limit the activity or aggressiveness that could be harmful to the resident or others

RELATED PROCEDURES:

PROCEDURE 9: PROTECTIVE DEVICES

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **APPLY VEST ACCORDING TO MANUFACTURER'S DIRECTIONS**	2. If device is not applied according to manufacturer's directions, legally you are responsible for injuries
3. **APPLY SOFT BELT ACCORDING TO MANUFACTURER'S DIRECTIONS**	3. If device is not applied according to manufacturer's directions, legally you are responsible for injuries
4. **FASTEN WITH QUICK RELEASE TIE TO MOVEABLE PART OF BED FRAME OR KICK SPURS OF WHEELCHAIR**	4. In an emergency, tie must release quickly. Device must move with resident if head of bed is elevated. When fastened to kick spurs, belt is at 45^{o} angle, reducing pressure on the diaphragm
5. **PLACE OPEN HAND FLAT BETWEEN RESIDENT AND PROTECTIVE DEVICE**	5. Ensures that device fits properly and is comfortable for the resident
6. **DO FINAL STEPS**	
7. **VISIT RESIDENT AT LEAST EVERY HOUR AND RELEASE PROTECTIVE DEVICE AT LEAST EVERY TWO HOURS**	7. Meets regulations. Visiting includes observing resident for safety and comfort and spending time communicating with resident. Releasing includes removing device, assisting with Activities of Daily Living and repositioning

TOPIC 8: EMERGENCIES

1. **An emergency is a sudden, unexpected severe problem that endangers people**. Emergencies can occur anywhere at anytime. Remain calm and know what to do.

2. Fire is a major concern in any building where large numbers of people live and work. **Three things necessary to start a fire are fuel (anything that will burn, i.e. paper, cloth, or grease), heat (a spark or flame), and oxygen (air).** If all three are present at the same time, in the same place, a fire will result.
   a. Common causes of fire in a health care facility are: faulty electrical wiring or equipment (overloaded circuits and plugs not properly grounded), and careless or unsupervised smoking.
   b. To prevent fires:
      1) Follow precautions for oxygen use:
         (a) Post "No Smoking, Oxygen In Use" signs on the inside and outside of the room door.
         (b) Do not allow any smoking or open flames near oxygen.
         (c) Do not use electrical appliances such as electric razors, hair dryers.
         (d) Remove flammable liquids from the room.
         (e) Use cotton instead of wool or synthetics that can cause static electricity.
      2) Follow smoking regulations:
         (a) Smoke only in designated areas.
         (b) Never leave smoking materials at the bedside of confused or sedated residents.
         (c) Provide ashtrays and dispose of contents into approved containers (metal with sand or water).
         (d) Supervise smoking of residents who cannot protect themselves.
   c. Actions necessary in the event of a fire include:
      1) **R**=remove residents from the immediate fire area to safety.
         A=activate the alarm.
         C=contain the fire by closing all doors and windows.
         E=extinguish the fire.
      2) Know how to use the facility fire extinguishers:
         (a) **Extinguishers are rated A, B or C according to the type of fire they put out**:
         A=paper, wood, cloth **B**=oil, grease **C**=electrical
         Most extinguishers in health care facilities are ABC (good for any type of fire).
         (b) To use an extinguisher:
         P=pull pin **A**=aim nozzle **S**=squeeze handle **S**=sweep from side to side
      3) Additional points to remember include:
         (a) Never use an elevator in the event of a fire.
         (b) Avoid smoke inhalation. Stay low and cover your mouth with a wet cloth.
         (c) If your clothing catches on fire, **STOP, DROP and ROLL** to smother the flames.

3. Resident emergencies such as choking, falls, shock, burns, seizures, fainting, hemorrhage or cardiac arrest require immediate action:
   a. Know your limitations. Do not perform any procedure for which you have not been trained.
   b. Call for assistance immediately.
   c. Remain calm and reassure the resident.
   d. Observe the resident for life threatening problems (breathing, pulse, bleeding).
   e. Keep the resident in the same position. Movement could cause further injury.
   f. Keep the resident warm.
   g. Do not give the resident any food or fluids.
   h. Follow the nurse's instructions.

4. Points to remember when responding to specific resident emergencies:
   a. **Choking** – a complete blockage of the airway requiring immediate action.
      1) The resident cannot breathe, speak or cough and has no chest movement.
      2) The resident gasps or clutches at the throat (the universal sign for choking).
      3) The procedure used on an adult is the "Heimlich procedure" or abdominal thrust. Knowing this procedure is required of all CNAs.
   b. **Falls** – preventing falls is the best way to avoid serious injury. If a resident begins to fall, never try to stop the fall. Gently ease the resident to the floor and :
      1) Call for help immediately. Keep the resident in the same position until the nurse examines the resident.
      2) Be calm, reassure the resident and follow nurse's instructions.
   c. **Shock** – occurs when vital parts of the body (brain, heart, and lungs) do not get enough blood.
      1) Call for help immediately.
      2) Keep the resident lying down.
      3) If bleeding is external, apply direct pressure to the bleeding site using Standard Precautions.
      4) Keep the resident warm and reassure her/him.
   d. **Burns** – smoking, spilled hot liquids and bath water that is too hot are some causes of burns.
      1) Call for help immediately.
      2) Follow nurse's instructions.
   e. **Seizures** (convulsions) – are sudden contractions of muscles due to a disturbance in brain activity.
      1) Call for help and stay with the resident.
      2) Protect the resident from injury.
      3) Never restrain the resident or place anything in the mouth.
      4) Loosen clothing, especially around the neck.
      5) After the seizure, turn the resident to the side to prevent choking and allow the resident to rest.
      6) Observe and report (time and duration of seizure).
   f. **Poisoning** – many products in a health care facility are dangerous if used improperly.
      1) Never use anything from an unlabeled container.
      2) In case of suspected poisoning, take container to the nurse immediately.
      3) Keep toxic substances and cleaning supplies locked and out of reach of the resident.
      4) Call for help and report observations to the nurse.
   g. **Fainting** – sudden loss of consciousness because of inadequate blood supply to the brain. Causes include hunger, fatigue, pain, fear. Dizziness, and perspiration are symptoms.
      1) Call for help.
      2) Have resident sit or lie down before fainting occurs. If sitting, have resident bend forward and place head between knees. If lying down slightly elevate resident's legs.
      3) Loosen tight clothing.
      4) Keep resident lying down until checked by the nurse.
   h. **Hemorrhage** – excessive loss of blood from a blood vessel.
      1) Use Standard Precautions.
      2) Apply direct pressure over the area with a sterile dressing or a clean piece of linen.
      3) Stay with resident and follow the nurse's instruction.
   i. **Cardiac Arrest** – heart function and circulation stop. Resident is unresponsive, no chest movement or pulse, pupils dilated and fixed, skin may be cyanotic.
      1) Touch or tap collar bones and ask the resident "Are you okay?"
      2) Check breathing. If breathing has stopped, call for the nurse.

5. **A disaster is a sudden event in which property is destroyed and many people may be killed or injured**. Floods, tornadoes, earthquakes, hurricanes and blizzards are natural disasters. Fires, explosions, train and air accidents are considered man-made disasters.

a. Know the community and facility disaster plans.
b. Know and follow specific facility policies and procedures relating to disasters.
c. Know the facility evacuation plan.
d. Remain calm.
e. Remove residents from immediate danger.
f. Follow the nurse's instructions.
g. Remove records for safekeeping as directed.

6. **CNA's Role**:
   a. Know where the facility pull boxes and fire extinguishers are located.
   b. Be informed about facility procedures regarding fire and other emergencies.
   c. Remain calm in any emergency.
   d. Always talk to the resident to reassure him.
   e. Call for help as soon as you notice an emergency.

QUESTIONS:

Explain RACE.
What three things are necessary to start a fire?
Describe the three types of fire extinguishers.
What is the universal sign that indicates choking?
List five natural disasters for which the CNA should be prepared.

ADDITIONAL DEFINITIONS:

Static electricity – the electricity produced by charged bodies
Sedate –state of calm and quiet induced by medication
Extinguish – to put out
Smoke Inhalation – a condition caused by breathing smoke into the lungs
Universal – common to all situations or conditions
Direct Pressure – applied force to a surface
Evacuation – to remove from a place for safety reasons

RELATED PROCEDURES:

PROCEDURE 45: CHOKING

STEP	RATIONALE
1. **CALL FOR NURSE AND STAY WITH RESIDENT**	1. Allows you to get help yet continuously provide for resident's safety and comfort
2. **ASK IF RESIDENT CAN SPEAK OR COUGH**	2. Identifies sign of a blocked airway (not being able to speak or cough)
3. **IF NOT, MOVE BEHIND RESIDENT AND SLIDE ARMS UNDER RESIDENT'S ARMPITS**	3. Puts you in correct position to perform procedure
4. **PLACE YOUR FIST WITH THUMBSIDE AGAINST ABDOMEN MIDWAY BETWEEN WAIST AND RIBCAGE**	4. Positions fist for maximum pressure with least chance of injury to resident
5. **GRASP YOUR FIST WITH YOUR OTHER HAND**	5. Allows you to stabilize resident and apply balanced pressure
6. **PRESS YOUR FIST INTO ABDOMEN WITH QUICK INWARD AND UPWARD THRUSTS**	6. Forces air from lungs to dislodge object
7. **REPEAT UNTIL OBJECT IS EXPELLED**	
8. **DO FINAL STEPS**	
9. **ASSIST WITH DOCUMENTATION ACCORDING TO CURRENT NURSING PRACTICES**	9. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen

PROCEDURE 46: FIRE

STEP	RATIONALE
1. **REMOVE RESIDENTS FROM AREA OF IMMEDIATE DANGER**	1. Residents may be confused, frightened or unable to help themselves
2. **ACTIVATE FIRE ALARM**	2. Alerts entire facility of danger
3. **CLOSE DOORS AND WINDOWS TO CONTAIN FIRE**	3. Prevents drafts that could spread fire
4. **EXTINGUISH SMALL FIRE WITH FIRE EXTINGUISHER IF POSSIBLE**	4. Prevents fire from spreading
5. **FOLLOW ALL FACILITY POLICIES**	5. Facilities have different methods of dealing with emergencies. You need to follow the procedures for your facility

PROCEDURE 47: SEIZURES

STEP	RATIONALE
1. **CALL FOR NURSE AND STAY WITH RESIDENT**	1. Allows you to get help yet continuously provide for resident's safety and comfort
2. **PLACE PADDING UNDER HEAD AND MOVE FURNITURE AWAY FROM RESIDENT**	2. Protects resident from injury
3. **DO NOT RESTRAIN RESIDENT OR PLACE ANYTHING IN MOUTH**	3. Any restriction may injure resident during seizure
4. **LOOSEN RESIDENT'S CLOTHING ESPECIALLY AROUND NECK**	4. Prevents injury or choking
5. **AFTER SEIZURE STOPS, POSITION RESIDENT ONTO SIDE**	5. Allows saliva to drain from mouth so resident doesn't choke
6. **NOTE DURATION OF SEIZURE AND AREAS INVOLVED**	6. Provides nurse with necessary information to properly assess resident's condition and needs
7. **DO FINAL STEPS**	
8. **ASSIST WITH DOCUMENTATION ACCORDING TO CURRENT NURSING PRACTICES**	8. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen

PROCEDURE 48: FALLING OR FAINTING

STEP	RATIONALE
1. **CALL FOR NURSE AND STAY WITH RESIDENT**	1. Allows you to get help yet continuously provide for resident's safety and comfort
2. **CHECK IF RESIDENT IS BREATHING**	2. Provides you with information necessary to proceed with procedure
3. **DO NOT MOVE RESIDENT**	3. Prevents further damage if resident is injured
4. Talk to resident in calm and supportive manner	4. Reassures resident
5. Apply direct pressure to any bleeding area	5. Slows or stops bleeding
6. Take pulse and respiration	6. Provides nurse with necessary information to properly assess resident's condition and needs
7. Assist nurse as directed	
8. **DO FINAL STEPS**	
9. **ASSIST WITH DOCUMENTATION ACCORDING TO CURRENT NURSING PRACTICES**	9. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen
10. **CHECK RESIDENT FREQUENTLY ACCORDING TO CURRENT NURSING PRACTICES**	10. Assures resident comfort and allows you to quickly report any change in resident condition

TOPIC 9: RESIDENT'S RIGHTS

1. **Rights are both human privileges and legal protections**. Residents have the legal rights of all United States citizens. Residents also have rights relating to their everyday lives and care in a nursing facility. A facility must inform residents of their rights and post the **"Residents Bill of Rights"** in writing in the facility. **CNAs must read and sign a document stating that they understand the resident's rights**.

2. Resident's rights include but are not limited to:
   a. **The resident has the right to confidentiality**. Personal information, medical records, written and telephone communications, medical treatment, personal care, behavior and meetings with family are not discussed unless appropriate. To maintain confidentiality, the CNA should:
      1) Never discuss a resident's personal or medical information with friends, news media, and family.
      2) Only discuss resident information with appropriate staff in a private place.
   b. **The resident has a right to privacy**. To provide privacy, the CNA should:
      1) Knock on door, announce yourself, pull curtains, close door and drape resident.
      2) Ask visitors to leave when providing care, if appropriate.
      3) Never open mail or go through resident's belongings unless requested.
      4) Provide privacy for visits.
   c. **The resident has the right to information, including the right to see personal and medical records** within 24 hours and a copy within two days, if requested; right to be fully informed of total health status in a language they can understand; right to be informed of any change in service that they are charged for and that they are not charged for, and to see financial records; right to be informed of advocacy groups and ombudsman program; right to read recent facility survey. The State survey and advocacy groups phone numbers and the most recent survey must be posted in the facility. To help residents be informed, the CNA should:
      1) Know where to find the information and who to go to for answers.
      2) Actively help residents find the answers.
      3) Go with residents to areas where information is posted and read to them if necessary.
      4) Inform the nurse about a resident's specific concerns regarding medical condition or treatment.
   d. **The resident has the right to choose**. The resident has the right to refuse treatment and self administer medication, if deemed safe; to choose a personal physician; to participate in their care planning; to perform voluntary or paid services; to keep and use personal possessions as space permits; to participate in activities in and out of facility; to have space available for private family meetings. To encourage choice the, CNA should:
      1) Make sure residents are aware of choices.
      2) Inform residents about activities.
      3) Find out the resident's interests and encourage participation.
   e. **The resident has the right to dispute services and file grievances**. The resident can voice complaints without fear of retaliation, get prompt action on complaints, have the ombudsman program investigate complaints from resident and family. To support the resident's right to complain, the CNA should:
      1) Tell the nurse if the resident or family voices a complaint.
      2) Never let a complaint negatively affect how you care for the resident.
      3) Understand that if the resident complains about you, staff must investigate.
   f. **The resident has the right to be free of restraint and abuse**, including physical and chemical restraint for discipline or convenience, verbal, mental, sexual, physical abuse, corporal punishment, or seclusion. Violations must be reported according to state laws and facilities must investigate thoroughly. Facilities must have written policies to prohibit abuse. To protect the resident from abuse, the CNA should:
      1) Report any suspected abuse to the nurse immediately.
      2) Ask for help if resident becomes aggressive or uncooperative.
      3) Never use a protective device without the nurse's permission.

3. **CNA's Role**:
   a. Understand that violating the resident's rights is against the law.
   b. You are the resident's advocate.
   c. Encourage the resident to exercise their rights.
   d. Report immediately anyone who abuses the resident's rights.
   e. Always treat residents the way you would expect to be treated if you were in the their situation.
   f. Remember that privacy and confidentiality promote dignity and self-esteem.
   g. Understand that when you talk about some one else's negative behavior or personal problems, you are the one who ends up looking bad.

QUESTIONS:

What is the "Residents Bill of Rights"?
How is the right to privacy protected in a health care facility?
Explain confidentiality.
What is the role of an ombudsman in a long-term care facility?
If a CNA suspects resident abuse, what steps must be taken?
For what reason may a restraint (protective device) be used?
What should a CNA do if a resident voices a complaint?

ADDITIONAL DEFINITIONS:

Privilege – a liberty or benefit
Appropriate – suitable for a particular purpose, occasion or person
Status – state or condition
Dispute – to oppose or call into question
Grievance – a wrong, considered grounds for complaint
Retaliation – to get back at, take revenge
Physical Restraint – a device or method used to limit the activity or restlessness of a resident where such activity or restlessness could be harmful to the resident or others
Chemical Restraint – use of chemical means to limit the activity or aggressiveness of a resident where such activity or aggressiveness could be harmful to the resident or others
Corporal Punishment – physical punishment inflicting bodily harm
Seclusion – removal from social contact and activity
Violation – disregard or disobey a law or code of conduct
Self Esteem – a person's belief in himself, self respect

TOPIC 10: BASIC ANATOMY

1. **The human body is composed of**:
   a. **Cells** - the basic structural unit of all living things. Cell function, size and shape may be different but each cell takes in food, water and oxygen, and eliminates waste to live and perform functions.
   b. **Tissues** - groups of similar cells that combine to perform a particular function.
   c. **Organs** - group of tissues forming a distinct unit that carries out one or more specific functions.
   d. **Systems** - groups of organs that work together to carry out a primary body function.

2. **Integumentary System structure** and function:
   a. Skin-prevents germs from entering body and is the first line of defense against infection.
   b. Hair-provides protection to skin and organs.
   c. Nails-protect tips of fingers and toes.
   d. Oil glands-help skin remain moist and smooth.
   e. Sweat glands-cool body.

3. **Musculoskeletal System** structure and function:
   a. Bones - provide the frame for the body. Joints are the point where two bones come together and allow movement.
   b. Muscles - tissue that contracts (shortens) and relaxes (lengthens) to make motion possible.
   c. Ligaments - connect bone to bone and support joints.
   d. Tendons - connect muscles to bones.
   e. Cartilage - cushions joints.

4. **Nervous System** structure and function:
   a. Brain – sends, receives and interprets messages to make sense of the outside world.
   b. Spinal cord – carries messages between nerves and brain.
   c. Nerves - carry messages between brain and the point of stimulation.

5. **Endocrine System** includes glands that produce hormones and secretions to regulate bodily functions.

6. **Reproductive System** structure and function:
   a. In males:
      1) Testes – glands that produce testosterone and sperm.
      2) Scrotum – sac containing testes.
      3) Prostrate – gland producing fluid for sperm.
      4) Penis – external sex organ through which males ejaculate and urinate.
   b. In females:
      1) Ovaries – produce estrogen, progesterone and ova.
      2) Fallopian tubes – carry ova from ovaries to uterus.
      3) Uterus – muscular sac where ova can develop.
      4) Vagina – muscular canal leading out of body.
      5) Breasts – produce nutrients for infants.

7. **Urinary System** structure and function:
   a. Kidneys - filter waste products from blood and produce urine.
   b. Ureters - carry urine from kidneys to bladder.
   c. Urinary bladder - stores urine.
   d. Urethra - carries urine from bladder out of body.

8. **Gastrointestinal System** structure and function:
   a. Mouth - takes in and masticates food and fluid.
   b. Esophagus – tube that transports masticated food from mouth to stomach.
   c. Stomach - sac that mixes food and fluid with digestive juices.
   d. Small intestine – tube that absorbs nutrients from food.
   e. Large intestine – tube that absorbs water from waste.
   f. Rectum – sac at end of large intestine which stores waste.
   g. Anus – opening at end of rectum through which waste is expelled.
   h. Other organs which aid in digestion include - gall bladder, liver.

9. **Circulatory System** structure and function:
   a. Heart – pumps blood through the body.
   b. Blood - body fluid.
   c. Blood vessels - tubes (arteries, veins, capillaries) through which the blood is transported.

10. **Respiratory System** structure and function:
   a. Mouth and nose - take in air.
   b. Trachea - tube connecting mouth and nose to lungs.
   c. Lungs - move oxygen from air into blood and remove carbon dioxide (gaseous waste product).

11. **CNA's Role**:
   a. Understand the body and how it functions.
   b. Think about the body and how it functions whenever performing procedures.

