

CAREGIVING FOR THE HUMAN CONDITION - AN OVERVIEW FOR NURSING ASSISTANT INSTRUCTION



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Nursing Assistant Instruction

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Preface

Preface

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MODULES

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Module 1 – Introduction to Healthcare

Learning Objectives

- Define the role of nursing assistants and articulate what makes a good nursing assistant
- Demonstrate understanding of how healthcare is organized in different settings
- Demonstrate understanding of the legal aspects of caring for residents as a nursing assistant
- Demonstrate professional communication

Welcome!

Welcome to *Caregiving for the Human Condition*, an Open Educational Resource (OER) for nursing assistant training. Congratulations on taking this next step in your professional life as a caregiver. Whether you want to be a career nursing assistant or use this as a stepping-off point for further credentials, Illinois (and the rest of the world) is lucky to have dedicated, caring individuals like you who want to make a career out of helping people become and stay well.

Holistic, Person-Centered Care

This goal of this text is to serve as instructional material for nursing assistant training with a focus on providing holistic, person-centered care in geriatric long-term care facilities, although its contents will be broadly applicable across caregiving contexts. What is holistic, person-centered care? In short, it means caring for a person *as a whole person*. A holistic approach to care doesn't reduce a person to their ailment or which specific aspects of their body require treatment. Instead a holistic approach treats each person in the entirety of their person, with a recognition that ailment or treatment that highlights one area of one's body impacts a person's whole life. When thinking about wellness and healing, the whole person should be the focus, not just their arm or back.

Person-centered means that the person receiving care is at the center of that care; they are in control of it. A person-centered approach to care means that the care team does everything they can to maximize the person's autonomy and agency. Receiving medical care should feel empowering, but all too often a person is left in the dark, doesn't know what is happening to them, or is not put in control of their own care.

What is person-centered care?

- Person-centered care recognizes the individuality of someone who needs care.
- Person-centered care understands healthcare as caring for a whole person.
- Person-centered care revolves around the person by doing the utmost to preserve the patient's autonomy, dignity, and choice.
- Person-centered care also ensures that an individual's background and identity will be respected.
- The ultimate goal of person-centered care is to improve the resident's overall quality of life by placing them in control.

A person who is already vulnerable should not also have to advocate for their needs to the very people who are supposed to help them, but unless medical professionals conscientiously exercise techniques rooted in holistic, person-centered care practices, a person receiving care may continue to feel that receiving care exacerbates their vulnerability rather than alleviates it. Throughout the text, readers will be asked to consider specific cases of caregiving through the lens of holistic, person-centered care.

In order to provide holistic, person-centered care, NAs will need to use critical thinking skills. What is critical thinking? Critical thinking occurs any time somebody closely analyzes something in order to form a judgment, such as whether they like it and why or what to do next about a situation. Applying a theory or conceptual framework to a real-world scenario is also an act of critical thinking.

NAs apply critical thinking in every step of their job. Whether making observations about a change in a resident's condition, determining the safest way to perform a task, or considering circumstances from the resident's point of view in order to demonstrate empathy and understanding, NAs deploy critical thinking at every moment.

Critical thinking begins with:

- assessing the situation
- observing all relevant factors
- weighing options
- acting based on reasoning

Throughout the text the reader will be asked to engage in critical thinking scenarios, where you will consider a situation and respond to it in a way that demonstrates critical thinking skills that align with the content of the chapter.

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The Big Three

Part of critical thinking for NAs involves always applying the Big Three to one's assigned responsibilities and care tasks. What is the Big Three? "The Big Three" refers to three essential frameworks for NAs to keep in mind at all times; Residents' Rights, Safety, and Infection Control. We will go into the specifics of each of these frameworks throughout the course of the texts.



We highlight these three frameworks for NAs because they are each relevant to everything a NA does. An important part of critical thinking as a nursing assistant is habitually asking oneself "Are the resident's rights being protected in my actions right now? Am I performing this task in the safest way possible? Am I following the steps necessary to prevent infection?" throughout each part of one's job. Like holistic, person-centered care, the Big Three are analytical frameworks and habits of thought that nursing assistants learn to use in a near-automatic way. We will continue to discuss the Big Three and its application throughout the

whole text.

What is a Nursing Assistant (NA)? What do NAs do?

Nursing assistants (NAs), also referred to as Certified Nursing Assistants (CNAs), are the first line of care in a variety of different medical care settings. Nursing assistants play an essential role in hospitals, assisted living facilities, home healthcare, and other medical contexts where patients or residents require assistance with their activities of daily living (ADLs).

ADLs include activities like brushing one's teeth, getting dressed, eating, showering, and walking. In other words, an ADL is any activity that somebody does daily or near-daily in their routine. It can be easy for somebody who does not need assistance not to think about their ADLs, but for somebody who *does* need assistance with daily tasks, a compassionate and understanding hand to do the helping can make a big impact on someone's sense of wellbeing, life-satisfaction, and dignity.

NAs tend to provide the most regular and hands-on care of all the members on the care team,

Hear from them

"Nursing Assistants are the first line of care, so it's really important that you know how to talk to people. People respond much better to care when you can get to know them personally." – Jacob G., NA at Northwestern Memorial Hospital

so it is important that they observe closely and take note of any changes in residents' physical and mental condition to report back to the care team. Talking and listening is an important part of gathering information about a resident's health, so getting to know specific residents and becoming familiar with their personalities can be an important part of providing holistic care.

NAs can provide emotional and spiritual support to residents in addition to providing basic assistance for ADLs. Listening and speaking with residents in a way that communicates an understanding of them as a whole person can provide residents with a sense of companionship and community.

NAs are an invaluable member of the care team; the value of NAs to a person's care can't really be overstated. An attentive and caring NA can be the difference between a positive and a negative care outcome, or between somebody's life and death.

The qualities of NAs

Nursing assistants to be empathetic, patient, and understanding with the people to whom they are providing care. What is an empathetic person? A person who practices empathy is able to put themselves in someone else's shoes. They are able to use their own life experiences to relate to and identify with the experiences of others.

It is important for everyone to practice using empathy, but it is especially important for NAs and anyone else who regularly cares for vulnerable adults. Practicing empathy every day trains us to see that everybody's lives and experiences are equally as valuable as one's own; as a nursing assistant, it will be part of your job to make sure that residents are treated in accordance with their inherent value as human beings.



"Smiling caregiver embracing happy senior woman in nursing home" by [agilemtg1](#) is marked with [Public Domain Mark 1.0](#).

Nursing assistants should also be conscientious, courteous, and accountable in their work. Being conscientious in this case means always doing your work to the best of your ability by being present, careful, observant, aware, thoughtful, and responsible in every situation.

Being courteous means showing basic respect to one's team mates, and to the people being cared for. Accountability means taking responsibility for one's work, and for one's mistakes; an accountable person always seeks to improve.

Being conscientious as a NA also means being trustworthy and completely honest, especially when it comes to being honest about what you don't know or when you've made a mistake. It means that your healthcare team and your residents' families can depend on you.

Courtesy is an important part of providing conscientious care; a nursing assistant provides courteous care when they respect everyone as individuals regardless of their beliefs, lifestyle, or identity. It means caring for somebody with the knowledge that they are a person deserving of dignity. This means that NAs must work to be unprejudiced and treat everyone in their care with kindness and equal standing.

Do's and Don'ts

It is important to know some basic rules about being a nursing assistant. Nursing assistants must remain within their scope of practice to protect the person receiving care from accidents, and to protect themselves and their team from liability^[1].

- NAs are assistants to the nurse. Nurses assign, supervise, and delegate all of the NA's work. NAs should only do the work that has been delegated to them.
- A nurse makes the decisions on what care a person should receive. NAs should always review the care plan with the nurse before proceeding.
- NAs should only perform tasks they have been trained to do and that their state and job description allow for. They should never perform a task if uncomfortable or unconfident performing it unless being guided by a nurse. NAs must always ask for help if unsure of their ability to safely do the delegated task.
- NAs need to know their own limitations. If they don't know their own limitations, everybody is at risk; if something goes wrong then the person being caring for could suffer the consequences of a mistake, the NA may lose their job and license, and the rest of the nursing team may be investigated for negligence. Everybody relies on one another in a care team, and in a setting where everybody relies on one another, being honest and trusting your team to support you is essential for the health of the person you are caring for.

Nursing Assistant "No"s

While the particulars of the NA job description may vary from state to state or from workplace to workplace, there are a few things that NAs should never do.

- Never give drugs
- Never insert or remove tubes or objects from a body
- Never take verbal or phone orders from a doctor
- Never perform procedures that require sterile technique
- Never tell the family or person the diagnosis or medical or surgical treatment plans. These are conversations that they should have with the nurse or doctor.
- Never supervise others, including other NAs. NAs should never perform a supervisory role.
- NAs should never ignore an order or request while following the chain of command.