QUESTIONS:

What do all living cells have in common?
Name the body systems and their structures and functions.
What body system is our first line of defense against infection?
What is a joint?
Name the structures within the urinary system.

ADDITIONAL DEFINITIONS:

Structure – the arrangement of tissues, parts, or organs
Function – the purpose for which something is designed
Interpret – to explain the meaning
Secretion – a substance released from specific organs for a particular purpose (enzyme, hormone)
Ova - egg
Masticate – to chew

TOPIC 11: THE AGING PROCESS

1. **The aging process is a series of physical, sensory and psychosocial changes that occur over many years**.

2. **Physical changes occur in all body systems causing body processes to slow down**:
   a. Respiratory system - lung capacity decreases as chest wall and lungs become more rigid. Deep breathing is more difficult. Air exchange decreases causing person to breathe faster to get enough air when exercising, ill, or stressed.
   b. Circulatory system – blood vessels become more rigid and narrow. Heart muscle has to work harder which may result in high blood pressure and poor circulation.
   c. Gastrointestinal system - taste buds loose sensitivity causing decreased appetite. Tooth and gum problems result in inability to eat properly. Digestive secretions decrease causing constipation and food intolerance.
   d. Urinary system - kidney function decreases slowing removal of waste. Bladder tone decreases resulting in more frequent urination, incontinence, bladder infections and urinary retention.
   e. Endrocine system - insulin production decreases possibly causing excess sugar in blood. Adrenal secretions decrease reducing ability to handle stress. Thyroid secretions decrease slowing metabolism.
   f. Reproductive system – hormone production decreases. Decreased estrogen in females causes menopause. Decreased testosterone in males slows sexual response. Prostate gland may become enlarged causing difficulty when urinating.
   g. Integumentary system - loss of fat and water in skin causes increased sensitivity to cold, dehydration, wrinkling and sagging. Decrease in oil production causes dry skin and hair. Decrease in sweat gland function causes loss of ability to regulate body temperature. Changes in pigmentation causes gray hair and liver spots. Loss of capillary function causes yellowing of skin, thickening of nails, and thinning hair.
   h. Musculoskeletal system – bones become more brittle and porous and may fracture more easily. Loss of muscle strength and tone causes weakness and feeling tired. Less flexible joints make moving more difficult. Changes in spine and feet result in height loss, postural changes and difficulty walking.
   i. Nervous system - decreased blood flow to certain areas of brain causes decreased short-term memory. Nerve cells die causing decreased perception of sensory stimuli and less awareness of pain and injury.

3. **Sensory changes affect how the older person perceives the environment**. All information about the environment is sent to the brain through the senses:
   a. Sight – changes in the eye affect visual perception. The lens becomes flattened and rigid and the small muscles lose elasticity, decreasing the ability to focus on things that are close (presbyopia). The lens becomes more yellow, therefore, greens and blues are difficult to see. Reds and oranges are easier to see. Pupil size becomes smaller, less light reaches the inner eye making it more difficult to see in low light.
   b. Hearing - structures within the ear become stiff causing the loss of hearing of high frequency sounds (presbycusis). Soft wax production decreases and hard, dry wax builds up causing hearing loss.
   c. Smell – ability to smell decreases causing decreased appetite. Identifying smells becomes more difficult, (i.e. body odors, smoke, chemicals).
   d. Taste – taste buds are less perceptive, especially salty and sweet. More seasoning may be needed on food.
   e. Touch - decreased sensitivity in the skin results in less information from touch. Hot items are difficult to detect causing burns. Injuries from bumping are not readily felt and treated. Person may drop things more often.

4. **Psychosocial changes that occur with aging affect how people perceive themselves as individuals and as a part of society**:
   a. Social changes - loss of friends and relatives, loss of ability to participate in social functions.
   b. Status changes - changes in the individual's role within a group (family, community, or workplace) may result in feelings of being less productive and less respected.
   c. Economic changes – changes in income and ownership. The person may have given up their home, car, or possessions.
   d. Positive self-esteem - becomes difficult to maintain.

5. **CNA's role**:
   a. Help each resident be as independent as possible. Avoid taking over tasks that resident's can accomplish for themselves.
   b. Be patient. Be a good listener.
   c. Be very aware of resident safety and potential hazards.
   d. Allow the resident as much freedom as possible.
   e. Help resident feel comfortable in his surroundings.
   f. Have empathy for the resident, his family and visitors.
   g. Touch can be an important means of reducing loneliness but understand and respect that some residents do not like to be touched.
   h. Help to create, but do not force, new relationships for the resident.
   i. Encourage a resident to set new goals as their needs change.
   j. Do not pass judgment on resident's preferences.
   k. Treat each resident as an adult. Address residents by the name and title they prefer.

QUESTIONS:

What is the aging process?
How do sensory changes affect the elderly?
Why does appetite decrease with aging?
Which colors are easier for the older person to see?
What must the CNA do to develop empathy?
Describe the physical changes that occur with aging.

ADDITIONAL DEFINITIONS:

Lung Capacity – amount of air the lungs can take in
Rigid – stiff, hard, unable to bend
Constipation – hard, dry stool usually occurring infrequently
Pigmentation – coloration in skin or eye
Porous – full of holes
Flexible – capable of being bent
Sensory Stimuli – information received through sight, hearing, taste, touch and smell

TOPIC 12: COGNITIVE IMPAIRMENT

1. **Cognitive impairment is a temporary or permanent change within the brain which affects a person's ability to think, reason and learn**. Temporary causes may include stress, medication, depression, vitamin deficiency, thyroid disease, alcohol, and head trauma. Permanent causes include severe head trauma, illness, brain disease and brain damage at birth.

2. Some disorders which may cause cognitive impairment include:
   a. Depression - emotional sadness and withdrawal, usually caused by loss (of person, possession, health, choice, self-esteem).
   b. Anxiety – persistent feelings of fear and nervousness.
   c. Suspiciousness - distrust of others.
   d. Delusion - false belief not supported by reality.
   e. Paranoia – irrational feeling of being persecuted, suspiciousness, hostility.
   f. Schizophrenia - suspiciousness, paranoia, and delusion resulting in inappropriate behavior.
   g. Mental retardation – process which slows or stops a child's brain from maturing. Most common causes include difficult birth, Down's Syndrome, high fever, drug or alcohol abuse during pregnancy.
   h. Dementia – progressive mental deterioration due to organic brain disease which causes structural changes within the brain. Alzheimer's Disease is the most common.

3. **Dementia causes progressive deterioration of memory, judgment, <u>orientation</u>, physical skills, language and communication**.
   a. Behaviors common to residents with advanced dementia include <u>sundowning</u>, <u>catastrophic reactions</u>, wandering, pacing, <u>pillaging</u>, <u>hoarding</u>, <u>agitation</u>, <u>anxiety</u>, <u>hallucinations</u>, and delusions.
   b. **Techniques used to reduce the effects of advanced dementia** and initiated only upon instruction from the nurse include:
      1) Reality orientation - helps resident remain aware of their environment, of time and of themselves.
      2) Validation therapy - helps resident improve dignity and self-worth by having their feelings and memories acknowledged.
      3) Reminiscing - allows resident to talk about past experiences, especially pleasant ones.
   c. **Difficult behavior may result from too much stimulation, change in routine or environment, physical pain or discomfort, reactions to medications, and fatigue**. Responses to difficult behavior:
      1) Remain calm. Speak slowly and clearly.
      2) Avoid approaching the resident from side or back.
      3) Try to calm the resident by holding hands, patting, singing, if appropriate.
      4) Try to distract the resident's attention and redirect behavior.
      5) Allow resident to express feelings if talking reduces agitation.
   d. **Dementia resident needs assistance in the following areas**:
      1) **Safety**
         (a) Monitor movement (wandering).
         (b) Do not move things around in room.
         (c) Watch for inappropriate use of objects (knives, forks, throwing things).
         (d) Check that clothing is worn properly (shoes tied, pants buttoned).
      2) **Nutrition**
         (a) Assist resident to dining area when food is being served.
         (b) Have food ready to eat when placed in front of resident (seasoned, opened, cut, and buttered).
         (c) Allow resident more time to swallow and tell resident to swallow, if necessary.
         (d) Serve only one food at a time or serve finger foods, if appropriate.
         (e) Monitor food intake according to current nursing practices to assure adequate nutrition.
         (f) Check if resident is hiding food.

3) **Hydration**
   (a) Offer fluids more often and in smaller amounts to assure adequate hydration, if appropriate.
   (b) Listen for spoken cues that resident may be thirsty (using words like water, ocean, rain).
   (c) Watch for nonverbal signs that resident is thirsty (dry mouth, searching, smacking lips).
4) **Dressing**
   (a) Assist resident to choose appropriate clothing. Offer the resident a choice of two outfits.
   (b) Assist resident to dress properly.
   (c) Simplify dressing according to needs (snaps or Velcro instead of buttons).
5) **Bathing**
   (a) Prepare bathing area before bringing resident into room.
   (b) Explain procedure and allow resident to feel water to reduce anxiety.
   (c) Assist resident to bathe, as necessary, and check water temperature frequently since resident may be unable to tell you if water turns too hot or too cold.
6) **Elimination**
   (a) Take resident to bathroom frequently.
   (b) Provide perineal care as needed.

4. **CNA's role**:
   a. Focus on what the resident can do. Do "with" and not "for" the resident.
   b. Treat each resident as an adult, with respect and dignity.
   c. Speak and move slowly. Never rush the resident.
   d. Be consistent in approach, **do not force care**. Remain calm and speak softly if a resident becomes agitated. If resident is agitated, stop and try again later. **Never argue with the resident**.
   e. Check resident frequently and always explain who you are and what you are doing.
   f. Encourage daily exercise.
   g. Give resident only one short, simple direction at a time and give resident extra time to process information and to respond.
   h. Use eye contact and appropriate body language. The resident can sense impatience.
   i. Watch resident's facial expressions and body language for feelings and moods.
   j. Learn each resident's past routines and patterns.
   k. Understand that all behavior has meaning. Try to discover that meaning.
   l. Understand that wandering may be necessary for some residents.

QUESTIONS:

What is depression?
List the types of deterioration that occur with dementia.
List the behaviors that are common with advanced dementia.
How should the CNA respond to a resident who is exhibiting difficult behaviors?
What techniques can be used to reduce the effects of dementia?

ADDITIONAL DEFININTIONS:

Orientation – being aware of person, place and time
Sundowning - increased confusion and restlessness in late afternoon, evening, and night
Catastrophic Reactions – being abnormally overwhelmed by stimuli; easily startled
Pillage – take what does not belong to you
Hoard – to accumulate and hide
Agitation – being overly excited
Anxiety – worry or uneasiness about what may happen
Hallucination – hearing, smelling or seeing things that are not there

TOPIC 13: RESIDENT'S FAMILY

1. **The family is an extension of the resident**. Family may include relatives, friends, neighbors, former co-workers, and/or guardian with durable power of attorney. Family members are a valuable part of the health care team and important to the resident, because the family:
   a. Is familiar to the resident in a facility that is unfamiliar.
   b. Can bring comfort to the resident.
   c. Offers knowledge about the resident to the health care team.
   d. Can provide assistance in caring for resident.

2. The family must adjust to life in the facility with the resident. Some **emotions expressed by the family during the <u>adjustment process</u> are**:
   a. **<u>Guilt</u>** – family may feel like they are abandoning a resident, or have broken a promise to take care of the loved one at home.
   b. **<u>Anger</u>** – family may feel anger about losing control and responsibility for the care of the resident. They may feel they are being replaced. Anger may be directed toward staff.
   c. **Uncertainty** – family may feel uncertain about their decision to place a loved one in a facility. They may be emotional when visiting and seem afraid, worried, nervous and tense.
   d. **<u>Sadness</u>** – family may have difficulty coping with the separation from the resident and the increased dependency of the resident.
   e. **<u>Relief</u>** – family may feel relieved, since sole responsibility for the resident's care has been removed.

3. Communication and interpersonal skills are important when relating to the family. **How the CNA relates to the resident's family reflects both care giving and the facility as a whole**:
   a. Let the family know who you are and get to know the family.
   b. Create a positive and trusting relationship.
   c. Be available to talk to the family in a quiet atmosphere.
   d. Become a resource and support for the family as their loved one's <u>primary caregiver</u>.
   e. Wear a name tag and identify yourself by name and position.

4. Encourage visits between the resident and the family:
   a. Have the room ready for a family visit.
   b. Remind a resident with memory loss of the names of family members to make the visit more comfortable.
   c. Assist the resident with grooming and dressing for the visit.
   d. The resident has a right to visit with family and friends in private without unnecessary interruptions.
   e. If care is necessary during the visit, remember the resident has a right to privacy.

5. **CNA's role**:
   a. Greet each family member with warmth, courtesy, kindness and respect.
   b. Refer family members requesting information about a resident to the nurse.
   c. Report to the nurse if you notice a visit is stressful or tiring to a resident.
   d. Listen to family members' suggestions, complaints and comments, and direct the family to the nurse.
   e. Be objective. Do not judge decisions made by the family. Do not agree or disagree or take sides.
   f. Include the family in the care of the resident whenever possible but never make the family feel that they are responsible for the care. Encourage the family to participate in the comprehensive care plan conference.

QUESTIONS:

What are some common feelings families experience when admitting a loved one to a health care facility?
What can the CNA do to help the resident prepare for a family visit?
What should a CNA tell the family if they ask about a resident's condition?
What benefits result when family remains involved in their loved one's care within the long-term facility?

ADDITIONAL DEFINITIONS:

Adjustment Process – a series of changes that occur over time to a situation or condition
Guilt – feeling of being at fault
Anger – a strong feeling of displeasure at a situation
Relief – a feeling of calm or comfort
Sadness – unhappiness or sorrow
Primary Caregiver – main person who takes care of another person

TOPIC 14: RESIDENT ENVIRONMENT

1. **The resident environment includes the facility, the grounds and especially the resident's room**. When a resident enters a long-term care facility, he or she experiences the loss of home and belongings. The staff's goal is to help each resident make the room his or her own. Familiar things create a positive environment.

2. **The resident's room contains all of the things necessary to make the resident feel safe and comfortable and usually includes the**:
   a. Bed - types of beds may vary in each facility. Most beds have controls to raise, lower and adjust positions. Some facilities may allow the resident to bring a bed from home.
   b. Side rails - half or full rails attached to the sides of the bed considered:
      1. A self-help aid to assist the resident with mobility.
      2. A safety device, and should be up if the bed is raised.
      3. A restraint if used for the sole purpose of confining the resident in bed and requires a doctor's order.
   c. Overbed Table – narrow table on wheels with adjustable height, which can be pushed over the bed and used for eating, writing and other activities.
   d. Bedside Stand - storage area for personal care items and personal belongings.
   e. Cushioned comfortable chair - for use by visitors or residents.
   f. Curtains or Screens - can be pulled around bed as needed to provide for a resident's right to privacy.
   g. Personal Care Items – may include a wash basin, emesis basin, soap dish, bedpan and/or urinal.
   h. Call System – used by the resident to request assistance - *must* be on the resident's unaffected side and within reach whenever the resident is alone in the room or the bathroom.

3. **A comfortable environment may positively affect how the resident feels physically and emotionally and improve the resident's sense of well being**:
   a. Temperature - the resident's condition and preferences should determine the appropriate temperature.
   b. Light - indirect lighting is preferable because glare causes fatigue. If more light is needed for a procedure, turn the added light off when the procedure is completed.
   c. Ventilation - good air circulation helps control odors and reduce pathogens. Promptly remove odor-causing waste.
   d. Floors - wipe up spills immediately. Keep floors clean and free from clutter to provide for safety.
   e. Noise - interferes with rest, which is important for health and recovery. Keep equipment in good condition and handle equipment quietly.
   f. Water - fresh water should be placed on the resident's unaffected side and within reach to ensure adequate hydration unless contraindicated by the resident's care plan.
   g. Equipment - Always report unsafe equipment and conditions to the nurse immediately.

4. **The Resident needs a clean, neat, wrinkle-free bed for comfort and dignity and to prevent skin irritation and skin breakdown.**
   a. When making a bed:
      1) Carry clean or dirty linens away from your uniform. Place clean linen on a clean surface. Never place dirty linens on the floor, which can spread infection and pose a safety hazard.
      2) Use good body mechanics.
      3) Dispose of soiled linens properly.
      4) Make sure bottom layers of linen are wrinkle-free.
      5) Make one side of the bed at a time. It is quicker, more efficient and conserves energy.

b. **An unoccupied bed can be either closed or open**:
   1) **A closed bed** is made when a resident gets out of bed for the day. The spread is pulled over the pillow.
   2) **An open bed** is made for the resident who is getting out of bed for a short time. The top linens are fanfolded so the resident can safely get into bed.

c. **An occupied bed is made when a resident is unable to get out of bed**.
   1) Respect and provide for the resident's privacy while changing the linens. Close the curtains and door. Keep the resident covered.
   2) Plan the procedure so the resident is turned the least number of times possible for the resident's comfort and safety.
   3) Turn the resident toward the raised side rail for safety and support.
   4) Make sure linen is smooth and stretched tightly under resident for comfort.

5. **CNA's Role**:
   a. Help arrange the resident's belongings as the resident wants them.
   b. Label the resident's clothing and other personal items so that the name does not show and store appropriately when not in use.
   c. Treat the resident's belongings with respect. Clothing is an important part of the resident's self-esteem.
   d. Encourage residents to use their personal items.
   e. Help safeguard the resident's personal belongings.
   f. Ask residents' permission before handling their belongings.

QUESTIONS:

What is the purpose of side rails on the beds in the resident's room?
What personal care items are most commonly kept in the resident's bedside stand?
What type of lighting should be provided in a resident's room and why?
Why must the bottom linen on a resident's bed be wrinkle-free?
Why is it important to make one side of a bed at a time?
What is the appropriate way to label a resident's clothing and personal belongings?

ADDITIONAL DEFINITIONS:

Emesis Basin – small kidney shaped pan used for spit or vomit
Bedpan – a device placed under a bedridden resident to collect urine or feces
Urinal – a container used by male residents to void
Adequate –enough

RELATED PROCEDURES:

PROCEDURE 21: UNOCCUPIED BED

STEP	RATIONALE
1. Collect clean linen in order of use	1. Organizing linen allows procedure to be completed faster
2. **CARRY LINEN AWAY FROM YOUR UNIFORM**	2. If linen touches your uniform, it becomes contaminated
3. **DO INITIAL STEPS**	
4. **PLACE LINEN ON CLEAN SURFACE** (bedside stand, overbed table or back of chair)	4. Prevents contamination of linen
5. Put bed in flattest position	5. Allows you to make a neat, wrinkle-free bed
6. **REMOVE PILLOWCASE**	
7. **LOOSEN SOILED LINEN. ROLL LINEN FROM HEAD TO FOOT OF BED AND PLACE IN HAMPER/BAG, AT FOOT OF BED OR IN CHAIR**	7. Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling puts dirtiest surface of linen inward, lessening contamination
8. **FANFOLD BOTTOM SHEET TO CENTER OF BED AND FIT CORNERS**	8. Shaking linen spreads infection
9. **FANFOLD TOP SHEET TO CENTER OF BED**	
10. Fanfold blanket over top sheet	
11. **TUCK TOP LINEN UNDER FOOT OF MATTRESS AND MITER CORNER**	11. Mitering prevents resident's feet from being restricted by or tangled in linen when getting in or out of bed
12. **MOVE TO OTHER SIDE OF BED**	12. Completing one side of bed at a time allows procedure to be completed faster and reduces strain on you
13. **FIT CORNERS OF BOTTOM SHEET, UNFOLD TOP LINEN, TUCK IT UNDER FOOT OF MATTRESS, AND MITER CORNER**	
14. Fold top of sheet over blanket to make cuff	
15. **PUT ON PILLOWCASE AND PLACE AT HEAD OF BED WITH OPEN END AWAY FROM DOOR**	
16. **FOR OPEN BED: MAKE TOEPLEAT AND FANFOLD TOP LINEN TO FOOT OF BED WITH TOP EDGE CLOSEST TO CENTER OF BED**	16. Top edge of top linen must be closest to head of bed so resident can easily reach covers
17. **FOR CLOSED BED: PULL BEDSPREAD OVER PILLOW AND TUCK BEDSPREAD UNDER LOWER EDGE OF PILLOW. MAKE TOEPLEAT**	17. Toepleat automatically reduces pressure of top linen on feet when resident returns to bed
18. **DO FINAL STEPS**	

PROCEDURE 22: OCCUPIED BED

STEP	RATIONALE
1. Collect clean linen in order of use	1. Organizing linen allows procedure to be completed faster
2. **CARRY LINEN AWAY FROM YOUR UNIFORM**	2. If linen touches your uniform, it becomes contaminated
3. **DO INITIAL STEPS**	
4. **PLACE LINEN ON CLEAN SURFACE** (bedside stand, overbed table or back of chair)	4. Prevents contamination of linen
5. Lower head of bed	5. When bed is flat, resident can be moved without working against gravity
6. **DRAPE RESIDENT** (according to procedure 14)	6. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
7. Turn resident away from you toward side rail	
8. **LOOSEN BOTTOM LINENS AND ROLL LINEN TOWARD RESIDENT TUCKING IT SNUGLY AGAINST RESIDENT'S BACK**	8. Rolling puts dirtiest surface of linen inward, lessening contamination. The closer the linen is rolled to resident, the easier it is to remove from the other side
9. **FANFOLD BOTTOM SHEET TO CENTER OF BED AND FIT CORNERS OVER MATTRESS**	9. Shaking linen spreads infection
10. **TURN RESIDENT ONTO BACK, RAISE SIDE RAIL, MOVE TO OTHER SIDE OF BED AND LOWER SIDE RAIL**	
11. Turn resident away from you toward side rail	
12. **LOOSEN SOILED LINEN. ROLL LINEN FROM HEAD TO FOOT OF BED AND PLACE IN HAMPER/BAG, AT FOOT OF BED OR IN CHAIR**	12. Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling puts dirtiest surface of linen inward, lessening contamination
13. **UNFOLD BOTTOM SHEET AND FIT CORNERS OVER MATTRESS**	
14. Place resident in supine position and raise side rail	
15. **REMOVE PILLOW, CHANGE PILLOWCASE AND PLACE PILLOW UNDER RESIDENT'S HEAD WITH OPEN END AWAY FROM DOOR**	
16. **PLACE CLEAN TOP SHEET OVER RESIDENT AND REMOVE DRAPE** (according to procedure 14)	16. Maintains resident's dignity and right to privacy by not exposing body
17. Unfold blanket over top sheet and make cuff	
18. **TUCK TOP LINENS UNDER FOOT OF MATTRESS AND MITER CORNERS**	18. Mitering prevents resident's feet from being restricted by or tangled in linen when getting in and out of bed
19. **LOOSEN TOP LINENS OVER RESIDENT'S FEET**	19. Prevents pressure on feet which can cause pressure sores
20. **DO FINAL STEPS**	

TOPIC 15: POSITIONING

1. **Positioning is the placement and alignment of the resident's body when assisting the resident to sit, lie down or turn**. If a resident has trouble moving or forgets to change position, the CNA must **change the resident's position at least every two hours** (ISDH regulation) or more often as indicated in the resident's care plan. Always check body alignment. **Shoulders should be directly above hips, head and neck straight, arms and legs in a natural position**. **Proper positioning** and good body alignment:
   a. Improves physical comfort and general well being.
   b. Relieves strain on the resident's body.
   c. Promotes good blood flow.
   d. Helps the body function more efficiently.
   e. Prevents deformities and complications including contractures and pressure sores.

2. **Frequent position** changes prevent:
   a. Musculoskeletal deformities.
   b. Development of pressure sores.
   c. Respiratory complications.
   d. Decreased circulation.

3. Commonly used positions include:
   a. **Semi-Fowler's position** – head elevated 30-45 degrees helps breathing, puts less pressure on coccyx than sitting up and allows resident to better view environment.
   b. **Fowler's position** – head elevated 45-60 degrees helps breathing and is comfortable for grooming, oral care, and eating but puts more pressure on coccyx.
   c. **Supine position** – flat on back; maybe necessary during some procedures including bedmaking, bed bath, and perineal care.
   d. **Lateral position** – lying on either right or left side reduces pressure on one side of body.

4. **CNA's role**:
   a. Use good body mechanics.
   b. Keep resident's body in good alignment. Support affected limbs during repositioning. Recheck alignment after the position change.
   c. Pay special attention to equipment such as oxygen tubing, urinary catheters and IV's during moves.
   d. Encourage resident to assist with positioning.
   e. Be patient and never rush the resident. Speak calmly and reassuringly because resident may feel anxious.
   f. Be gentle with the resident to prevent pain and injury.
   g. Be informed of what positions are safe for each resident.
   h. Position urinary catheter over (not under) the leg to prevent pressure sores.
   i. Prevent skin tears by never sliding or dragging a resident on the bed.
   j. Use side rails while moving resident in bed.
   k. Reposition a resident who is sitting in a chair every hour.

QUESTIONS:

Define good body alignment and its benefits.
What problems or conditions are prevented by frequent position changes?
List the commonly used positions.
Why should the CNA never drag or slide a resident across the bed linens?
How can a CNA encourage a resident to help when moving or positioning?

ADDITIONAL DEFINITIONS:

Alignment – to put in a straight line
Deformities – abnormally formed parts of the body
Coccyx – triangular bone at the base of the spine

RELATED PROCEDURES:

PROCEDURE 3: SUPINE POSITION

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Lower head of bed	2. When bed is flat, resident can be moved without working against gravity
3. Move resident to head of bed if necessary (according to procedure 4)	3. Places resident in proper position in bed
4. **POSITION RESIDENT FLAT ON BACK WITH LEGS SLIGHTLY APART**	4. Prevents friction in thigh area
5. Align resident's shoulders and hips	5. Reduces stress to spine
6. Use supportive padding if necessary	6. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees unless directed by nurse as it may restrict blood flow to lower legs
7. **DO FINAL STEPS**	

PROCEDURE 4: LATERAL POSITION

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Place resident in supine position (according to procedure 3)	2. Places resident in proper position and alignment
3. Move resident to side of bed closest to you	3. Allows resident to be positioned in center of bed when turned
4. Cross resident's arms over chest	4. Reduces stress on shoulders during move
5. Slightly bend knee of nearest leg to you or cross nearest leg over farthest leg at ankle	5. Reduces stress on hip joint during turn
6. **PLACE YOUR HANDS UNDER RESIDENT'S SHOULDER BLADE AND BUTTOCK. TURN RESIDENT AWAY FROM YOU ONTO SIDE**	6. Prevents stress on shoulder and hip joints
7. **PLACE SUPPORTIVE PADDING BEHIND BACK, BETWEEN KNEES AND ANKLES, AND UNDER TOP ARM**	7. Maintains position, prevents friction and reduces pressure on bony prominences
8. **DO FINAL STEPS**	

PROCEDURE 5: FOWLER'S POSITION

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Move resident to supine position (according to procedure 3)	2. Places resident in proper position and alignment
3. **ELEVATE BED 45 to 60 DEGREES**	3. Improves breathing, allows resident to see room and visitors
4. Use supportive padding if necessary	4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees unless directed by nurse as it may restrict blood flow to lower legs
5. **DO FINAL STEPS**	

PROCEDURE 6: SEMI-FOWLER'S POSITION

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Move resident to supine position (according to procedure 3)	2. Places resident in proper position and alignment
3. **ELEVATE HEAD OF BED 30 TO 45 DEGREES**	3. Improves breathing, allows resident to see room and visitors
4. Use supportive padding if necessary	4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees unless directed by nurse as it may restrict blood flow to lower legs
5. **DO FINAL STEPS**	

PROCEDURE 7: SIT ON EDGE OF BED

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **ADJUST BED HEIGHT TO LOWEST POSITION**	2. Allows resident's feet to touch floor when sitting. Reduces chance of injury if resident falls
3. Move resident to side of bed closest to you	3. Resident will be close to edge of bed when sitting up
4. Raise head of bed to sitting position, if necessary	4. Resident can move without working against gravity
5. **PLACE ONE ARM UNDER RESIDENT'S SHOULDER BLADES AND THE OTHER ARM UNDER RESIDENT'S THIGHS**	5. Placing your arm under the resident's neck may cause injury
6. **ON COUNT OF THREE, SLOWLY TURN RESIDENT INTO SITTING POSITION WITH LEGS DANGLING OVER SIDE OF BED**	
7. **SUPPORT FOR 10 TO 15 SECONDS, CHECK FOR DIZZINESS**	7. Change of position may cause dizziness due to a drop in blood pressure
8. **ASSIST RESIDENT TO PUT ON SHOES OR SLIPPERS**	8. Prevents sliding on floor and protects resident's feet from contamination
9. **MOVE RESIDENT TO EDGE OF BED SO FEET ARE FLAT ON FLOOR**	9. Allows resident to be in stable position
10. **DO FINAL STEPS**	

PROCEDURE 8: ASSIST RESIDENT TO MOVE TO HEAD OF BED

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **LOWER HEAD OF BED AND LEAN PILLOW AGAINST HEAD BOARD**	2. When bed is flat, resident can be moved without working against gravity. Pillow prevents injury should resident hit the head of bed
3. Ask resident to bend knees, put feet flat on mattress	3. Gives resident leverage to help with move
4. **PLACE ONE ARM UNDER RESIDENT'S SHOULDER BLADES AND THE OTHER ARM UNDER RESIDENT'S THIGHS**	4. Putting your arm under resident's neck could cause injury
5. **ASK RESIDENT TO PUSH WITH FEET ON COUNT OF THREE**	5. Enables resident to help as much as possible and reduces strain on you
6. Place pillow under resident's head	6. Provides for resident's comfort
7. **DO FINAL STEPS**	

TOPIC 16: VITAL SIGNS AND MEASUREMENTS

1. **Vital signs include temperature, pulse, respiration and blood pressure**. Vital signs provide important information about:
   a. How the body is functioning.
   b. How the resident is responding to treatment.
   c. How the resident's condition is changing.

2. **Temperature is a measurement of heat in the body**. Temperature is affected by time of day, age, exercise, emotional state, environmental temperature, medication, pregnancy, illness, and menstruation.
   a. Methods used to measure temperature include:
      1) Oral (by mouth) – normal range is 97.6°F to 99.6°F.
      2) Axillary (placed in the armpit) – normal range is 96.6°F to 98.6°F.
      3) Aural (placed in the ear) – normal range is 98.6°F to 100.6°F.
   b. Types of thermometers include:
      1) Glass - a hollow tube (stem) filled with a liquid metal (mercury) that expands and contracts with changes in temperature. One end is the tip (often red for rectal and blue for oral). The other end is the bulb (short and round for rectal and longer and slender for oral). To read, measure the mercury level against marks on the stem of the thermometer.
      2) Electronic - a probe is covered by a plastic disposable sheath and placed under the tongue. The result is displayed on a screen.
      3) Paper or plastic tape - placed on the forehead or abdomen. Changes in color indicate temperature.
      4) Aural (tympanic) – a covered probe is placed in the ear to measure temperature at the eardrum and is considered as accurate as a rectal temperature.

3. **Pulse rate is the measurement of the number of heartbeats per minute.** Pulse rate is affected by age, sex, emotions, body position, medication, illness, fever, physical activity and fitness level. The pulse can be felt at many locations on the body.
   a. The pulse points most often used are:
      1) Carotid - located on either side of the neck and used during CPR.
      2) Apical - located on the left side of the chest under the breastbone, and taken with a stethoscope.
      3) Radial - located on the thumb side of the wrist and used for standard pulse rate.
      4) Brachial – located at the bend of the elbow and used for blood pressure measurement.
   b. When taking a pulse, note three things:
      1) Rate – number of beats per minute (normal rate is 60 to 100 per minute).
      2) Rhythm – the regularity or skipping of beats.
      3) Force – strength or weakness of beats.

4. **Respiration rate is the measurement of the number of times a person inhales per minute**. Respirations are affected by age, sex, emotional stress, medication, lung disease, heat and cold, heart disease, and physical activity.
   a. When taking respirations, note three things:
      1) Rate – number of respirations per minute (normal rate is 12 to 20 per minute).
      2) Rhythm – the regularity or irregularity of breathing.
      3) Character – the type of breathing (shallow, deep, labored).
   b. Special considerations when taking respirations:
      1) Count respirations after finishing the pulse, without taking your fingers off the wrist or the stethoscope from the chest so that the resident is unaware you are checking his respirations.
      2) If resident is agitated, place hand on resident's chest and feel chest rise and fall during breathing.

5. **Blood pressure is a measurement of the force the blood exerts against the walls of the arteries**. In addition to the factors affecting other vital signs, heredity, diet, condition of vessels and volume of blood in the system affect blood pressure. Abnormally high blood pressure is called hypertension. Abnormally low blood pressure is called hypotension.
   a. Two measurements are taken:
      1) Systolic – first beat heard; upper number.
      2) Diastolic – last beat heard; lower number.
   b. In order to ensure accurate readings:
      1) Take blood pressure only if the resident is lying or sitting unless otherwise instructed.
      2) Correctly apply the proper sized cuff and keep resident's arm at or below the level of the heart.
      3) Place diaphragm of the stethoscope over brachial artery and read the sphygmomanometer gauge accurately.

6. The resident's height and weight are other important measurements.
   a. The resident's height is measured at the time of admission or at significant change.
   b. The resident's weight is recorded at the time admission and at least monthly according to the resident's care plan. Different types of scales include: standard, chair, and bed scales.
      1) Weight must be checked at least every month to:
         (a) Assist physician to determine medication dosage.
         (b) Assess fluid balance, kidney and heart function.
         (c) Determine changes in nutritional status.
      2) To weigh resident:
         (a) Have resident wear the same type of clothing each time they are weighed.
         (b) Have resident empty bladder before being weighed.
         (c) Schedule daily weights at the same time each day.
         (d) Follow manufacturer's guidelines for use of the scale.

7. **CNA's role**:
   a. Be certain measurements are accurate. Document measurements and report unusual readings to the nurse immediately. If unsure of measurements, tell the nurse.
   b. Provide for resident's privacy when taking measurements.
   c. Never leave the resident unattended with a thermometer inserted.
   d. Never take the oral temperature of a resident who is unconscious or has seizures.
   e. Never leave resident standing or sitting on the scale.
   f. Wait 15 minutes after smoking or drinking to take an oral temperature.

QUESTIONS:

What four things are measured when assessing vital signs?
List the normal range for each method of measuring temperature.
What are the commonly used pulse points in the body?
What is the normal pulse range for adults?
How can respirations be measured so the resident is unaware of the procedure?
How can the CNA measure respirations of an agitated resident?
Why is it necessary to check a resident's weight at least monthly?

ADDITIONAL DEFINITIONS:

Diaphragm – piece at the end of the stethoscope which magnifies sound
Stethoscope – instrument used to convey to the ear sounds produced in the body
Sphygmomanometer – instrument for determining arterial pressure

RELATED PROCEDURES:

PROCEDURE 40: WEIGHT

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **BALANCE SCALE**	2. Scale must be balanced on zero for weight to be accurate
3. **DEPENDING ON SCALE USED, ASSIST RESIDENT TO STAND ON PLATFORM OR SIT IN CHAIR WITH FEET ON FOOTREST OR TRANSPORT WHEELCHAIR ONTO SCALE AND LOCK BRAKES**	3. When using chair scale, if resident has feet on floor, weight will not be accurate. Wheel locks prevent chair from moving when using a wheelchair scale
4. **WHEN USING A STANDARD SCALE - MOVE LOWER WEIGHT TO FIFTY POUND MARK THAT CAUSES ARM TO DROP. MOVE IT BACK TO PREVIOUS MARK. MOVE UPPER WEIGHT TO POUND MARK THAT BALANCES POINTER IN MIDDLE OF SQUARE. ADD LOWER AND UPPER MARKS** **WHEN USING A DIGITAL SCALE - PRESS WEIGH BUTTON. WAIT UNTIL NUMBERS REMAIN CONSTANT**	4. When arm drops, weight is too high When pointer is suspended, weight is accurate Total gives accurate weight
5. **SUBTRACT WEIGHT OF WHEELCHAIR FROM TOTAL WEIGHT, IF APPLICABLE**	
6. **ACCURATELY RECORD RESIDENT'S WEIGHT ACCORDING TO CURRENT NURSING PRACTICES.**	6. Record weight immediately so you won't forget. Weight changes are an indicator of resident condition. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen
7. **DO FINAL STEPS**	
8. **REPORT UNUSUAL READING TO NURSE**	8. Provides nurse with information to assess resident's condition and needs

PROCEDURE 41: PULSE AND RESPIRATION

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Place resident's hand on comfortable surface	
3. **FEEL FOR PULSE ABOVE WRIST ON THUMB SIDE WITH TIPS OF FIRST THREE FINGERS**	3. Because of artery in your thumb, pulse would not be accurate if you use your thumb
4. **COUNT BEATS FOR 60 SECONDS, NOTING RATE, RHYTHM AND FORCE**	4. Ensures accurate count. Rate is number of beats. Rhythm is regularity of beats. Force is strength of beats
5. **CONTINUE POSITION AS IF FEELING FOR PULSE**	5. Resident could alter breathing pattern if aware that respirations are being taken
6. **COUNT EACH RISE AND FALL OF CHEST AS ONE RESPIRATION**	
7. **COUNT RESPIRATION FOR 60 SECONDS NOTING RATE, REGULARITY AND SOUND**	7. Ensures accurate count. Rate is number of breaths. Regularity is pattern of breathing. Sound is shallowness or depth of breathing
8. **RECORD PULSE AND RESPIRATION RATES ACCORDING TO CURRENT NURSING PRACTICES**	8. Record pulse and respirations immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen
9. **DO FINAL STEPS**	
10. **REPORT UNUSUAL FINDINGS TO NURSE**	10. Provides nurse with information to assess resident's condition and needs

PROCEDURE 42: ORAL TEMPERATURE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Position resident comfortably in bed or chair	
3. Rinse thermometer in cool water and dry with clean tissue, if necessary	
4. **HOLD THERMOMETER AT STEM END AND SHAKE DOWN TO BELOW THE LOWEST NUMBER**	4. Holding the stem end prevents contamination of the bulb end. The thermometer reading must be below the resident's actual temperature
5. Put on disposable sheath, if applicable	5. Equipment used incorrectly may cause discomfort and injury to resident
6. **PLACE BULB END OF THERMOMETER UNDER RESIDENT'S TONGUE**	6. The thermometer measures heat from blood vessels under the tongue
7. Ask resident to close lips	7. The lips hold the thermometer in position. If broken, injury to the mouth and mercury poisoning may occur
8. **LEAVE IN PLACE FOR AT LEAST 3 MINUTES OR LONGER BASED ON THE NEEDS OF THE INDIVIDUAL RESIDENT**	8. More time may be required if resident opens mouth to breathe or talk
9. **REMOVE THERMOMETER, WIPE WITH TISSUE FROM STEM TO BULB OR REMOVE SHEATH . DISPOSE OF TISSUE OR SHEATH**	9. Reduces contamination
10. **HOLDING THERMOMETER AT EYE LEVEL, SLOWLY ROTATE UNTIL LINE APPEARS. ACCURATELY READ AND RECORD TEMPERATURE ACCORDING TO CURRENT NURSING PRACTICES**	10. Record temperature immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen
11. Shake down thermometer, clean and return thermometer according to current nursing practices	11. Facilities have different methods of sanitation. You need to carry out the policies of your facility
12. **DO FINAL STEPS**	
13. **REPORT UNUSUAL READINGS TO NURSE**	13. Provides nurse with necessary information to properly assess resident's condition and needs