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Quick Questions

What is critical thinking, and why is it a particularly important skill for nursing assistants to exercise? When will nursing assistants need to use critical thinking? Spend 5 minutes writing a response, and share with a friend or classmate.

The Organization and Operation of Care in Different Settings^[2]

Contexts

Nursing assistants are essential members of care teams in a variety of different healthcare contexts. Because nursing assistants most often work in long-term care contexts, that will be the focus of this text.

“Long-term care” is a general term used for facilities that provide 24-hour skilled medical care;

Someone who lives in a long-term care facility really does *live* there; it is their home, and will be until they move to a different facility or return to their regular residence.

long-term care facilities exist for people who are unable to stay in the hospital but who need more intensive care than can be provided at home. Long-term care is often necessary for people with chronic health conditions, or a health condition that takes place over a long period of time. NAs should treat a resident’s space as a guest would the home of a friendly host.

Assisted living facilities are places where staff can help a resident with whatever they may need. The residents in assisted living facilities do not usually need intensive medical care, but do require assistance with some ADLs due to restricted mobility and aging. If a resident develops higher care needs, some assisted living facilities may move them to a specialized wing for more attention and access to skilled care.

Hospitals are where somebody receives short-term skilled care. Someone may go to a hospital for a surgery, an emergency wound or burn, for a blood infusion, or any number of other medical problems.

Someone is placed in hospice care when they have a terminal condition; somebody’s condition is labeled “terminal” when it is likely going to be the cause of their immanent death, usually anticipated in less than six months.

The care team

What is a healthcare team? A patient’s healthcare team consists of all of the healthcare workers assigned to that patient’s recovery and care. Many different kinds of healthcare workers will be on your care teams, and each one brings specialized knowledge, skills, and talents to meet the varied needs of the person receiving care. Please read through this non-exhaustive list of some of the roles that you will encounter on your future healthcare teams.

Nursing assistants play one essential role on their care teams, but what are some of the other roles most often assigned to a care

team.

- Registered Nurse (RN): RNs are people who have successfully completed a state-licensed nursing program and passed the requisite state exam. They have a variety of responsibilities depending on the context including hands-on care and dispensing medication. They work as staff nurses, nurse supervisors and managers, directors of nursing, administrators, or instructors. With further study, RNs can become nurse practitioners or clinical nurse specialists.
- Licensed Practical or Licensed Vocational Nurse (LPN/LVN): an LPN/LVN provides basic nursing care and must possess a license. They may be supervised by RNs, doctors, and dentists. An LPN/LVN has fewer responsibilities and functions than an RN.
- Physician/doctor (MD): Provides prescriptions and diagnoses, and performs certain kinds of medical procedures. There are many different kinds of doctors specializing in various ailments or bodily systems.
- Physician's Assistant (PA): PAs assist doctors in diagnosing illness and prescribing treatment.
- Physical therapist (PT or DPT): A PT is somebody with extensive training on the body's physical systems and administering treatment meant to ease pain, maintain mobility, or improve breathing and circulation.
- Speech-language pathologist (SLP): An SLP is trained to diagnose speech and language disorder and constructs a treatment plan to address it.
- Registered dietitian nutritionist (RDN): An RDN creates nutrition plans for patients or residents with particular dietary needs, whether due to a specific illness or in the interest of overall health.
- Respiratory therapist (RT): An RT is somebody trained to provide treatment to people with respiratory illness.
- Medical social worker (MSW): An MSW is a health professional trained to help patients address the social support aspects of their care and recovery. A graduate degree and state licensure are required to perform this role.
- Ombudsman: An Ombudsman is a person who addresses patient and resident complaints about the facility from a fair and neutral perspective; they are often affiliated with the state, rather than directly affiliated with the healthcare facility. An Ombudsman's role is to help people address situations of injustice and conflict from a perspective of fairness and patient advocacy.

The patient and their family are essential members of the care team. The person receiving care must be included in conversations about the direction of the care; their family should also be included as a member of the care team, because they will most likely be the ones caring for the person once they leave the hospital or facility.



“doctor/nurse team photo” by [ReSurge International](#) is licensed under [CC BY-NC-ND 2.0](#).