PROCEDURE 43: AXILLARY TEMPERATURE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Position resident comfortably in bed or chair	
3. Rinse thermometer in cool water and dry with clean tissue	
4. **REMOVE RESIDENT'S ARM FROM SLEEVE OF GOWN AND WIPE AXILLARY AREA WITH TOWEL**	4. To remove moisture from axillary area
5. **HOLD THERMOMETER AT STEM END AND SHAKE DOWN TO BELOW THE LOWEST NUMBER**	5. The mercury must be below resident's actual temperature
6. Put on disposable sheath, if applicable	6. Equipment used incorrectly may cause discomfort and injury to resident
7. **PLACE BULB END OF THERMOMETER IN CENTER OF ARMPIT AND FOLD RESIDENT'S ARM OVER CHEST**	7. Puts thermometer against blood vessels to get reading
8. **HOLD IN PLACE FOR 10 MINUTES**	
9. **GENTLY REMOVE THERMOMETER, WIPE WITH TISSUE FROM STEM TO BULB OR REMOVE SHEATH. DISPOSE OF TISSUE OR SHEATH**	9. Reduces pathogens and removes residue so thermometer can be read accurately
10. **HOLDING THERMOMETER AT EYE LEVEL, SLOWLY ROTATE UNTIL LINE APPEARS. ACCURATELY READ AND RECORD TEMPERATURE ACCORDING TO CURRENT NURSING PRACTICES**	10. Record temperature immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen
11. Shake down, clean and store thermometer according to current nursing practice	11. Facilities have different methods of sanitation. You need to carry out the policies of your facility
12. Put resident's arm back into sleeve of gown	12. Restores resident privacy
13. **DO FINAL STEPS**	
14. **REPORT UNUSUAL READING TO NURSE**	14. Provides nurse with necessary information to properly assess resident's condition and needs

PROCEDURE 44: BLOOD PRESSURE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **CLEAN EARPIECES AND DIAPHRAGM OF STETHOSCOPE WITH ANTISEPTIC WIPE**	2. Reduces pathogens, prevents ear infections and prevents spread of infection
3. Uncover resident's arm to shoulder	
4. **REST RESIDENT'S ARM, LEVEL WITH HEART, PALM UPWARD ON COMFORTABLE SURFACE**	4. A false low reading is possible if arm is above heart level
5. **WRAP SPHYGMOMANOMETER CUFF AROUND UPPER UNAFFECTED ARM APPROXIMATELY 1-2 INCHES ABOVE ELBOW**	5. Cuff must be proper size and put on arm correctly so amount of pressure on artery is correct. If not, reading will be falsely high or low
6. **PUT EARPIECES OF STETHOSCOPE IN EARS**	6. Earpieces should fit into ears snugly to make hearing easier
7. **PLACE DIAPHRAGM OF STETHOSCOPE OVER BRACHIAL ARTERY AT ELBOW**	
8. **CLOSE VALVE ON BULB. IF BLOOD PRESSURE IS KNOWN, INFLATE CUFF TO 20 mm/hg ABOVE THE USUAL READING. IF BLOOD PRESSURE IS UNKNOWN, INFLATE CUFF TO 160 mm/hg**	8. Inflating cuff too high is painful and may damage small blood vessels
9. Slowly open valve on bulb	9. Releasing valve slowly allows you to hear beats accurately
10. Watch gauge and listen for sound of pulse	
11. **NOTE GAUGE READING AT FIRST PULSE SOUND**	11. First sound is systolic pressure
12. **NOTE GAUGE READING WHEN PULSE SOUND DISAPPEARS**	12. Last sound is diastolic pressure
13. Completely deflate and remove cuff	13. An inflated cuff left on resident's arm can cause numbness and tingling. If you must take blood pressure again, completely deflate cuff and wait 30 seconds. Never partially deflate a cuff and then pump it up again. Blood vessels will be damaged and reading will be falsely high or low
14. **ACCURATELY RECORD SYSTOLIC AND DIASTOLIC READINGS ACCORDING TO CURRENT NURSING PRACTICE**	14. Record readings immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen
15. **DO FINAL STEPS**	
16. **REPORT UNUSUAL READINGS TO NURSE**	16. Provides nurse with information to properly assess resident's condition

TOPIC 17: BATHING

1. **Bathing helps keep skin healthy and prevents skin problems**. State regulations say that a "resident shall be bathed or assisted to bathe as frequently as is necessary, but at least twice weekly." Bathing:
   a. Cleanses the skin of perspiration, dirt and germs.
   b. Increases circulation to the skin.
   c. Promotes resident comfort and well being.

2. Consideration is given to a resident's preferences and condition when determining the type, time and frequency of bathing. Residents may choose to bathe before bedtime or in the morning, according to their habits before entering the long term care facility. Types of baths include:
   a. Complete Bed Bath - given to a resident who is weak or unable to leave the bed and includes washing the resident's entire body.
   b. Partial Bath - bathing certain parts of the body between complete baths or to provide comfort; involves washing the face, hands, underarms, and then perineal area.
   c. Tub Bath - relaxing method of bathing for a resident who can tolerate sitting in water.
   d. Shower - taken by a resident who is strong enough to move or be moved. Residents may prefer to use a shower chair in the shower.

3. During bathing, observe and report any of the following:
   a. Color changes of the lips, skin, nail beds and whites of the eyes.
   b. Rashes, dry skin, bruises, broken skin, reddened areas, abnormal skin temperature.
   c. Drainage, bleeding, complaints of pain or itching.
   d. Excessive hair loss.

4. **Perineal care means cleaning the genital and anal area to prevent infection and odor and improve the resident's comfort**. Perineal care is a routine part of a complete bed bath. Perineal care may be necessary between baths, especially for incontinent residents, residents with diarrhea and residents with skin irritation and/or discharge. When performing perineal care:
   a. Provide privacy and dignity. Drape resident.
   b. Follow Standard Precautions. Clean from front to back.
   c. Clean catheter from meatus out.
   d. Retract and clean foreskin of uncircumcised male.
   e. Separate and wash labia of female.
   f. Provide for comfort (warm water, handle genitals carefully, rinse well).

5. **Back rubs should be offered after a bath and before bedtime to keep skin healthy and prevent skin breakdown**. Back rubs stimulate circulation and relieve tension. Bedridden residents need back rubs more often to stimulate circulation.
   a. Use lotion to reduce friction. Warm lotion in hands before applying to resident's skin.
   b. Keep your nails short to prevent injury.
   c. Check skin for unusual findings before beginning back rub.
   d. Use good body mechanics.
   e. Use long, smooth strokes up spine from lower back to shoulders to relax muscles.
   f. Use short, circular strokes down sides of back from shoulders to lower back to stimulate circulation.

6. **CNA's role**:
   a. Provide for the resident's privacy and encourage the resident to do as much as possible to promote independence.
   b. Check water temperature before resident checks it. ISDH regulations state that the water temperature

at the point of use must be maintained between 100 – 120° F. Recommended bath temperature is approximately 105° F.

c. Follow Standard Precautions when performing perineal care or when bathing a resident with skin lesions or rashes.
d. Always help a resident in and out of a tub or shower to prevent falls.
e. Dry resident's skin by patting with a towel which decreases friction and prevents skin breakdown.
f. Never leave a resident unattended in a bathing room.
g. Wash from cleanest to dirtiest.
h. Observe and report unusual findings to the nurse.
i. Clean incontinent residents every time urine and/or feces touch the skin.
j. Offer resident backrub after bathing and at bedtime to stimulate circulation and relieve stress.
k. Apply lotion to dry skin if requested.
l. Clean tub, shower and shower chair before and after each use.
m. Always check each resident's skin during bathing.

QUESTIONS:

What are the important purposes of bathing?
What factors determine the type, time and frequency of bathing for a resident?
What parts of the body are washed during a partial bath?
Why is perineal care so important?
What observations can be made during bathing?
What is the recommended temperature for bathing?
What are the benefits of a back rub?

ADDITIONAL DEFINITIONS:

Preferences – personal likes and dislikes
Drape – cover; flannel blanket put over resident to maintain privacy and warmth
Nail Beds – base of a nail
Bruise – discoloration of skin due to injury
Lesion – infected or broken patch of skin
Bedridden – confined to bed

RELATED PROCEDURES:

PROCEDURE 14: DRAPE AND UNDRAPE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **TO DRAPE, UNFOLD DRAPE OVER TOP LINEN**	2. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
3. Ask resident to hold drape or tuck drape under resident's shoulders	3. Keeps drape in place while linen is being removed
4. **ROLL TOP LINEN FROM BENEATH DRAPE TO FOOT OF BED**	4. Reduces spread of infection and makes it easier to re-cover resident
5. Perform procedure	
6. **TO UNDRAPE, COVER RESIDENT WITH TOP LINEN**	6. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
7. Ask resident to hold top of linen or tuck under resident's shoulders	
8. **ROLL DRAPE FROM UNDER TOP LINEN TO FOOT OF BED AND REMOVE**	8. Reduces spread of infection
9. **DO FINAL STEPS**	

PROCEDURE 15: RUB BACK

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **PLACE RESIDENT ONTO SIDE WITH BACK TOWARD YOU**	
3. Expose back and shoulders	
4. **RUB LOTION BETWEEN YOUR HANDS**	4. Warms lotion and increases resident's comfort
5. **MAKE LONG, FIRM STROKES ALONG SPINE FROM BUTTOCKS TO SHOULDERS. MAKE CIRCULAR STROKES DOWN ON SHOULDERS, UPPER ARMS AND BACK TO BUTTOCKS**	5. Long upward strokes release muscle tension. Circular strokes increase circulation in muscle areas
6. Repeat for at least 3-5 minutes	6. Ensures minimum benefit from procedure
7. Gently pat off excess lotion with towel. Cover and position resident as requests	7. Provides for resident's comfort
8. **DO FINAL STEPS**	

PROCEDURE 32: SHOWER

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Clean shower area and shower chair	2. Reduces pathogens and prevents spread of infection
3. Help resident remove clothing. Drape resident with bath blanket	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
4. **TURN ON WATER AND HAVE RESIDENT CHECK WATER TEMPERATURE**	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature
5. **ASSIST RESIDENT INTO SHOWER AND LOCK WHEELS OF SHOWER CHAIR**	5. Chair may slide if resident attempts to get up
6. **LET RESIDENT WASH AS MUCH AS POSSIBLE, STARTING WITH FACE**	6. Encourages resident to be independent
7. Help resident shampoo and rinse hair	
8. **STAY WITH RESIDENT DURING PROCEDURE**	8. Provides for resident's safety
9. **GIVE RESIDENT TOWEL AND ASSIST TO PAT DRY**	9. Patting dry prevents skin tears and reduces chaffing
10. Assist resident out of shower	
11. Help resident dress, comb hair and return to room	11. Combing hair in shower room allows resident to maintain dignity when returning to room
12. **DO FINAL STEPS**	

PROCEDURE 33: BED BATH

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Offer resident urinal or bedpan	2. Reduces chance of urination during procedure which may cause discomfort and embarrassment
3. **DRAPE RESIDENT** (according to procedure 14)	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
4. **FILL BATH BASIN WITH WARM WATER AND HAVE RESIDENT CHECK WATER TEMPERATURE**	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature
5. If resident has open lesions or wounds, put on gloves (procedure 2)	5. Protects you from contamination by bodily fluids
6. Fold washcloth and wet	
7. **GENTLY WASH EYE FROM INNER CORNER OUT. USING A DIFFERENT PART OF CLOTH WASH OTHER EYE**	7. Helps prevent eye infections. Always wash from cleanest to dirtiest. Using separate area of cloth reduces contamination
8. **WET WASHCLOTH AND APPLY SOAP, IF REQUESTED. WASH, RINSE AND PAT DRY FACE, NECK, EARS AND BEHIND EARS**	8. Patting dry prevents skin tears and reduces chaffing
9. Remove resident's gown	
10. **PLACE TOWEL UNDER FAR ARM**	10. Prevents linen from getting wet
11. **WASH, RINSE AND PAT DRY HAND, ARM, SHOULDER AND UNDERARM**	11. Soap left on the skin may cause itching and irritation
12. **REPEAT STEPS 10 AND 11 WITH OTHER ARM**	
13. **PLACE TOWEL OVER CHEST AND ABDOMEN. LOWER BATH BLANKET TO WAIST**	13. Maintains resident's right to privacy
14. **LIFT TOWEL AND WASH, RINSE AND PAT DRY CHEST AND ABDOMEN**	14. Exposing only the area of the body necessary to do the procedure maintains resident's dignity and right to privacy
15. Pull up bath blanket and remove towel	
16. **PLACE TOWEL UNDER FAR LEG**	16. Prevents linen from getting wet
17. **WASH, RINSE AND PAT DRY LEG AND FOOT**	17. Soap left on the skin may cause itching and irritation
18. **REPEAT STEPS 16 AND 17 WITH OTHER LEG AND FOOT**	
19. **CHANGE BATH WATER**	19. Water is contaminated after washing feet. Clean water should be used for neck and back
20. Turn resident	
21. **WASH, RINSE AND PAT DRY FROM NECK TO BUTTOCKS INCLUDING ANAL AREA**	21. Always wash from cleanest to dirtiest
22. **CHANGE BATH WATER AND GLOVES. USE CLEAN WASHCLOTH AND TOWEL**	22. Water and linen are contaminated after washing anal area
23. **PROVIDE PERINEAL CARE** (according to procedure 34, steps 8 through 13)	
24. Help resident put on clean gown	
25. **DO FINAL STEPS**	

PROCEDURE 34: PERINEAL CARE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Offer resident urinal or bedpan	2. Reduces chance of urination during procedure which may cause discomfort and embarrassment
3. **ASSIST RESIDENT TO SUPINE POSITION** (according to procedure 3)	3. Prepares resident for procedure
4. Place waterproof pad under resident's hips	4. Prevents linen from getting wet
5. **DRAPE RESIDENT** (according to procedure 14)	5. Maintains resident's right to privacy by not exposing body. Keeps resident warm
6. **FILL WASH BASIN WITH WARM WATER AND HAVE RESIDENT CHECK WATER TEMPERATURE**	6. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature
7. **PUT ON GLOVES** (according to procedure 2)	7. Protects you from contamination by bodily fluids
8. **ASSIST RESIDENT SPREAD LEGS AND LIFT KNEES IF POSSIBLE**	8. Exposes perineal area
9. **WET AND SOAP FOLDED WASHCLOTH**	9. Folding creates separate areas on cloth to reduce contamination
10. **IF RESIDENT HAS CATHETER, CHECK FOR LEAKAGE, SECRETIONS OR IRRITATIONS. GENTLY WIPE FOUR INCHES OF CATHETER FROM MEATUS OUT**	10. Washes pathogens away from the meatus
11. **WIPE FROM FRONT TO BACK AND FROM CENTER OF PERINEUM TO THIGHS. CHANGE WASHCLOTH AS NECESSARY**	11. Prevents spread of infection
FOR FEMALES:	Females: Removes secretions in skin folds which may cause infection and odor
A. SEPARATE LABIA. WASH URETHRAL AREA FIRST	
B. WASH BETWEEN AND OUTSIDE LABIA IN DOWNWARD STROKES, ALTERNATING FROM SIDE TO SIDE AND MOVING OUTWARD TO THIGHS. USE DIFFERENT PART OF WASHCLOTH FOR EACH STROKE	
FOR MALES:	
A. **PULL BACK FORESKIN IF MALE IS UNCIRCUMCISED. WASH AND RINSE THE TIP OF PENIS USING CIRCULAR MOTION BEGINNING AT URETHRA**	Males: Removes secretions from beneath foreskin which may cause infection and odor
B. CONTINUE WASHING DOWN THE PENIS TO THE SCROTUM AND INNER THIGHS	
12. **CHANGE WATER IN BASIN. WITH A CLEAN WASHCLOTH, RINSE AREA THOROUGHLY IN THE SAME DIRECTION AS WHEN WASHING**	12. Water used during washing contains soap and pathogens. Soap left on the body can cause irritation and discomfort
13. **GENTLY PAT AREA DRY IN SAME DIRECTION AS WHEN WASHING**	13. If area is left wet, pathogens can grow more quickly. Patting dry prevents skin tears and reduces chaffing
14. Assist resident to turn onto side away from you	
15. **WET AND SOAP WASHCLOTH**	
16. **CLEAN ANAL AREA FROM FRONT TO BACK. RINSE AND PAT DRY THOROUGHLY**	16. Prevents spread of infection
17. **REMOVE PAD, ASSIST RESIDENT TO TURN ONTO BACK AND UNDRAPE RESIDENT** (according to procedure 14)	
18. **REMOVE GLOVES** (according to procedure 2)	
19. **DO FINAL STEPS**	

PROCEDURE 33: BED BATH

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Offer resident urinal or bedpan	2. Reduces chance of urination during procedure which may cause discomfort and embarrassment
3. **DRAPE RESIDENT** (according to procedure 14)	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
4. **FILL BATH BASIN WITH WARM WATER AND HAVE RESIDENT CHECK WATER TEMPERATURE**	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature
5. If resident has open lesions or wounds, put on gloves (according to procedure 2)	5. Protects you from contamination by bodily fluids
6. Fold washcloth and wet	
7. **GENTLY WASH EYE FROM INNER CORNER OUT. USING A DIFFERENT PART OF CLOTH WASH OTHER EYE**	7. Helps prevent eye infections. Always wash from cleanest to dirtiest. Using separate area of cloth reduces contamination
8. **WET WASHCLOTH AND APPLY SOAP, IF REQUESTED. WASH, RINSE AND PAT DRY FACE, NECK, EARS AND BEHIND EARS**	8. Patting dry prevents skin tears and reduces chaffing
9. Remove resident's gown	
10. **PLACE TOWEL UNDER FAR ARM**	10. Prevents linen from getting wet
11. **WASH, RINSE AND PAT DRY HAND, ARM, SHOULDER AND UNDERARM**	11. Soap left on the skin may cause itching and irritation
12. **REPEAT STEPS 10 AND 11 WITH OTHER ARM**	
13. **PLACE TOWEL OVER CHEST AND ABDOMEN. LOWER BATH BLANKET TO WAIST**	13. Maintains resident's right to privacy
14. **LIFT TOWEL AND WASH, RINSE AND PAT DRY CHEST AND ABDOMEN**	14. Exposing only the area of the body necessary to do the procedure maintains resident's dignity and right to privacy
15. Pull up bath blanket and remove towel	
16. **PLACE TOWEL UNDER FAR LEG**	16. Prevents linen from getting wet
17. **WASH, RINSE AND PAT DRY LEG AND FOOT**	17. Soap left on the skin may cause itching and irritation
18. **REPEAT STEPS 16 AND 17 WITH OTHER LEG AND FOOT**	
19. **CHANGE BATH WATER**	19. Water is contaminated after washing feet. Clean water should be used for neck and back
20. Turn resident	
21. **WASH, RINSE AND PAT DRY FROM NECK TO BUTTOCKS INCLUDING ANAL AREA**	21. Always wash from cleanest to dirtiest
22. **CHANGE BATH WATER AND GLOVES. USE CLEAN WASHCLOTH AND TOWEL**	22. Water and linen are contaminated after washing anal area
23. **PROVIDE PERINEAL CARE** (according to procedure 34, steps 8 through 13)	
24. Help resident put on clean gown	
25. **DO FINAL STEPS**	

TOPIC 18: SKIN CARE

1. **Skin is the body's largest organ**. Skin helps control body temperature and is the first line of defense against infection because it prevents pathogens from entering the body. As people age, the skin becomes thinner, less elastic and easier to damage. The skin can tear and bruise more easily.

2. **The resident's skin should be closely observed for any sign of**:
   a. Rashes.
   b. Abrasions.
   c. Dryness.
   d. Changes in color.
   e. Pressure areas.
   f. Temperature.
   g. Bruising.
   h. Swelling.

3. **Pressure sores (decubitus ulcers, bedsores) are areas where the skin has been damaged due to excessive pressure or friction**. Factors contributing to skin breakdown include mobility, nutrition and hydration. Residents who are at risk for developing pressure sores include those who are the:
   a. elderly,
   b. very thin,
   c. obese,
   d. paralyzed,
   e. diabetic,
   f. unconscious,
   g. chair-bound or bedridden.

4. **Pressure sores occur most frequently at**:
   a. **Pressure points -** any area on the body that bears the body's weight when lying or sitting and where bones are close to the skin's surface (toes, heels, ankles hips and knees; coccyx, spine and shoulder blades; elbow, ears and back of the head).
   b. **Friction areas** – places where skin rubs on skin (beneath breasts and abdominal folds; between buttocks and legs; under arms, in groin area and around any tubing sight (nasogastric or feeding tubes, catheters).

5. **CNA's role**:
   a. Keep resident's skin clean and dry. Check and clean incontinent resident frequently.
   b. Reposition resident at least every two hours or more often if necessary. Prevent shearing (sliding) of skin against linens.
   c. Pat resident's skin dry instead of rubbing and use lotion on dry areas of skin.
   d. Check that clothing and shoes fit properly.
   e. Keep linens dry, wrinkle-free, and free of objects to avoid irritation.
   f. Encourage resident to get adequate nourishment and fluids.
   g. Give backrubs to increase comfort and circulation.
   h. Cushion pressure areas with heel and elbow protectors, pillows or foam pads to prevent irritation.
   i. Use Standard Precautions if resident's skin is damaged in any way.
   j. Observe skin carefully for any changes and report unusual findings to nurse immediately.
   k. Reposition a chair-bound resident frequently.
   l. Be certain incontinence briefs are not too tight and plastic is away from the skin.
   m. Be aware of safety hazards to prevent residents from injuring skin.

QUESTIONS:

Explain the two most important functions of the skin?
What factors are important to maintain healthy skin?
Describe the changes that occur as skin ages.
What are pressure sores and where on the body would they be located?
What special skin care measures must be taken if the resident is incontinent?

ADDITIONAL DEFINITIONS:

Abrasion – an area of the body's surface where outer layer of skin is damaged due to friction
Mobility – ability to move
Nutrition – the process by which an organism takes in and uses food
Hydration – the process by which the body takes in and uses fluid
Obese – a condition of being overweight
Chair Bound – confined to a chair

RELATED PROCEDURES:

PROCEDURE 16: HEEL OR ELBOW PROTECTORS

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Check skin on resident's heels or elbows	2. Allows you to identify early signs of skin breakdown
3. Report any unexpected findings to nurse immediately	3. Provides nurse with necessary information to properly assess resident's condition and needs
4. **APPLY HEEL OR ELBOW PROTECTORS ACCORDING TO MANUFACTURER'S DIRECTIONS**	4. Equipment used incorrectly may cause discomfort and injury to resident
5. **PLACE WIDTH OF TWO FINGERS BETWEEN RESIDENT AND PROTECTOR**	5. Ensures that device fits properly and is comfortable for the resident
6. **DO FINAL STEPS**	

PROCEDURE 17: CHECK SKIN

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Drape resident (according to procedure 14)	2. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
3. **CHECK BONY AREAS INCLUDING EARS, SHOULDER BLADES, ELBOWS, COCCYX, HIPS, KNEES, ANKLES AND HEELS FOR REDNESS AND WARMTH**	3. Redness and warmth indicates that the skin is under pressure and position should be changed more frequently
4. **CHECK FRICTION AREAS INCLUDING UNDER BREASTS AND ARMS, BETWEEN BUTTOCKS, GROIN, THIGHS, SKIN FOLDS, CONTRACTED AREAS, AND AROUND ANY TUBING FOR REDNESS, IRRITATION, MOISTURE AND ODOR**	4. Pressure, rubbing and perspiration will cause skin to break down
5. Undrape resident (according to procedure 14)	
6. **REPORT ANY UNUSUAL FINDINGS TO THE NURSE IMMEDIATELY**	6. Provides nurse with necessary information to properly assess resident's condition and needs
7. **DO FINAL STEPS**	

TOPIC 19: ORAL CARE

1. **Oral care includes cleaning the teeth, gums, tongue, inside of mouth and dentures and must be performed at least daily according to ISDH regulations**. Oral care:
   a. Reduces the number of pathogens in the mouth.
   b. Helps prevent bad breath, gum disease, caries (cavities) and infections.
   c. Improves a resident's sense of well being and appearance.
   d. Improves a resident's sense of taste and helps improve appetite.
   e. Eliminates particles from beneath dentures, preventing gum injuries and improving the ability to chew.

2. **When assisting with oral care, observe the condition of the teeth, gums, tongue and lips**.
   a. Excessively bad breath - a sign of decay, infection or gastrointestinal problems.
   b. Bleeding - a sign of decay or infection.
   c. Bright red or pale gums – a sign of a disease process.
   d. Decayed, broken or loose teeth – can cause pain, infection and inability to eat.
   e. Swelling – a sign of irritation.
   f. Any sore - a sign of infection, injury, improperly fitted dentures.
   g. Coated tongue - a sign of a disease process.

3. **Dentures are removable false teeth**. Full dentures replace a resident's entire upper and lower teeth. Partial dentures replace some of the resident's teeth. When performing oral care for a resident with dentures:
   a. Provide privacy. Dentures are a very personal and private item.
   b. Handle dentures carefully. Dentures are expensive to replace.
   c. When not in use, store dentures in cool water in a denture cup labeled with the resident's name.
   d. Observe for signs that dentures do not fit properly. Report unusual findings to the nurse.
   e. Encourage residents to wear their dentures to prevent gum shrinkage, improve speech, allow for proper chewing and improve self-image and appearance.

4. **More frequent oral care is needed by residents who**:
   a. Are unconscious.
   b. Have been vomiting.
   c. Have a high temperature.
   d. Are taking certain medications.
   e. Are dehydrated.
   f. Breathe through the mouth.
   g. Are being given oxygen.
   h. Are dying.
   i. Have a history of mouth, tooth and gum problems.

5. **CNA's Role**:
   a. Provide for privacy and encourage the resident to do as much as possible to promote independence.
   b. Use Standard Precautions when performing or assisting with oral care.
   c. Report any unusual findings and complaints of pain or discomfort to the nurse immediately.
   d. Perform mouth care gently to prevent injuries.
   e. Rinse toothpaste from mouth thoroughly.

QUESTIONS:

What are the benefits of good oral hygiene?
List the problems that may develop with structures in the mouth and what these problems indicate.
Why should residents be encouraged to wear their dentures?
Which residents require more frequent oral care?

RELATED PROCEDURES:

PROCEDURE 26: DENTURE CARE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Raise head of bed so resident is sitting up	2. Prevents fluids from running down resident's throat, causing choking
3. **PUT ON GLOVES** (according to procedure 2)	3. Prevents you from contamination by bodily fluids
4. Drape towel under resident's chin	4. Protect resident's clothing and bed linen
5. **REMOVE UPPER DENTURES BY GENTLY MOVING THEM UP AND DOWN TO RELEASE SUCTION. TURN LOWER DENTURES SLIGHTLY TO LIFT OUT OF MOUTH**	5. Prevent injury or discomfort to resident
6. Put dentures in denture cup marked with resident's name and take to sink	
7. **LINE SINK WITH TOWEL AND FILL HALFWAY WITH WATER**	7 Prevents dentures from breaking if dropped
8. Apply denture cleaner to toothbrush	
9. **HOLD DENTURES OVER SINK AND BRUSH ALL SURFACES**	
10. Rinse dentures under warm water, place in cup and fill with cool water	10. Hot water may damage dentures
11. Clean resident's mouth with swab if necessary. Help resident rinse mouth with water or mouthwash diluted with half water if requested	11. Removes food particles. Full strength mouthwash may irritate resident's mouth
12. **CHECK TEETH, MOUTH, TONGUE, AND LIPS FOR ODOR, CRACKING, SORES, BLEEDING AND DISCOLORATION. CHECK FOR LOOSE TEETH. REPORT UNUSUAL FINDINGS TO NURSE**	12. Provides nurse with necessary information to properly assess resident's condition and needs
13. Help resident place dentures in mouth if requested	13. Restores resident's dignity
14. **REMOVE GLOVES** (according to procedure 2)	
15. **DO FINAL STEPS**	

PROCEDURE 27: ORAL CARE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **RAISE HEAD OF BED SO RESIDENT IS SITTING UP**	2. Prevents fluids from running down resident's throat, causing choking
3. **PUT ON GLOVES** (according to procedure 2)	3. Brushing may cause gums to bleed
4. Drape towel below resident's chin	4. Protects resident's clothing and bed linen
5. Wet brush and put on small amount of toothpaste	5. Water helps distribute toothpaste
6. **FIRST BRUSH UPPER TEETH AND THEN LOWER TEETH**	6. Brushing upper teeth first minimizes production of saliva in lower part of mouth
7. Hold emesis basin under resident's chin	
8. **HAVE RESIDENT RINSE MOUTH WITH WATER AND SPIT INTO EMESIS BASIN**	8. Removes food particles and toothpaste
9. If requested, give resident mouthwash diluted with half water	9. Full strength mouthwash may irritate resident's mouth
10. **CHECK TEETH, MOUTH, TONGUE, AND LIPS FOR ODOR, CRACKING, SORES, BLEEDING AND DISCOLORATION. CHECK FOR LOOSE TEETH REPORT UNUSUAL FINDINGS TO NURSE**	10. Provides nurse with necessary information to properly assess resident's condition and needs
11. Remove towel and wipe resident's mouth	
12. **REMOVE GLOVES** (according to procedure 2)	
13. **DO FINAL STEPS**	

PROCEDURE 28: ORAL CARE FOR UNCONSCIOUS

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Drape towel over pillow	2. Protects linen
3. **TURN RESIDENT ONTO UNAFFECTED SIDE**	3. Prevents fluids from running down resident's throat, causing choking
4. **PUT ON GLOVES** (according to procedure 2)	4. Protects you from contamination by bodily fluids
5. Place an emesis basin under resident's chin	5. Protects resident's clothing and bed linen
6. Hold mouth open with padded tongue blade	6. Enables you to safely clean mouth
7. **DIP SWAB IN CLEANING SOLUTION AND WIPE TEETH, GUMS, TONGUE AND INSIDE SURFACES OF MOUTH, CHANGING SWAB FREQUENTLY**	7. Stimulates gums and removes mucous
8. **RINSE WITH CLEAN SWAB DIPPED IN WATER**	8. Removes solution from mouth
9. **CHECK TEETH, MOUTH, TONGUE, AND LIPS FOR ODOR, CRACKING, SORES, BLEEDING AND DISCOLORATION. CHECK FOR LOOSE TEETH. REPORT UNUSUAL FINDINGS TO NURSE**	9. Provides nurse with necessary information to properly assess resident's condition and needs
10. Cover lips with thin layer of petroleum jelly	10. Prevents lips from drying and cracking. Improves resident's comfort
11. **REMOVE GLOVES** (according to procedure 2)	
12. **DO FINAL STEPS**	

TOPIC 20: HAIR AND NAIL CARE

1. **Care of the hair, facial hair, fingernails and toenails is an important part of the resident's daily grooming**. Cultural, ethnic, religious and personal choices influence each resident's needs and practices.

2. **Daily hair care improves appearance, self-esteem and a sense of well being**.
   a. Brushing and combing hair increases circulation and promotes healthy scalp and hair.
   b. Hair is shampooed at least once per week or more often, if necessary, according to ISDH regulations.
   c. Hair should be styled according to the resident's preference.
   d. Remove tangles by dividing hair into small sections and gently combing out from ends of hair to scalp.
   e. Hair preparations are a personal choice and should be used at the resident's request.

3. **Shaving is part of daily routine, especially for men and occasionally for women**. The resident has the right to grow facial hair and to choose the preferred method of shaving if not medically contraindicated.
   a. When using a safety razor (manual razor):
      1) Soften hair with damp warm washcloth, apply shaving cream and lather well.
      2) Shave in direction of hair growth (downward on face, upward on neck).
      3) Rinse skin thoroughly to prevent irritation and use after-shave lotion as resident requests.
   b. When using an electric razor (plug in or battery operated):
      1) Do not use near water source, oxygen or if resident has certain type of pacemaker.
      2) Use pre-shave and after-shave lotions as resident requests.
      3) Shave with back and forth motion (foil head razor) or circular motion (three-head razor).
      4) Clean razor after each use.
   c. Check with the charge nurse before trimming a woman's facial hair.

4. **Nails require daily attention**. Clean, trimmed and smooth nails prevent infection, injuries and odor.
   a. To provide fingernail care clean under and around nails to keep skin healthy, intact and infection free. Soak nails to soften and trim nails straight across, then file smooth, gently rounding corners.
   b. To provide toenail care clean under and around nails to keep skin healthy, intact and infection free. **Never cut toenails if resident is diabetic or circulation impaired**. A podiatrist provides the best care. If instructed by nurse, cut toenails straight across to prevent ingrowths and file smooth.

5. **CNA's role**:
   a. Provide privacy and encourage resident to do as much as possible to promote independence.
   b. Show resident how they look when you have finished.
   c. Use Standard Precautions when shaving or cutting nails.
   d. Observe and report signs of dryness, tenderness, color changes in nails (cyanosis or redness), swelling, drainage, cuts or splits in skin.
   e. Be familiar with facility policy since some facilities do not allow the CNA to cut toenails.
   f. Never cut a resident's hair unless specifically instructed by the nurse.

QUESTIONS:

How should tangles be removed from hair?
What problems are prevented when nails are clean, trimmed and smooth?
Whose toenails should a CNA never cut?

ADDITIONAL DEFINITIONS:

Pacemaker – electrical device that controls heartbeat by stimulating the heart muscle
Intact – unimpaired; whole
Cyanosis – bluish or grayish discoloration of skin

RELATED PROCEDURES:

PROCEDURE 23: FINGERNAIL CARE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **CHECK FINGERS AND NAILS FOR COLOR, SWELLING, CUTS OR SPLITS. CHECK HANDS FOR EXTREME HEAT OR COLD. REPORT ANY UNUSUAL FINDINGS TO NURSE BEFORE CONTINUING PROCEDURE**	2. Provides nurse with necessary information to properly assess resident's condition and needs
3. Raise head of bed so resident is sitting up	3. Puts resident in more natural position
4. **FILL BATH BASIN HALFWAY WITH WARM WATER AND HAVE RESIDENT CHECK WATER TEMPERATURE**	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature
5. **SOAK RESIDENT'S HANDS AND PAT DRY**	5. Nail care is easier if nails are first softened
6. **PUT ON GLOVES** (according to procedure 2)	6. Nail care may cause bleeding
7. **CLEAN UNDER NAILS WITH ORANGE STICK**	7. Most pathogens on hands come from beneath the nails
8. **CLIP FINGERNAILS STRAIGHT ACROSS, THEN FILE IN A CURVE**	8. Clipping nails straight across prevents damage to skin. Filing in a curve smoothes nails and eliminates edge which may catch on clothes or tear skin
9. **REMOVE GLOVES** (according to procedure 2)	
10. **DO FINAL STEPS**	

PROCEDURE 24: SAFETY RAZOR

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Raise head of bed so resident is sitting up	2. Puts resident in more natural position
3. **FILL BATH BASIN HALFWAY WITH WARM WATER**	3. Hot water opens pores and causes irritation
4. Drape towel under resident's chin	4. Protects resident's clothing and bed linen
5. **PUT ON GLOVES** (according to procedure 2)	5. Shaving may cause bleeding
6. **MOISTEN BEARD WITH WASHCLOTH AND PUT SHAVING CREAM OVER AREA**	6. Softens skin and hair
7. **HOLD SKIN TAUT AND SHAVE BEARD IN DOWNWARD STROKES ON FACE AND UPWARD STROKES ON NECK**	7. Maximizes hair removal by shaving in the direction of hair growth
8. **RINSE RESIDENT'S FACE AND NECK**	8. Removes soap which may cause irritation
9. Apply after-shave lotion as requested	9. Improves resident's self-esteem
10. Remove towel	
11. **REMOVE GLOVES** (according to procedure 2)	
12. **DO FINAL STEPS**	

PROCEDURE 25: ELECTRIC RAZOR

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Raise head of bed so resident is sitting up	2. Puts resident in more natural position
3. **DO NOT USE ELECTRIC RAZOR NEAR ANY WATER SOURCE, WHEN OXYGEN IS IN USE OR IF RESIDENT HAS PACEMAKER**	3. Electricity near water may cause electrocution. Electricity near oxygen may cause explosion. Electricity near some pacemakers may cause an irregular heartbeat
4. Drape towel under resident's chin	4. Protects resident's clothing and bed linen
5. **PUT ON GLOVES** (according to procedure 2)	5. Shaving may cause bleeding
6. Apply pre-shave lotion as resident wishes	
7. **HOLD SKIN TAUT AND SHAVE RESIDENT'S FACE AND NECK ACCORDING TO MANUFACTURER'S GUIDELINES**	7. Smoothes out skin. Shave beard with back and forth motion in direction of beard growth with foil shaver. Shave beard in circular motion with three head shaver
8. Apply after-shave lotion as resident wishes	8. Improves resident's self-esteem
9. Remove towel from resident	9. Restores resident's dignity
10. **REMOVE GLOVES** (according to procedure 2)	
11. **DO FINAL STEPS**	

PROCEDURE 29: COMB HAIR

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Raise head of bed so resident is sitting up	2. Puts resident in more natural position
3. Drape towel over pillow	3. Protects linen
4. Remove resident's glasses and any hairpins or clips	4. Prevents injury or discomfort
5. **REMOVE TANGLES BY DIVIDING HAIR INTO SMALL SECTIONS AND GENTLY COMBING OUT FROM ENDS OF HAIR TO SCALP**	5. Reduces hair breakage, scalp pain and irritation
6. Use hair preparations as resident wishes	6. Each resident may prefer different products
7. **STYLE HAIR AS RESIDENT WISHES**	7. Each resident has right to choose
8. Offer mirror	8. Improves self-esteem
9. **DO FINAL STEPS**	

TOPIC 21: DRESSING

1. **Clothing is an expression of each resident's personality and individuality**. Residents have their own style and preferences. When residents like the way they look outside, they feel good inside. Most residents dress in their own street clothes each day.

2. Each piece of the resident's clothing should be:
   a. Inventoried according to facility policy, adding new items and deleting discarded items as necessary.
   b. Labeled with the resident's name in an inconspicuous place.
   c. Neatly folded in drawers or hung in the closet.
   d. Kept clean and in good repair.

3. **When assisting the resident to dress**:
   a. Affected limbs should be dressed first and undressed last.
   b. Avoid pullover garments if the resident has an affected side or difficulty with the neck or shoulders unless requested by the resident.
   c. Simplify dressing for residents with dementia (one-piece dresses, Velcro instead of buttons).
   d. Understand that the resident's perception of room temperature may differ from yours.

4. **CNA's role**:
   a. Provide for privacy and encourage the resident to do as much as possible to promote independence.
   b. Assist the resident to choose clothing and accessories appropriate for the weather, season, and event. If confused, offer the resident a choice of two outfits.
   c. Inventory and label clothing as necessary.
   d. Encourage resident to use napkins or clothes protectors to help keep clothing clean when eating.
   e. Report clothing in need of repair to the nurse.
   f. Assist resident to change clothing if soiled and put soiled clothing in appropriate container.
   g. Check that shoes and slippers have non-skid soles and fit properly to prevent falls.
   h. When using incontinence briefs, be certain plastic is away from skin and check for proper fit.

QUESTIONS:

When assisting to dress a resident with one-sided weakness, what should the CNA remember?
How can dressing be made easier for a resident with dementia?
What should the CNA do if a resident's clothing is in need of repair?
Who chooses the resident's clothing for the day?