Continuity of care amongst the healthcare team is vital, as is continuity of care between what care the patient receives at the medical facility and the care received at home. Effective coordination between members of the care team is essential for a successful recovery. Healthcare team members need to communicate with one another effectively to provide high-quality care.

The nursing team is a specific subgroup of the healthcare team made up of RNs, LPNs/LVNs, and nursing assistants. Each member of the nursing team focuses on the physical social, emotional, and spiritual needs of the person and family.

Everybody on the care team performs a specific and important role. However, even though each role is specific and carries particular responsibilities, expertise, and obligations, everyone on the care team is working collaboratively towards the same end: the person's health, recovery, and maximum quality of life. Because everyone works collaboratively, giving and insisting on respect is a practice NAs should become comfortable with.

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The Legal Dimension of Caregiving

Resident Rights



What are Resident Rights? Residents' Rights are the dimension of the Big Three that addresses what kinds of services, conditions, and treatment are legally and ethically required for people living in long-term care and assisted living facilities^[3].

Laws and ethics are different things, though they can overlap. Laws are rules and regulations that a government passes; healthcare professionals are subject to healthcare laws made at the federal and state level.

The most sweeping healthcare law enacted at the federal level is the Omnibus Budget Reconciliation Act of 1987, which continued to be revised and improved since its passage.

Ethics is the question of right and wrong, and how to design rules to determine them. Healthcare agencies and facilities often have a code of ethics that details what they consider to be ethical and unethical behavior in the workplace.

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National Ombudsmen Resource Center. (2021, October 6). Residents' rights: Your life, your care, your choice [Video]. Youtube. <https://www.youtube.com/watch?v=34Z0LYhLtIs>

While workplaces will have their own codes of conduct, these are some general guidelines for future NAs.

- Always maintain confidentiality; it is absolutely necessary to keep the information of those in your care as private as possible. Only share things that are relevant to the person's care, and only with the particular members of the care team.
- Always be honest in your communications with persons receiving care, the other members on the nursing team, and in your documentation. This goes hand in hand with being trustworthy and reliable; always show up for work on time, and always let your supervisor know if you are having any problems or difficulties.
- Never arrive at work under the influence of intoxicating substances.
- Never be prejudiced or biased in your interactions with persons in your care or in interactions with colleagues. Prejudice and bias occurs when we make judgments about somebody based on a single aspect of their personality or appearance, such as perceived sex and gender, ethnicity, race, taste in clothing, etc.
- Medical racism, or the ways in which health conditions and healthcare outcomes are partially determined by a person's race, is a pervasive issue in healthcare today. Hoffman et al. (2016) found that 73% of the medical professionals they surveyed held at least one false belief about biological differences between white and Black people.

NAs should believe the things that persons being cared for tell the care team about their condition and how it feels; failing to do so is an injustice, and can result in the care team allowing a preventable death.

They also found that false beliefs about biological difference based on race had a significant impact on how likely a healthcare professional was to believe a Black person's description of their pain levels, and whether Black person communicating their pain receives effective treatment^[4]. This basic insight that the prejudices of caregivers impact care outcomes applies to other forms of prejudice too, like sexism and fatphobia.

- Patience is a virtue, especially when providing care. NAs should always be patient with the persons in their care. Healthcare settings are often stressful places; NAs need to be able to help someone through pain and the trials of recovery without becoming frustrated or rushing them.
- Always read and follow the workplace code of ethics closely.

Understanding the laws and codes of ethics is important. It is also important to understand why such laws and ethics are in place. People receiving care are often vulnerable. Laws and codes of ethics are necessary measures to ensure that vulnerable people are not taken advantage of or easily mistreated. NAs should always follow the spirit and motivation of such laws and ethics in addition to abiding by their minimum standards; we have all been or will be vulnerable at different points in our lives, but NAs are in the unique position to turn an awareness of vulnerability into attentive and empowering care.

Quick Question

What is the relationship between Residents' Rights and ethics? Why is following ethical conduct important for maintaining Residents' Rights? Write for 5 minutes and share with a friend or a classmate.

The Nurse Practice Act

Each state has a Nurse Practice Act that defines the scope of practice for nurses and nursing assistants, delineates their education and licensing requirements, and outlines the requirements for revoking or suspending a license.

These laws are put in place to protect people from unqualified or unsafe healthcare workers; these laws are also in the interest of nurses, whose own health and professional status are protected. State laws about nursing assistants are based on that state's Nurse Practice Act, and describe what it means for a nursing assistant to function with safety, skill, and accountability.

What is a Healthcare Worker Registry? As part of the Omnibus Reconciliation Act of 1987, NAs are added to a state-wide registry once they have completed their requisite training and meet competency requirements. The Illinois Healthcare Worker Registry can be found at <https://hcwrpub.dph.illinois.gov/Search.aspx>. The Healthcare Worker Registry is a comprehensive resource containing a list of every certified medical professional by name. Other information such as sex, race, height, certification status, and the date of most recent background check is also listed^[5].

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law passed at the federal level that establishes rules about what healthcare and insurance agencies can do with individuals' protected health information (PHI). PHI is any identifying information about a person's health plan, healthcare history, or any conditions or treatments they may have or will undergo^[6].

The two most important elements of HIPAA for nursing assistants to know are the Privacy Rule and the Security Rule. The Privacy Rule was added to HIPAA in 2000, and sets national standards for the protection of private health information. The Security Rule was published in HIPAA in 2003 and outlines standards for protecting the "confidentiality, integrity, and availability of electronic health information"^[7].

The reason for a higher level of concern regarding the privacy and integrity of PHI comes from the security risk posed by progresses in computer technology; as it became easier to use technology to steal a person's healthcare information, it became more important to pass regulation to ensure that any identifying information is kept safe and private.

NATCEP

What is NATCEP? NATCEP stands for the Nurse Aide Training and Competency Evaluation Program. It was implemented as a result of OBRA's passage. OBRA was necessary because of the poor, negligent, and sometimes abusive conditions present in long-term care and assisted living facilities up to that point. To address this, the federal government legislated minimum standards of care, including minimum standards of education for nurse assistants.

NATCEP requires at least 75 hours of combined theoretical and hands-on instruction and successful completion of a competency evaluation before a nursing assistant can legally work. NATCEP also mandates at least 12 hours of continuing education for nursing assistants each year to keep skills sharp and current.

NAs must continue working as a NA in some capacity if they want to keep their certification. If a nursing assistant goes 24 consecutive months without providing professional care for pay they will have to re-take the requisite written competency exam to reacquire certification. It is in one's best interest not to let NA certification expire; not only can it be time-consuming or costly to become re-certified, it may also cause potential employers to doubt someone's professionalism.

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Resident Rights; their importance and enforcement

Residents' Rights are basic quality of life standards that long-term care residents always have a legitimate claim to because they are human beings and because they are protected by federal and state law.

Protecting Resident Rights is necessary and grows from a general concern for human rights, with the added recognitions that vulnerable elders have historically not had their human rights protected. Adults who are already vulnerable due to age and disability may be even more vulnerable when they reside in long-term care and aren't in a position to advocate for themselves.

OBRA, or the Omnibus Budget Reconciliation Act of 1987, is a federal law that was put in place to protect residents in long-term care facilities from reported patterns of abuse, neglect, and substandard care. OBRA establishes some policies intended to increase the accountability and standards of long-term care facilities and puts minimum certification requirements in place for NAs.

OBRA has been updated multiple times since 1987, with its most recent update occurring in 2016 when the Center for Medicare

and Medicaid Services implemented additional safety and resident rights requirements for long-term care facilities if they want to access federal funds. OBRA goes hand-in-hand with the Elder Justice Act of 2010, a comprehensive piece of legislation at the federal level passed to protect residents in long-term care facilities from abuse, neglect, and exploitation.

Legislation like OBRA and the Elder Justice Act apply to nursing assistants because it establishes baseline educational, certification, and registration requirements. It is also part of what defines the NA scope of practice.

According to the Illinois Department on Aging, residents in long-term care facilities have a specific set of rights that long-term care facilities are required to uphold^[8].