ADDITIONAL DEFINITIONS:

Individuality – all the characteristics that set one person apart from another
Inventory – a detailed list of articles
Inconspicuous – not easily seen
Independent – not relying on others for help or support
Incontinence Briefs – protective garment

RELATED PROCEDURES:

PROCEDURE 19: CHANGE GOWN

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Untie soiled gown	
3. **DRAW TOP SHEET OVER RESIDENT'S CHEST**	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
4. **REMOVE RESIDENT'S ARMS FROM GOWN, UNAFFECTED ARM FIRST**	4. Undressing unaffected arm first requires less movement
5. **ROLL SOILED GOWN FROM NECK DOWN AND REMOVE FROM BENEATH SHEET**	5. Rolling reduces spread of infection
6. **SLIDE RESIDENT'S ARMS INTO CLEAN GOWN, AFFECTED ARM FIRST**	6. Dressing affected side first requires less movement and reduces stress to joints
7. Tie gown	
8. **REMOVE TOP SHEET FROM BENEATH CLEAN GOWN AND COVER RESIDENT**	8. Maintains resident's dignity and right to privacy
9. **DO FINAL STEPS**	

PROCEDURE 20: DRESSING A DEPENDENT RESIDENT

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Assist resident to choose clothing	2. Allows resident as much choice as possible to improve self-esteem
3. Move resident onto back	
4. **DRAPE RESIDENT** (according to procedure 14)	4. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm
5. **GUIDE FEET THROUGH LEG OPENINGS OF UNDERWEAR AND PANTS, AFFECTED LEG FIRST. PULL GARMENTS UP LEGS TO BUTTOCKS**	5. Dressing affected side first requires less movement and reduces stress to joints
6. **SLIDE ARM INTO SHIRT SLEEVE, AFFECTED SIDE FIRST**	6. Dressing lower and upper body together reduces number of times resident needs to be turned
7. **TURN RESIDENT ONTO UNAFFECTED SIDE. PULL LOWER GARMENTS OVER BUTTOCKS AND HIP. TUCK SHIRT UNDER RESIDENT**	
8. **TURN RESIDENT ONTO AFFECTED SIDE. PULL LOWER GARMENTS OVER BUTTOCKS AND HIP AND STRAIGHTEN SHIRT**	
9. **TURN RESIDENT ONTO BACK AND SLIDE ARM INTO SHIRT SLEEVE. ALIGN AND FASTEN GARMENTS**	
10. **DO FINAL STEPS**	

TOPIC 22: TRANSFERRING

1. **Moving or transferring a resident to and from a bed, wheelchair, or stationary chair requires the use of proper body mechanics with emphasis on planning and safety**. A safe transfer for the resident and CNA is the primary goal. Refer to the resident's care plan before moving the resident. To prepare for a move:
   a. Gather all equipment. Be certain it is safe and in good working order.
   b. Provide for privacy. Observe resident for tubing, catheters or other devices that indicate a special need. Clear the immediate area and position furniture for safety.
   c. Assess the resident's size and ability to assist. Determine if you need help to move the resident safely.

2. **Moving the resident from a lying to a sitting position can cause dizziness and fainting**. To avoid falls and injuries, residents should be moved into a sitting position at the edge of the bed with their feet flat on the floor for at least 10-15 seconds prior to the move. When transferring a resident:
   a. Be sure the resident is wearing shoes or slippers with nonskid soles.
   b. Ask for assistance if the resident is too heavy or cannot help in the transfer.
   c. Determine if the resident has an affected (weak) side. Place the chair on the resident's unaffected side and transfer toward the unaffected side.
   d. If the chair has wheels, set the brakes before transferring resident.
   e. **Communicate with the resident. Count to three to let the resident know when to move**.
   f. Ask resident to put his hands on your upper arms, never around your neck (which could injure you).
   g. Frequently encourage the resident to help as much as possible and be alert for any sign of a problem.

3. **A stretcher** is a cart with wheels used to move a resident from one place to another.
   a. If the resident is dependent, place a sheet or bath blanket under the resident for transfer to the stretcher.
   b. Have at least two co-workers assist when transferring to a stretcher.
   c. Lock wheels of bed and stretcher before transfer and raise bed to same height as stretcher.
   d. Once resident is on the stretcher, use safety straps and side rails.
   e. Elevate head of stretcher as directed by the charge nurse.

4. **A mechanical lift is a hydraulic** or electric device used to transfer dependent or obese residents in and out of bed, wheelchair, or tub. Most lifts include a sling that is placed under the resident. Have at least one co-worker assist when using a mechanical lift. Follow manufacturer's guidelines for use of a mechanical lift.

5. Transporting residents to therapies, activities, and meals is a common task in a health care facility.
   a. Approach the resident from the front and explain what is going to happen.
   b. Observe for special equipment. Protect tubing to avoid resident discomfort.
   c. Transport only one resident at a time.
   d. Always push forward except when moving on and off an elevator, down a ramp, or up to a closed door. Turn the wheelchair or stretcher around and back on and off elevators and down ramps. When approaching a closed door, open door, and back through the door after checking for traffic.
   e. Be certain resident's legs, arms, and hands are inside the framework of the wheelchair or stretcher.
   f. **Set brakes at the destination**.

6. **CNA's role**:
   a. Provide for privacy and encourage the resident to help as much as possible to promote independence.
   b. Use proper body mechanics and check that equipment is safe and in good repair before use.
   c. Check the resident's care plan before moving the resident.
   d. Be patient and give the resident time to adjust to changes in position.
   e. Be very aware of the position and location of the resident's arms and legs when transferring and transporting and keep safety first. If unsure, get help.

QUESTIONS:

What problems can occur when moving a resident from a lying to a sitting position?
What observations should be made before transferring the resident?
If the resident has an affected side, where should the chair be placed during transfer?
How many residents should a CNA transport at one time?

ADDITIONAL DEFINITIONS:

Stationary – not moving
Dizziness – sensation of unsteadiness or faintness causing inability to maintain balance
Dependent – relying on others for help or support
Bath Blanket – flannel sheet used to provide warmth and privacy

RELATED PROCEDURES:

PROCEDURE 12: ASSIST TO CHAIR

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **PLACE CHAIR ON RESIDENT'S UNAFFECTED SIDE. BRACE FIRMLY AGAINST SIDE OF BED**	2. Unaffected side supports weight. Helps stabilize chair and is shortest distance for resident to turn
3. **ASSIST RESIDENT TO SIT ON EDGE OF BED** (according to procedure 7)	3. Allows resident to adjust to position change
4. Stand at resident's side	4. Puts you in position to help resident if needed
5. **HAVE RESIDENT GRASP FARTHEST ARM OF CHAIR**	5. Maintains stability during move
6. **TELL RESIDENT TO STAND ON COUNT OF THREE**	6. Allows you and resident to work together
7. Help resident slowly turn and sit	
8. Check body alignment	8. Shoulders and hips should be in straight line to reduce stress to spine and joints
9. **DO FINAL STEPS**	

PROCEDURE 13: TRANSFER TO WHEELCHAIR AND TRANSPORT

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **PLACE WHEELCHAIR ON RESIDENT'S UNAFFECTED SIDE. BRACE FIRMLY AGAINST SIDE OF BED WITH WHEELS LOCKED AND FOOT RESTS OUT OF WAY**	2. Unaffected side supports weight. Helps stabilize chair and is the shortest distance for the resident to turn. Wheel locks prevent chair from moving
3. **ASSIST RESIDENT TO SIT ON EDGE OF BED** (according to procedure 7)	3. Allows resident to adjust to position change
4. **STAND IN FRONT OF RESIDENT AND BLOCK RESIDENT'S FEET WITH YOUR FEET**	4. Allows you to stabilize resident and prevent slipping
5. **PLACE YOUR HANDS UNDER RESIDENT'S ARMS AND AROUND RESIDENT'S SHOULDER BLADES**	5. Reduces pressure on armpits and shoulders
6. **ASK RESIDENT TO PLACE HIS HANDS ON YOUR UPPER ARMS**	6. You may be injured if resident grabs around your neck
7. **ON COUNT OF THREE, HELP RESIDENT INTO STANDING POSITION BY STRAIGHTENING YOUR KNEES**	7. Allows you and resident to work together. Minimizes strain on your back
8. **ALLOW RESIDENT TO GAIN BALANCE, CHECK FOR DIZZINESS**	8. Change of position may cause dizziness due to drop in blood pressure
9. **MOVE YOUR FEET 18 INCHES APART AND SLOWLY TURN RESIDENT**	9. Improves your base of support and allows space for resident to turn
10. **LOWER RESIDENT INTO WHEELCHAIR BY BENDING YOUR KNEES AND LEANING FORWARD**	10. Minimizes strain on your back
11. Align resident's body and position foot rests	11. Shoulders and hips should be in straight line to reduce stress on spine and joints
12. **TRANSPORT RESIDENT FORWARD THROUGH OPEN DOORWAY AFTER CHECKING FOR TRAFFIC**	12. Provides for safety
13. **TRANSPORT RESIDENT UP TO CLOSED DOOR, OPEN DOOR AND BACK WHEELCHAIR THROUGH DOORWAY**	13. Prevents door from closing on resident
14. **TAKE RESIDENT TO DESTINATION AND LOCK WHEELCHAIR**	14. Prevents wheelchair from rolling if resident attempts to get up
15. **DO FINAL STEPS**	

TOPIC 23: MOBILITY

1. **Physical movement is important for mental and physical well being**. Residents who walk should be encouraged and/or assisted to walk frequently throughout the day. Residents in wheelchairs should be encouraged to transport themselves if possible.

2. **Residents with assistive devices should be encouraged to use the devices when ambulating**. Assistive devices are ordered by the doctor and fitted specifically to the resident. Assistive devices should never be borrowed or shared. Some assistive devices include:
   a. **Brace** – supports a specific part of the body.
   b. **Cane** – used by the resident with weakness on one side.
   c. **Crutches** – used when weight-bearing ability is reduced.
   d. **Walker** – used for support and steadiness.

3. **Range of motion exercises (ROM) are exercises that move each joint in the body to the fullest extent possible without causing pain.** Each movement is different based on the structure of the joint. Residents should be encouraged to actively do range of motion exercises each day. Residents who have difficulty moving by themselves will require assistance to exercise (passive range of motion).
   a. Check joints for redness and swelling. Report unusual findings to the nurse immediately and do not continue with procedure.
   b. Remove obstacles that may block motion.
   c. Support above and below the joint being exercised.
   d. Perform ROM exercises according to resident's care plan.
   e. Frequently ask resident if he is uncomfortable or in pain. Watch facial expression and response if a resident is unable to verbalize pain. Stop ROM immediately if resident experiences pain and report to nurse immediately.

4. **CNA's role**:
   a. Notice when a resident is using a piece of equipment improperly; help the resident to a safe place; report to the nurse immediately.
   b. Check equipment to see that it is in good condition.
   c. Help resident use assistive devices properly.
   d. Watch for signs of discomfort or fatigue.
   e. Make sure resident is wearing well-fitted nonskid shoes or slippers.
   f. Use proper body mechanics to prevent injury to both you and the resident.
   g. Provide for privacy and encourage the resident to do as much as possible to promote independence.
   h. When assisting the resident to walk with cane, stand on the resident's affected side.

QUESTIONS:

List and define four assistive devices.
What are range of motion exercises and why are they important?
Before doing range of motion exercises with a resident, what should the CNA check?
Besides a verbal complaint, how can the CNA tell if the resident is experiencing pain?

ADDITIONAL DEFINITIONS:

Assistive Devices – equipment used to help resident increase independence
Ambulate – to walk
Obstacle – anything that stands in the way
Verbalize – expresses in words

RELATED PROCEDURES:

PROCEDURE 10: WALKING

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **ASSIST RESIDENT TO SIT ON EDGE OF BED** (according to procedure 7)	2. Allows resident to adjust to position change
3. **ASSIST RESIDENT TO STAND ON COUNT OF THREE**	3. Allows you and resident to work together
4. **ALLOW RESIDENT TO GAIN BALANCE**	4. Change in position may cause dizziness due to a drop in blood pressure
5. **STAND TO SIDE AND SLIGHTLY BEHIND RESIDENT**	5. Allows clear path for the resident and puts you in a position to assist resident if needed
6. Walk at resident's pace	6. Reduces risk of resident falling
7. **DO FINAL STEPS**	

PROCEDURE 11: ASSIST WITH WALKER

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **ASSIST RESIDENT TO SIT ON EDGE OF BED** (according to procedure 7)	2. Allows resident to adjust to position change
3. **PLACE WALKER IN FRONT OF RESIDENT**	
4. Have resident grasp both arms of walker	4. Helps steady resident
5. **BRACE LEG OF WALKER WITH YOUR FOOT AND PLACE YOUR HAND ON TOP OF WALKER**	5. Prevents walker from moving
6. **ASSIST RESIDENT TO STAND ON COUNT OF THREE**	6. Allows you and resident to work together
7. **STAND TO SIDE AND SLIGHTLY BEHIND RESIDENT**	7. Puts you in a position to assist resident if needed
8. Have resident move walker ahead 6 to 10 inches then step up to walker	8. Resident may fall forward if he steps too far into walker
9. **DO FINAL STEPS**	

PROCEDURE 18: RANGE OF MOTION

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Position resident in good body alignment	2. Reduces stress to joints
3. **CHECK JOINTS. IF SWELLING, REDNESS OR WARMTH IS PRESENT, OR IF RESIDENT COMPLAINS OF PAIN, NOTIFY NURSE. CONTINUE PROCEDURE ONLY IF INSTRUCTED**	3. Indicates inflammation in joint which can be worsened if procedure is continued
4. **SUPPORT LIMB ABOVE AND BELOW JOINT**	4. Allows you to control joint movement and minimize resident's discomfort
5. **BEGIN RANGE OF MOTION AT SHOULDERS AND INCLUDE THE SHOULDERS, ELBOWS, WRISTS, THUMBS, FINGERS, HIPS, KNEES, ANKLES, AND TOES**	
6. **SLOWLY MOVE JOINT IN ALL DIRECTIONS IT NORMALLY MOVES**	6. Rapid movement may cause injury
7. **REPEAT MOVEMENT AT LEAST FIVE TIMES**	7. Ensures benefit from procedure
8. Encourage resident to participate as much as possible	8. Promotes resident's independence and self-esteem
9. **STOP PROCEDURE AT ANY SIGN OF PAIN AND REPORT TO NURSE IMMEDIATELY**	9. Pain is a warning sign for injury
10. **DO FINAL STEPS**	

TOPIC 24: NUTRITION AND HYDRATION

1. **Nutrition is the process by which the body takes in food to maintain health**. Good nutrition is important because it promotes physical and mental health, increases energy level and resistance to illness, and aids in the healing process. **A balanced diet is necessary for good nutrition and health**.
   a. **Nutrients include**:
      1) Carbohydrates – provide energy and fiber.
      2) Proteins – promote growth and repair of tissue.
      3) Fats – help the body use certain vitamins; provide a concentrated form of energy.
      4) Vitamins – help the body function.
      5) Minerals – build body tissue, regulate body fluids, promote bone and tooth formation, affect nerve and muscle function.
   b. The energy potential of food is measured in calories. The amount of calories needed depends on age, illness, activity, climate, and sleep. More calories are needed if a resident has an illness, infection, or pressure sore. **Individual food choices are affected by**:
      1) **Culture** – dietary content and cooking methods differ greatly throughout the world.
      2) **Religion** – some religions have food restrictions and periods of fasting.
      3) **Illness** – pain, medication, and treatment such as chemotherapy affect the ability to eat.
      4) **Finances** – a limited food budget influences the types of foods in a person's diet.
      5) **Personal preferences** – everyone has likes and dislikes.
   c. Most residents are on a basic diet. Some residents need special diets, which may:
      1) Restrict, eliminate or change the proportions of specific foods (sodium restricted, low fat, low cholesterol, diabetic).
      2) Be modified in consistency (clear liquids, full liquids, pureed, mechanical soft).
   d. When serving food, the CNA should:
      1) Prepare the dining area by being certain it is clean and free of unpleasant odors.
      2) Assist resident with elimination before the meal. Incontinent residents should be clean and dry.
      3) Assist resident with oral hygiene needs and handwashing.
      4) Identify the resident and position resident for comfort and safety.
      5) Check the resident's menu card for name, diet, restrictions, likes and dislikes and be certain that the tray is complete and correct.
      6) Be certain that hot foods are not too hot to eat. Stir hot foods to cool them. If food is cold, return to dietary and request a replacement.
      7) Allow resident time to pray before the meal to show respect and caring.
      8) Encourage resident to do as much as possible for themselves. Offer to help cut meats, open packages and pour liquids.
      9) Assist resident with visual impairment by using the numbers on a clock to describe location of the foods on the plate.
   e. **When feeding residents who cannot feed themselves** because of weakness, paralysis, casts, or confusion:
      1) Sit at eye level with the resident.
      2) Protect resident's clothing with covering.
      3) Identify the food with each bite.
      4) Feed slowly and in small amounts to prevent choking and aspiration.
      5) Place spoon on unaffected side of mouth.
      6) Offer fluids at regular intervals.
      7) Be patient, empathetic and encouraging.
      8) Record food intake according to current nursing practices.
   f. **Supplements and in-between meal snacks** increase protein and calories and can be ordered mid morning, mid afternoon and at bedtime for some residents.

2. **Approximately 2000-2500cc of fluid should** be taken into the body each day (liquids include water and some foods like gelatin, soup, and ice cream). Approximately the same amount of fluid should be excreted from the body through urine, feces, lungs (breathing) and skin (perspiration). This is called "fluid balance".
   a. Intake and Output (I&O) is the measurement of the amount of fluid the resident takes into the body and the amount of fluid leaving the body.
      1) Determine the resident's total fluid intake. Include liquids taken with meals and between meals and foods which are considered liquid (gelatin, soup, ice cream).
      2) Use metric measurements. 1 oz = 30cc.
      3) Use a graduated measuring container to measure output including urine and emesis.
      4) Record results immediately according to current nursing practices.
   b. Understand that:
      1) Fluid requirements change in hot weather, with exercise, fever and illness.
      2) The elderly may have a decreased sense of thirst.
      3) Fresh water must be available for each resident unless otherwise instructed by the nurse.
      4) Some residents will have special orders to restrict fluids.

3. Residents unable to take in food and fluid in a normal manner may require:
   a. Nasogastric tube - inserted into the nose and throat into the stomach.
   b. Gastrostomy tube - inserted through an opening in the abdomen directly into the stomach.
   c. Intravenous (IV) infusion – needle inserted into a vein.
   d. Report to the nurse immediately:
      1) Resident complaints of discomfort related to feeding.
      2) Redness, swelling, drainage or complaint of pain at needle or tube site.
      3) Tension or pulling on the tube, loose tape, difficulty breathing or choking.
   e. Provide frequent oral care to resident with a nasogastric tube feeding.

4. **CNA's role**:
   a. Encourage the resident to eat as much of the meal as possible.
   b. Note the foods the resident avoids and report to the nurse.
   c. Be patient when feeding or assisting the resident to eat.
   d. Create a positive environment during meals.
   e. Encourage socialization during meals.
   f. Offer fluids to the resident according to their care plan.
   g. Measure Intake and Output accurately.
   h. Observe and report any problems with tubing.
   i. Check with nurse before offering residents additional foods.

QUESTIONS:

Why is adequate nutrition especially important for the elderly?
What are the basic nutrients?
On what factors does a person's caloric need depend?
List the factors that influence a person's food choices.
Other than orally, what methods are used to provide nutrition and fluid to certain residents and what observations should the CNA make?

ADDITIONAL DEFINITIONS:

Nutrient - chemical substances contained in food
Basic Diet - a regular or general well balanced diet
Special Diet – therapeutic or modified

Aspiration – inhaling a foreign object or substance (food, liquids)
Supplement – to add

RELATED PROCEDURES:

PROCEDURE 30: ASSIST TO EAT

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Assist resident with elimination if necessary	2. Resident will be more comfortable when eating
3. **ASSIST RESIDENT TO WASH HANDS**	3. Promotes good hygiene and prevents spread of infection
4. Help resident into comfortable sitting position	4. Puts resident in more natural position
5. **CHECK MEAL CARD FOR NAME AND DIET. CHECK TRAY FOR CORRECT FOOD, CONDIMENTS AND UTENSILS**	5. Since resident's diet is ordered by the doctor, tray should contain foods permitted by the diet
6. Serve tray with main course closest to resident	
7. Offer resident napkin	7. Protects resident's clothing
8. **CUT AND SEASON FOOD, BUTTER BREAD, AND OPEN CARTONS AS REQUESTED**	8. Resident should do as much as possible to improve independence and self-esteem
9. Check resident every 10-15 minutes	9. Allows you to assist resident if needed and provides for resident's safety
10. Remove napkin and tray	
11. Assist resident to wash hands and face	11. Promotes self-esteem and prevents spread of infection
12. Measure and record intake if required	12. Provides nurse with necessary information to properly assess resident's condition and needs
13. **DO FINAL STEPS**	

PROCEDURE 31: FEEDING

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Assist resident with elimination if necessary	2. Resident will be more comfortable when eating
3. Assist resident to wash hands	3. Promotes good hygiene and prevents spread of infection
4. **PLACE RESIDENT IN COMFORTABLE SITTING POSITION**	4. Puts resident in more natural position
5. **CHECK MEAL CARD FOR NAME AND DIET. CHECK TRAY FOR CORRECT FOOD, CONDIMENTS AND UTENSILS**	5. Since diet is ordered by the doctor, tray should contain foods permitted by the diet
6. **SET TRAY ON OVERBED TABLE AND DESCRIBE FOOD**	
7. Place napkin or clothing protector under resident's chin and across chest	7. Protects resident's clothing
8. **ASK RESIDENT WHAT FOOD IS PREFERRED**	8. Resident has right to choose
9. **FILL SPOON HALF FULL WITH FOOD. DIRECT FOOD TO UNAFFECTED SIDE OF MOUTH**	9. Resident will be able to chew and swallow smaller amounts offered on the strong side
10. Allow resident time to chew and swallow. Offer fluids as resident wishes	10. Minimizes choking
11. Wipe resident's mouth as needed	11. Maintains resident's dignity
12. Remove napkin or clothing protector and tray	
13. Wash resident's face and hands	13. Promotes self-esteem and prevents spread of infection
14. Measure and record intake if required	14. Provides nurse with necessary information to properly assess resident's condition and needs
15. **DO FINAL STEPS**	

TOPIC 25: ELIMINATION

1. **Elimination is the process of ridding the body of waste through urination and defecation**.
   a. Urine – a liquid waste secreted by the kidneys every two to eight hours. Normal urine is pale yellow, clear and free of particles, blood and pus. The act of urination may be called voiding.
   b. Feces (stool, bowel movement) – a semisolid waste from the digestive tract passed through the anus as frequently as one to three times per day or as infrequently as two times per week. Feces should be medium brown and free of blood or mucous.

2. **To assist the resident to maintain normal elimination**:
   a. Provide and properly use equipment (urinal, bedpan, fracture pan, bedside commode, toilet).
   b. Assist the resident to a position that is as normal as possible (Raise head of bed to sitting position. Have men stand to urinate if possible).
   c. Check residents frequently for elimination needs.
   d. Provide privacy and enough time to eliminate. If the resident is stable leave the immediate area.
   e. Report complaints or observations of diarrhea or constipation.
   f. Encourage good nutrition, and adequate fluids and exercise.
   g. Always wipe from cleanest to dirtiest (front to back).

3. **Incontinence** is the inability to control bowel and/or bladder function. Causes include injury, disease, infection, certain medications and lack of access to toilet facilities.
   a. To meet the needs of the incontinent resident the CNA must:
      1) Respond to call light immediately.
      2) Check resident often for wetness and soiling. Provide frequent perineal care and skin care.
      3) Use incontinence briefs according to manufacturer's guidelines. Check for fit and keep plastic side away from skin.
   b. **Bowel and bladder training programs** may be ordered for the incontinent resident to help improve control of elimination. The CNA should:
      1) Follow elimination schedules exactly as the nurse instructs.
      2) Document success or lack of success accurately. Training does not happen overnight.
      3) Work cooperatively with team members. Continuity is vital.
      4) Be supportive and sensitive.

5. A **urinary catheter** is a tube inserted by the nurse through the urethra into the bladder to drain urine. An indwelling catheter is left in the bladder continually. The CNA's should:
   a. Keep drainage bag below level of bladder to allow gravity flow.
   b. Check tubing for kinks, blockages and signs of leakage.
   c. Place tubing over, never under, leg to prevent pressure sores.
   d. Attach bag to bed frame, never to guard rail. Keep bag and tubing off floor.
   e. Consider urinary drainage system whenever moving or transferring resident.
   f. Clean catheter from meatus out.
   g. Empty drainage bag and measure amount of urine at least once every shift and document observations.
   h. Use leg straps according to manufacturer's instructions.

6. **CNA's role**:
   a. Provide for the resident's privacy during elimination.
   b. Respect the resident's right to confidentiality if the resident is incontinent.
   c. Clean an incontinent resident immediately to prevent skin breakdown.
   d. Follow Standard Precautions when performing elimination related procedures.
   e. Assist residents to wash their hands after elimination.

f. Be aware of an indwelling catheter when moving the resident.
g. Never embarrass the resident if the resident is incontinent.
h. Observe color, odor, amount and character of urine or feces. Report unusual findings to the nurse before discarding.

QUESTIONS:

Define urine and feces.
How can the CNA assist the resident in maintaining normal elimination?
List the guidelines a CNA should follow when caring for a resident with an indwelling catheter.
What are the CNA's duties when caring for a resident on a bowel and/or bladder training program?

ADDITIONAL DEFINITIONS:

Fracture pan – a smaller flatter bedpan used by residents who have difficulty moving and lifting their hips
Diarrhea – loose watery stools, usually occurring frequently
Constipation – hard, dry stool usually occurring infrequently
Character – consistency and clarity (sediment, mucous**,** blood)

RELATED PROCEDURES:

PROCEDURE 35: ASSIST TO BATHROOM

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Walk with resident into bathroom	
3. Assist resident lower garments and sit	3. Allows resident to do as much as possible to help promote independence
4. **GIVE RESIDENT CALL LIGHT AND TOILET PAPER**	4. Ensures ability to communicate need for assistance
5. If resident is able to be left alone, step out of bathroom and return when called	5. Provides for resident's right to privacy
6. **PUT ON GLOVES** (according to procedure 2)	6. Protects you from contamination by bodily fluids
7. **ASSIST RESIDENT TO WIPE AREA FROM FRONT TO BACK**	7. Prevents spread of pathogens toward meatus which may cause urinary tract infection
8. **REMOVE GLOVES** (according to procedure 2)	
9. Assist resident to raise garments	
10. **ASSIST RESIDENT TO WASH HANDS**	10. Hand washing is the best way to prevent the spread of infection
11. Walk with resident back to bed or chair	
12. **DO FINAL STEPS**	

PROCEDURE 36: BEDSIDE COMMODE

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **PLACE COMMODE NEXT TO BED ON RESIDENT'S UNAFFECTED SIDE**	2. Helps stabilize commode and is the shortest distance for resident to turn
3. **ASSIST RESIDENT TO COMMODE**	
4. **GIVE RESIDENT CALL LIGHT AND TOILET PAPER**	4. Ensures ability to communicate need for assistance
5. If resident is able to be left alone, step behind curtain and return when called	5. Provides resident's right to privacy
6. **PUT ON GLOVES** (according to procedure 2)	6. Protects you from contamination by bodily fluids
7. **ASSIST RESIDENT WIPE FROM FRONT TO BACK**	7. Prevents spread of pathogens toward meatus which may cause urinary tract infection
8. Help resident into bed	
9. Remove and cover pan and take to bathroom	9. Pan should be covered to prevent the spread of infection
10. **CHECK URINE AND/OR FECES FOR COLOR, ODOR, AMOUNT & CHARACTER AND REPORT UNUSUAL FINDINGS TO NURSE**	10. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives attention quickly
11. Dispose of urine and/or feces, sanitize pan and return pan according to current nursing practices	11. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility
12. **REMOVE GLOVES** (according to procedure 2)	
13. **ASSIST RESIDENT TO WASH HANDS**	13. Hand washing is the best way to prevent the spread of infection
14. **DO FINAL STEPS**	

PROCEDURE 37: BEDPAN/FRACTURE PAN

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Lower head of bed	2. When bed is flat, resident can be moved without working against gravity
3. **PUT ON GLOVES** (according to procedure 2)	3. Protects you from contamination by bodily fluids
4. Turn resident away from you	
5. **PLACE BEDPAN OR FRACTURE PAN ACCORDING TO MANUFACTURER'S DIRECTIONS**	5. Equipment used incorrectly may cause discomfort and injury to resident
6. **GENTLY ROLL RESIDENT BACK ONTO PAN AND CHECK FOR CORRECT PLACEMENT**	6. Prevents linen from being soiled
7. **COVER RESIDENT**	7. Provides for resident's privacy
8. Raise head of bed to sitting position	8. Increases pressure on bladder to help with elimination
9. **GIVE RESIDENT CALL LIGHT AND TOILET PAPER**	9. Ensures ability to communicate need for assistance
10. Leave resident and return when called	10. Provides for resident's privacy
11. Lower head of bed	11. Places resident in proper position to remove pan
12. **PRESS BEDPAN FLAT ON BED AND TURN RESIDENT**	12. Prevents bedpan from spilling
13. **WIPE RESIDENT FROM FRONT TO BACK**	13. Prevents spread of pathogens toward meatus which may cause urinary tract infection
14. Provide perineal care if necessary (according to procedure 34)	
15. **CHECK URINE AND/OR FECES FOR COLOR, ODOR, AMOUNT & CHARACTER AND REPORT UNUSUAL FINDINGS TO NURSE**	15. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives attention quickly
16. Cover bedpan	16. Pan should be covered to prevent the spread of infection
17. Dispose of urine and/or feces, sanitize pan and return pan according to current nursing practices	17. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility
18. **REMOVE GLOVES** (according to procedure 2)	
19. **ASSIST RESIDENT TO WASH HANDS**	19. Hand washing is the best way to prevent the spread of infection
20. **DO FINAL STEPS**	

PROCEDURE 38: URINAL

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. Raise head of bed to sitting position	2. Increases gravity on top of bladder to help urination
3. **PUT ON GLOVES** (according to procedure 2)	3. Protects you from contamination by bodily fluids
4. **OFFER URINAL TO RESIDENT OR PLACE URINAL BETWEEN HIS LEGS AND INSERT PENIS INTO OPENING**	4. Allows resident to do as much as possible to help promote independence
5. **COVER RESIDENT**	5. Maintains resident's right to privacy
6. **GIVE RESIDENT CALL LIGHT AND TOILET PAPER**	6. Ensures the ability to communicate need for assistance
7. **LEAVE RESIDENT AND RETURN WHEN CALLED**	7. Provides for resident's privacy
8. Remove and cover urinal	8. Urinal should be covered to prevent the spread of infection
9. **TAKE URINAL TO BATHROOM, CHECK URINE FOR COLOR, ODOR, AMOUNT & CHARACTER AND REPORT UNUSUAL FINDINGS TO NURSE**	9. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives attention quickly
10. Dispose of urine, sanitize and return urinal according to current nursing practices	10. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility
11. **REMOVE GLOVES** (according to procedure 2)	
12. **ASSIST RESIDENT TO WASH HANDS**	12. Hand washing is the best way to prevent the spread of infection
13. **DO FINAL STEPS**	

PROCEDURE 39: EMPTY URINARY DRAINAGE BAG

STEP	RATIONALE
1. **DO INITIAL STEPS**	
2. **PUT ON GLOVES** (according to procedure 2)	2. Protects you from contamination by bodily fluids
3. Place paper towel on floor below bag and place graduate on paper towel	3. Reduces contamination of graduate and protects floor from drips
4. **DETACH SPOUT AND POINT IT INTO CENTER OF GRADUATE WITHOUT LETTING TUBE TOUCH SIDES**	4. Prevents contamination of tubing
5. **UNCLAMP SPOUT AND DRAIN URINE**	
6. **CLAMP SPOUT**	
7. **REPLACE SPOUT IN HOLDER**	
8. **CHECK URINE FOR COLOR, ODOR, AMOUNT & CHARACTER AND REPORT UNUSUAL FINDINGS TO NURSE**	8. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives attention quickly
9. **MEASURE AND ACCURATELY RECORD AMOUNT OF URINE**	9. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen
10. Dispose of urine, sanitize and return graduate according to current nursing practices	10. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility
11. **REMOVE GLOVES** (according to procedure 2)	
12. **DO FINAL STEPS**	

TOPIC 26: CARE OF THE DYING RESIDENT

1. **Death is the natural conclusion to life**. A person's response to death is based on their personal, cultural and religious beliefs and experiences. Resident and family may pass through five stages of grief, according to Dr. Elizabeth Kubler-Ross. Each person may experience the stages at a different rate or time.
   a. **Denial** - begins when a person is told of impending death; person may refuse to accept diagnosis or discuss situation.
   b. **Anger** – person expresses rage and resentment; often upset by smallest things; lashes out at anyone.
   c. **Bargaining** - person tries to arrange for more time to live to take care of unfinished business; bargains with the doctors or God.
   d. **Depression** - person begins the process of mourning; cries, withdraws from others.
   e. **Acceptance** - person has worked through feelings and understands that death is imminent.

2. Dying residents must have a **living will (Advance Directive)** which outlines their choices regarding withdrawing or withholding life-sustaining procedures if terminally ill. A living will must be written while the resident is mentally competent or by the resident's legal representative.
   a. Because of the resident's choice, the doctor may write a "Do Not Resuscitate" (DNR) order which tells the health care team that the resident does not wish any extraordinary measures to be used if the resident suffers cardiac or respiratory arrest.
   b. Hospice care may then be offered. Hospice care:
      1) Provides comfort measures and pain management.
      2) Preserves dignity, respect and choice.
      3) Offers empathy and support for the resident and the family.

3. **The physical needs of the dying resident include**:
   a. **Comfort**
      1) Place resident in the most comfortable position for breathing and avoiding pain. Maintain body alignment. Change resident's position frequently to avoid pressure sores.
      2) Bathe and groom resident frequently to promote self-esteem.
      3) Keep resident's environment as normal as possible. Room should be well lighted and well ventilated. Open drapes and door. Play resident's favorite music.
      4) Provide skin care, including back rubs, more frequently.
   b. **Mouth and Nose**
      1) Clean sores or bleeding in mouth following Standard Precautions.
      2) Provide oral care as needed. Cover lips with thin layer of petroleum jelly.
      3) Check for difficulty swallowing or choking.
      4) Gently clean nose.
      5) Offer drinking water as often as possible.
   c. **Elimination**
      1) Keep the resident's skin and linen clean.
      2) Provide perineal care as often as necessary.
   d. **Nutrition**
      1) Offer resident's favorite foods; include liquids or semi-liquids.
      2) Offer foods frequently and in small amounts. A balanced diet is not a primary concern.

4. **The emotional and psychological needs of a dying resident differ widely**:
   a. Identify incidents that affect resident's moods. Note behavior changes and report to the nurse immediately.
   b. Use touch where appropriate.
   c. Communicate with the resident even if he is not responsive; identify yourself and explain everything

you are doing.
   d. Be guided by the resident's attitude.
   e. Respect each person's idea of death and spiritual beliefs.
   f. Give the resident and the family privacy but not isolation.

5. **The physical changes that occur as a resident approaches death include**:
   a. Circulation - slows as heart fails; extremities become cold; pulse becomes rapid and weak.
   b. Respiration – irregular, rapid and shallow or slow and heavy.
   c. Muscle tone - jaw may sag; body becomes limp; bodily functions slow and become involuntary.
   d. Senses – sensory perception declines; may stare yet not respond; hearing is believed to be the last sense to be lost.

6. After death, facility procedures should be followed regarding **postmortem care** of the body. When performing postmortem care:
   a. Respect the family's religious restrictions regarding care of the body, if applicable.
   b. Provide privacy and assist a roommate to leave the area until the body is prepared and removed.
   c. Put body in the supine position with one pillow under the head to prevent facial discoloration.
   d. Put in dentures, and if instructed by the nurse, remove tubes and dressings.
   e. Wash the body and comb hair.
   f. Put on gown and cover perineal area with a pad.

7. **CNA's role**:
   a. Present a positive attitude and provide positive physical and emotional care.
   b. Be a good listener and use good communication skills.
   c. Spend time with the resident even when not providing care. Your physical presence is reassuring.
   d. Don't take anger directed at you personally.
   e. Be supportive.
   f. Observe and report to the nurse any physical or psychological changes that are noticed.
   g. Respect the resident's and family's spiritual beliefs.
   h. Encourage family members to participate as much as they can.
   i. Don't always think that you need to say something. Words are not always appropriate or important. Being kind, caring and concerned is.

QUESTIONS:

On what is a person's response to death based?
How does a CNA meet a dying resident's need for physical comfort?
Explain the five stages of grief.
How does a CNA provide for the emotional and psychosocial needs of the dying resident and their family?

ADDITIONAL DEFINITIONS:

Diagnosis – identification of a disease or condition usually by examination and testing
Imminent – likely to happen without delay
Postmortem – after death

TOPIC 27: SURVEY PROCESS AND TYPES OF FACILITIES

1. Several types of facilities employ CNAs.
   a. **Certified nursing facility** - receives Medicaid, Medicare funding and/or private pay.
   b. **Transitional Care Unit** - located within an acute care facility (hospital); accepts private pay payments and Medicare.
   c. **ICF/MRDD -** accepts mentally retarded and developmentally disabled individuals; receives Medicaid funding.
   d. **State licensed facility -** accepts no federal funding. (Medicaid or Medicare).
   e. **Residential facility -** for private pay residents. No federal money is accepted. Often set up as apartments. Residents require very minimal care. Many residents have their own cars and prepare their own meals. Sometimes the residents are there just to have their medications administered.

2. All facilities and institutions that utilize CNA's are licensed by the ISDH. In order to maintain their licensure they are required to meet state rules and federal requirements. During the survey process the surveyors determine if the facility is in compliance with federal requirements. These requirements are also known as the **Code of Federal Regulations**.
   a. During the survey process, the surveyors may observe care and ask questions (interview). You should tell them the truth and answer to the best of your ability. You are not breaking any confidentiality when discussing the resident with a state surveyor or other state agency personnel, the police or other state or federal enforcement agency personnel.
   b. Types of surveys include:
      1) Annual survey done on a routine basis to determine compliance with state and federal rules and requirements.
      2) Post Survey Review (PSR) determines if the deficiencies in the annual survey have been corrected and if the plan of correction was effective.
      3) Allegation of Breach Survey conducted when someone has registered a "complaint" against the facility. All allegations of breach are confidential as to whom actually registered the complaint.
      4) Life Safety Code surveys required by the Code of Federal Regulations and the State Fire Marshal to determine if the facility is in compliance with fire safety requirements.
      5) Nurse Aide Training Onsite visit specifically deals with issues of compliance with Nurse Aide Training conducted by the facility.
      6) Nurse Aide investigation is conducted when a charge of abuse, neglect and misappropriation of a resident's property or funds has been made against a nurse aide.

3. **The role of the CNA is**:
   a. Cooperate with any and all state investigations.
   b. Always tell the truth.
   c. Always work within the boundaries of your training and current nursing practices.
   d. Know the rules and requirements and abide by them.

QUESTIONS:

List the types of facilities that employ CNAs.
How should you respond in an interview with a state inspector?

APPENDIX: DISORDERS

ALZHEIMER'S DISEASE is a disease of the brain affecting memory, judgement, ability to think and, eventually, all physical functions. May begin as early as middle age but usually affects the elderly. **Symptoms** occur in three phases. **Phase One**- forgetfulness, particularly of recent events, avoiding unfamiliar situations and seeking the familiar, moodiness. **Phase Two**-restlessness particularly in the evening, inability to recognize dangerous situations, needs assistance with ADLs, speaks in one or two word responses and repeats, increased agitation. **Phase Three**-unable to recognize family, staff or self, dependent for all ADLs, incontinent, unable to walk. Death usually results from complications of infection, aspiration or heart failure.

PARKINSON'S DISEASE is a slow, progressive disease of the brain that affects physical function but, generally, not intelligence. **Symptoms** include tremors, stiff muscles, slurred slow speech, shuffling while walking, difficulty swallowing, and a mask-like expression.

MULTIPLE SCLEROSIS is a progressive disease of the nervous system that destroys the covering around the nerves. Often affects young adults. **Symptoms** include weakness, fatigue, and absence of feeling in a part of the body, incontinence, vision problems, and depression.

CLOSED HEAD INJURIES are injuries to the soft tissue of the brain as a result of falls or blows to the head which result in concussion, cerebral contusion and closed skull fractures. **Effects** of severe head injuries include paralysis, speech difficulties, personality change, difficulty breathing and incontinence.

DEVELOPMENTAL DISABILITY (DD) is a disability, which is attributable to:

1. Mental retardation, cerebral palsy, epilepsy or autism.
2. Any other condition found to be closely related to mental retardation because this condition results in similar impairment of general intellectual functioning or adaptive behavior or requires similar treatment or services.
3. Dyslexia resulting from a disability.

The disability originates before the person is eighteen years of age and has continued or is expected to continue indefinitely and constitutes a substantial handicap to the person's ability to function normally in society.

CEREBROVASCULAR ACCIDENT (CVA, STROKE) is a decreased blood flow to the brain resulting in brain injury. **Symptoms** include headache, dizziness, weakness or paralysis of an extremity or one side of the body, inability to talk, incontinence.

HYPERTENSION is abnormally high blood pressure due to narrowing of blood vessels, which causes the heart to work harder to pump blood. **Symptoms** include dizziness, headache, blurred vision.

CORONARY ARTERY DISEASE (CAD) is the narrowing of the coronary arteries causing reduced blood supply to the heart muscle. Angina pectoris (chronic persistent chest pain) may result. A complete blockage of the arteries to the heart muscle results in a **myocardial infarction (heart attack). Symptoms** include indigestion, nausea, crushing chest pain, perspiration, cool skin, paleness and shortness of breath.

CONGESTIVE HEART FAILURE is a disorder that develops when heart muscle is weakened and the heart becomes unable to pump enough blood. The weakened heart may be a result of chronic hypertension, myocardial infarction or narrowed blood vessels. **Symptoms** include difficulty breathing, fluid in the lungs, edema in feet and ankles, confusion, irregular pulse and cyanosis.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) is a disorder in which the flow of air into and out of the lungs is restricted as a result of such diseases as emphysema, chronic bronchitis and asthma. **Symptoms** include shortness of breath, coughing up mucous, fatigue, and with emphysema, the development of a barrel shaped chest.

DIABETES MELLITUS is a disorder in which the pancreas does not produce enough insulin (a hormone which enables glucose to enter the cells). **Symptoms** include excessive thirst, frequent urination, excessive hunger, weight loss, blurred vision and slow healing of wounds. Immediate action is required if a diabetic exhibits signs of:

1. **Hyperglycemia (high blood sugar) which can result in diabetic coma. Symptoms** appear gradually and include thirst, increase urination, abdominal pain, cramps, nausea, vomiting, dim vision, confusion, slurred speech, rapid pulse, drowsiness, flushed, hot dry skin, deep labored breathing, fruity breath odor.
2. **Hypoglycemia (low blood sugar) which can result in insulin shock. Symptoms** include hunger, restlessness, irritability, nervousness, weakness, dizziness, headache, nausea, blurred or double vision, pale, cold or clammy skin, sweaty, shallow breathing, confusion, and strange or unusual behavior

CANCER is the uncontrolled division of mutated cells resulting in tumors. Malignant cells may spread to other parts of the body through blood and lymph system. **Seven warning signs** (American Cancer Society) are:

1. Change in a wart or mole,
2. Lump or thickening in the breast or anywhere in the body,
3. Difficulty swallowing or indigestion,
4. Change in bladder or bowel habits,
5. Persistent cough or hoarseness,
6. Sore that does not heal,
7. Unusual bleeding or discharge.

OSTOMIES are surgically created openings on the surface of the body. Cancer, trauma and severe inflammatory disease of the bowel may result in the need for an ostomy. The attachment of a part of the intestine to the abdominal wall through which the person will defecate is called a colostomy or ileostomy.

KIDNEY FAILURE is a disorder resulting from infection, disease or injury that restricts the kidney's ability to filter the blood and remove waste from the body. **Symptoms** include intense itching, an ammonia-like odor to the skin, weakness, fatigue, high blood pressure and weight loss.

OSTEOPOROSIS is a disorder in which the bones lose calcium causing them to become spongy and brittle. **Symptoms** include back pain, gradual loss of height and stooped posture. Fractures are a major concern.

FRACTURE is a break in a bone resulting from a fall, accident or as a result of osteoporosis. Fractures may be simple (broken but within the body) or compound (broken and penetrating through the skin. **Symptoms** include swelling, pain visible deformity, bruising and inability to move normally**. With a hip fracture, the leg may also appear externally rotated and shortened.**

ARTHRITIS is an inflammatory condition of the joints caused by infection, injury or degenerative joint disease. Types of arthritis include:

1. **Osteoarthritis**-caused by the wear and tear on the smooth covering of the joint. **Symptoms** include pain, stiffness and swelling.
2. **Rheumatoid arthritis**-caused by a chronic inflammatory disease of connective tissue in the joints and other parts of the body. **Symptoms** include redness, swelling, severe pain in the joints, fever, fatigue and weight loss.

ARTHROPLASTY (total joint replacement) is a surgical procedure that replaces a diseased joint (hip, knee) with an artificial mechanism to re-establish motion.

PRESSURE SORE means ischemic ulceration and/or necrosis of tissues overlying a bony prominence that has been subjected to pressure, friction or shear. The staging system is one method of describing the extent of tissue damage in the pressure sore. Pressure sores cannot be adequately staged when covered with eschar or necrotic tissue. Staging should be done after the eschar has sloughed off or the wound has been debrided.

- Stage I: A persistent area of skin redness (without a break in the skin) that is nonblanchable. Redness can be expected to be present for one-half to three-fourths as long as the pressure applied that has occluded blood flow to the areas. For example: If a resident is lying on his right side for 30 minutes and turned to his back, redness may be noticed over his right hip bone. Redness in that area can be expected to remain for up to 20 minutes. Just having the redness does not indicate a stage I. To identify the presence of stage I pressure ulcers in residents with darkly pigmented skin, look for changes such as changes in skin color (grayish hue), temperature, swelling, and tenderness or texture.
- Stage II: A partial thickness loss of skin layers either dermis or epidermis that presents clinically as an abrasion, blister or shallow crater.
- Stage III: A full thickness of skin is lost, exposing the subcutaneous tissues-presents as a deep crater with or without undermining adjacent tissue.
- Stage IV: A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.

APPENDIX II: DEFINITIONS

TOPIC 1: HEALTH CARE DELIVERY

Acute Care-treatment for illnesses which come on suddenly and are usually of short duration
Subacute Care-treatment for illnesses after acute phase
Terminal Care-treatment for the dying person to improve comfort and quality of life
Health Care Team-group of professionals and non-professionals with special skills who work together to meet a resident's needs
Minimum Data Set (MDS)-form used to identify physical, mental, and psychological status of each resident
Maintenance Care-care that preserves function
Preventative Care-care that stops disease or injury from happening
Restorative Care-care aimed at regaining health and strength
Activities of Daily Living (ADL)-physical activities of everyday life
Advocate-one who defends the rights of another
Spiritual-the search for meaning in life usually through religion
Psychosocial Needs-need for independence, a supportive environment, recognition as an individual, spiritual fulfillment, and social interaction
Continuity of Care-getting everyone from every department on all shifts working towards the same goals using compatible methods
Actively Listen-paying attention to what is said in a conversation
Communicate-exchange information

TOPIC 2: ROLE OF THE NURSE AIDE

Job Description-list of tasks that a CNA is expected to perform
Environment-surroundings
Trust-to have confidence and faith in, to rely on
Call Light-a means of communicating with staff to get help
Ethical Behavior-doing what is right according to the rules of conduct of a particular group
Accountable-being responsible for your own choices (words and actions)
Respect-to treat with courtesy and consideration
Confidentiality-keeping information secret
Privacy-freedom from outsiders entering and watching without your consent
Abuse-act that causes harm
Neglect-failure to act in a reasonable and caring manner
Incident-any unusual event that occurs in the health care facility
Current Nursing Practices-up-to-date, proven and accepted ways of providing nursing care
Stress-pressure or strain that disturbs a person's mental or physical well being
Inservice Education-opportunities for learning offered by an employer
Verified Complaint-wrong doing that has been proven

TOPIC 3: OBSERVING AND REPORTING

Observing-gathering information through the use of the senses and feelings
Reporting-verbally informing the person in authority
Documentation-written account of what has happened
Accurate-correct, exact
Legally Responsible-accountable by law for one's actions
Chronological Order-the sequence in which events occur
Medical Terminology-the specific language of medicine
Abbreviation-a shortened form of a word

TOPIC 4: COMMUNICATION AND INTERPERSONAL SKILLS

Communication-the exchange of information and messages
Barrier-anything that hinders or blocks
Culture-values, beliefs and customs passed on from generation to generation by a group of people
Impairment-diminished function
Sign Language-method of communication using hand signals usually used to communicate with the deaf
Cognitively Impaired-diminished mental capacity for awareness and ability to make correct judgements

TOPIC 5: INFECTION CONTROL

Infection Control-preventing the spread of microorganisms by following certain practices and procedures
Standard Precautions-guidelines developed by the Center for Disease Control (CDC) to reduce the risk of transmission of pathogens from both known and unknown sources of infection in a health care setting
Hepatitis-contagious disease of the liver caused by a virus and spread by exposure to infected blood, sexual contact and fecal/oral contact
Scabies-skin infection caused by a mite and spread by direct contact
Tuberculosis (TB)-chronic bacterial infection that affects the lungs
Acquired Immune Deficiency Syndrome (AIDS)-set of diseases resulting from infection with Human Immunodeficiency Virus (HIV) which destroys the body's ability to fight infection
Methicillin Resistant Staphlococcus Aureus (MRSA)-bacteria that no longer responds to antibiotics normally used to treat staphlococcal infections
Microorganism-tiny living thing which can only be seen with a microscope
Pathogen-microorganism capable of producing disease
Vaccine-weakened or killed disease-producing organism taken orally or by injection to protect against disease
Mantoux Test-skin test to determine past or present exposure to Tuberculosis
Personal Hygiene-cleanliness
Sharps-any piece of medical equipment that has the potential to cut or puncture the skin
Nosocomial Infection-an infection acquired during a stay at a health care facility
Disinfect-using chemicals or boiling water to reduce the number of microorganisms
Sterilize-process of killing all microorganisms

TOPIC 6: BODY MECHANICS

Body mechanics-using the body properly to coordinate balance and movement
Efficient-using the least amount of effort to accomplish a task
Pelvis-the hip area
Balance-a state of being stable
Friction-rubbing one surface against another
Assess-to evaluate or check

TOPIC 7: SAFETY

Traffic Pattern-usual path taken in a room or hallway
Side Rail (guard rail)-metal or plastic rails on the sides of hospital beds
Cross Contamination-spread of different pathogens between two surfaces
Restraint-device or method including chemical means used to limit the activity or aggressiveness that could be harmful to the resident or others

TOPIC 8: EMERGENCIES

Emergency-a sudden, unexpected severe problem that endangers people
Choking-complete blockage of the airway requiring immediate action
Shock-occurs when vital parts of the body (brain, heart, and lungs) do not get enough blood
Seizures (convulsions)-sudden contractions of muscles due to a disturbance in brain activity

Fainting – sudden loss of consciousness
Hemorrhage-excessive loss of blood from a blood vessel
Cardiac Arrest-heart function and circulation stop
Disaster-sudden event in which property is destroyed and many people may be killed or injured
Static Electricity-the electricity produced by charged bodies
Sedate–state of calm and quiet induced by medication
Extinguish-to put out
Smoke Inhalation-a condition caused by breathing smoke into the lungs
Universal-common to all situations or conditions
Direct Pressure-applied force to a surface
Evacuation-to remove from a place for safety reasons

TOPIC 9: RESIDENT'S RIGHTS
Rights-human privileges and legal protections
Privilege-a liberty or benefit
Appropriate-suitable for a particular purpose, occasion or person
Status-state or condition
Dispute-to oppose or call into question
Grievance-a wrong, considered grounds for complaint
Retaliation-to get back at, take revenge
Physical Restraint-a device or method used to limit the activity or restlessness of a resident where such activity or restlessness could be harmful to the resident or others
Chemical Restraint-use of chemical means to limit the activity or aggressiveness of a resident where such activity or aggressiveness could be harmful to the resident or others
Corporal Punishment-physical punishment inflicting bodily harm
Seclusion-removal from social contact and activity
Violation-disregard or disobey a law or code of conduct
Self Esteem-a person's belief in himself, self respect

TOPIC 10: BASIC ANATOMY
Structure-the arrangement of tissues, parts, or organs
Function-the purpose for which something is designed
Interpret-to explain the meaning
Secretion-a substance released from specific organs for a particular purpose (enzyme, hormone)
Ova-egg
Masticate-to chew

TOPIC 11: THE AGING PROCESS
Aging Process-series of physical, sensory and psychosocial changes that occur over many years
Lung Capacity-amount of air the lungs can take in
Rigid-stiff, hard, unable to bend
Constipation-hard, dry stool usually occurring infrequently
Pigmentation-coloration in skin or eye
Porous-full of holes
Flexible-capable of being bent
Sensory Stimuli-information received through sight, hearing, taste, touch and smell

TOPIC 12: COGNITIVE IMPAIRMENT
Cognitive Impairment-temporary or permanent change within the brain that affects a person's ability to think, reason and learn
Depression-emotional sadness and withdrawal, usually caused by loss (of person, possession, health, choice,

self-esteem)
Anxiety-persistent feelings of fear and nervousness
Suspiciousness-distrust of others
Delusion-false belief not supported by reality
Paranoia-irrational feeling of being persecuted, suspiciousness, hostility
Schizophrenia-suspiciousness, paranoia, and delusion resulting in inappropriate behavior
Mental Retardation-process which slows or stops a child's brain from maturing
Dementia-progressive mental deterioration due to organic brain disease which causes structural changes within the brain
Reality Orientation-approach that helps resident remain aware of their environment, of time and of themselves
Validation Therapy-helps resident improve dignity and self-worth by having their feelings and memories acknowledged
Reminiscing-approach that allows resident to talk about past experiences, especially pleasant ones
Orientation-being aware of person, place and time
Sundowning-increased confusion and restlessness in late afternoon, evening, and night
Catastrophic Reactions-being abnormally overwhelmed by stimuli; easily startled
Pillage-take what does not belong to you
Hoard-to accumulate and hide
Agitation-being overly excited
Anxiety-worry or uneasiness about what may happen
Hallucination-hearing, smelling or seeing things that are not there

TOPIC 13: RESIDENT'S FAMILY
Family-extension of the resident including relatives, friends, neighbors, former co-workers, and/or guardian with durable power of attorney
Adjustment Process-a series of changes that occur over time to a situation or condition
Guilt-feeling of being at fault
Anger-a strong feeling of displeasure at a situation
Relief-a feeling of calm or comfort
Sadness-unhappiness or sorrow
Primary Caregiver-main person who takes care of another person

TOPIC 14: RESIDENT ENVIRONMENT
Resident Environment-includes the facility, the grounds and especially the resident's room
Side Rails-half or full rails attached to the sides of the bed considered a self-help aid to assist the resident with mobility, a safety device, and should be up if the bed is raised, a restraint if used for the sole purpose of confining the resident in bed and requires a doctor's order
Overbed Table-narrow table on wheels with adjustable height, which can be pushed over the bed and used for eating, writing and other activities
Bedside Stand-storage area for personal care items and personal belongings
Closed Bed-made with spread pulled over the pillow
Open Bed-made with linens fanfolded
Occupied Bed-made while resident is in bed
Emesis Basin-small kidney shaped pan used for spit or vomit
Bedpan-a device placed under a bedridden resident to collect urine or feces
Urinal-a container used by male residents to void
Adequate-enough

TOPIC 15: POSITIONING
Positioning-placement and alignment of the body when assisting the resident to sit, lie down or turn
Semi-Fowler's Position-head elevated 30-45

Fowler's Position-head elevated 45-60 degrees
Supine Position-flat on back
Lateral Position-lying on either right or left side
Alignment-to put in a straight line
Deformities-abnormally formed parts of the body
Coccyx-triangular bone at the base of the spine

TOPIC 16: VITAL SIGNS AND MEASUREMENTS
Vital Signs-essential body functions including temperature, pulse, respiration and blood pressure.
Temperature-measurement of heat in the body
Pulse Rate-measurement of the number of heartbeats per minute
Respiration Rate-measurement of the number of times a person inhales per minute
Blood Pressure-measurement of the force the blood exerts against the walls of the arteries
Diaphragm-piece at the end of the stethoscope which magnifies sound
Stethoscope-instrument used to convey to the ear sounds produced in the body
Sphygmomanometer-instrument for determining arterial pressure

TOPIC 17: BATHING
Perineal Care-cleaning the genital and anal area
Preferences-personal likes and dislikes
Drape-cover; flannel blanket put over resident to maintain privacy and warmth
Nail Beds-base of a nail
Bruise-discoloration of skin due to injury
Lesion-infected or broken patch of skin
Bedridden-confined to bed

TOPIC 18: SKIN CARE
Pressure Sores (decubitus ulcers, bedsores)-areas where skin has been damaged due to excessive pressure or friction
Pressure Points-any area on the body that bears the body's weight when lying or sitting and where bones are close to the skin's surface
Friction Areas-places where skin rubs on
Abrasion-an area of the body's surface where outer layer of skin is damaged due to friction
Mobility-ability to move
Nutrition-the process by which an organism takes in and uses food
Hydration-the process by which the body takes in and uses fluid
Obese-a condition of being overweight
Chair Bound-confined to a chair

TOPIC 19: ORAL CARE
Oral Care-cleaning the teeth, gums, tongue, inside of mouth and dentures
Dentures-removable false teeth

TOPIC 20: HAIR AND NAIL CARE
Pacemaker-electrical device that controls heartbeat by stimulating the heart muscle
Intact-unimpaired; whole
Cyanosis-bluish or grayish discoloration of skin

TOPIC 21: DRESSING
Individuality-all the characteristics that set one person apart from another
Inventory-a detailed list of articles

Inconspicuous-not easily seen
Independent-not relying on others for help or support
Incontinence Briefs-protective garment

TOPIC 22: TRANSFERRING
Mechanical Lift-hydraulic or electric device used to transfer dependent or obese residents in and out of bed, wheelchair, or tub
Stretcher-a cart with wheels used to move a resident from one place to another
Stationary-not moving
Dizziness-sensation of unsteadiness or faintness causing inability to maintain balance
Dependent-relying on others for help or support
Bath Blanket-flannel sheet used to provide warmth and privacy

TOPIC 23: MOBILITY
Range of Motion Exercises (ROM)-exercises that move each joint in the body to the fullest extent possible without causing pain
Assistive Devices-equipment used to help resident increase independence
Ambulate-to walk
Obstacle-anything that stands in the way
Verbalize-expresses in words

TOPIC 24: NUTRITION AND HYDRATION
Nutrition-process by which the body takes in food to maintain health
Fluid Balance-approximately the same amount of fluid is taken in and excreted from the body from the
Nutrient-chemical substances contained in food
Basic Diet-a regular or general well balanced diet
Special Diet-therapeutic or modified
Aspiration-inhaling a foreign object or substance (food, liquids)
Supplement-to add

TOPIC 25: ELIMINATION
Elimination-the process of ridding the body of waste through urination and defecation
Urine-a liquid waste secreted by the kidneys every two to eight hours
Feces (stool, bowel movement)-a semisolid waste from the digestive tract passed through the anus
Incontinence-the inability to control bowel and/or bladder function
Urinary Catheter-tube inserted by the nurse through the urethra into the bladder to drain urine
Indwelling Catheter-catheter left in the bladder continually
Fracture Pan-a smaller flatter bedpan used by residents who have difficulty moving and lifting their hips
Diarrhea-loose watery stools, usually occurring frequently
Constipation-hard, dry stool usually occurring infrequently
Character-consistency and clarity (sediment, mucous**,** blood)

TOPIC 26: CARE OF THE DYING RESIDENT
Death-stopping of all body functions-natural conclusion to life
Living Will (Advance Directive)-document which outlines person's choices regarding withdrawing or withholding life-sustaining procedures if terminally ill
Diagnosis-identification of a disease or condition usually by examination and testing
Imminent-likely to happen without delay
Postmortem-after death