- Residents have a right to dignity and respect. This means that residents have a right to make their own choice, a right to treatment that promotes quality of life, and a right to equal access to care.
- Residents have a right to safety; this means that residents have a right to be free from abuse, neglect, and exploitation. Residents have a right to complain without fear of retaliation and discrimination. Residents have a right to quality physical and mental health services, and a clean, comfortable, and homelike environment. Residents have a right to be free from chemical or physical restraint; residents can only be given mood or thought altering medication with their permission.
- Residents have the right to participate in their own care. This means that they may attend care conferences, may see and request changes to the care plan, choose their own doctor, make a living will, refuse treatments, and move out of the facility. Residents have a right to be fully informed and empowered in their own care.
- Residents have a right to confidentiality and privacy. They are entitled to a knock before facility staff enter, a right to private visits at any hour as long as they don't infringe on other residents' rights, a right to control who has access to their information, and a right to privacy and access to mail and telephone services.
- Residents have a right to their personal money, even if their personal money is managed by their facility. They also have a right to their personal property; facilities must take steps to keep residents' personal property safe and secure.
- Residents have a right to be fully informed about the expected and actual costs of their care; they also have a right to be provided with accurate information about Medicare and Medicaid. Residents also have a right to advanced directives, which are documents that gives instructions on care should the resident be unresponsive or unable to make their own medical decisions.
- Residents also have a right to stay in their facility, unless in case of certain exceptions. If a facility wants to involuntarily discharge a resident, they must meet some requirements; first, there must be some reason that the resident can no longer receive care at this facility, such as being a danger to themselves or others, an unmet care need, improved condition, unpaid bills, or facility closure. If a facility wants to evict a resident, they must provide notice at least 21 days in advance, provide information on the appealing the decision to the Illinois Department of Public Health, and provide a mailing envelope for the appeal.

If you suspect that your workplace is violating any of these rights, you should discuss it with your supervisor and bring the problem up with the resident council. The resident council is a group of residents who meet to discuss issues with their facility and advocate for improvements on behalf of residents.

If you or the resident council need further help solving the problem, you may want to contact your state's long term care Ombudsman program or file a complaint with the Department of Public Health^[9].



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Policy, Procedure, and Job Description

A policy is a course of action that is meant to be taken every time in response to particular situations. A healthcare facility may have a policy on workplace attire, on sharing details of a person's recovery with their family, or on the appropriate use of psychiatric medication, to give a few examples.

A procedure is a specific method or way of doing something. A healthcare facility will have procedures on how to change a bed, how to fill out a medical chart, and on how to properly remove PPE like gloves and masks.

NAs must closely follow all of their workplace policies and procedures. Failure to do so could make them or their supervisors liable any resulting negative consequences. Policies and procedures are in place to protect the patient, the healthcare professionals, and the healthcare facility; it is in everyone's best interest, including one's own, to follow policies and procedures to the letter.

Some policies and procedures are mandated and overseen by federal and state governments, while others are specific to the workplace. If you have a question about your workplace's policies and procedures, always ask your supervisor or consult the document where they can be found.

A job description refers to one's clearly defined duties and responsibilities. Job descriptions may be written by government legislation, agencies, and specific workplaces. If a nursing assistant is asked to do something that is not in their job description, they should refrain from performing the task and discuss it with their supervisor.

Federal and state agencies may perform oversight on long-term care facilities by hosting surveys; a survey is when a federal or state oversight body reviews the work done by a long-term care facility to ensure that minimum legal standards are consistently met. These surveys will assess whether residents are receiving satisfactory care and whether their needs are being met. In doing so they will talk with staff, residents, and families, as well as review all charts and documentation done by the staff.

A NA's role during a survey is the same as it always is – provide quality care, pay attention to the Big Three, and be professional and honest. If an oversight agency finds a problem with a facility, they will issue a citation; depending on the severity, a citation may result in the care facility being forced to correct the issue, being fined, or loss of license, certification, and accreditation. NAs should always be honest if an auditor asks them questions about their facility.

Abuse and Neglect

Before OBRA's passage, abusive and neglectful treatment of residents was significantly more common than it is today. Sadly, in spite of necessary legislation, the problem does still persist.

Residents have a right to be free from abuse and neglect. Abuse is purposeful mistreatment and can come in many forms, physical, financial, or psychological. Neglect is a form of mistreatment that occurs when a vulnerable person's needs are not met while in the responsible party's care; neglect or negligence can result in harm to a person, which then makes it malpractice.

Every resident is every NA's responsibility. NAs work to make sure that everyone in their care has as high a quality of life as possible every day. A high quality of life, understood in terms of the residents' rights outlined above, is not compatible with suffering abuse^[10].

Elder abuse can come from different sources. Residents are especially vulnerable to abuse from staff members, and potentially from other residents. Residents may also be abused by family members who visit or take the resident elsewhere. It is important for NAs to recognize the possibility of abuse and to observe any potential warning signs that a resident is being abused.

There are many signs of potential abuse and neglect; unexplained injuries (especially if reoccurring), weight loss and dehydration, fear and anxiety around a particular caregiver, uncleanliness, a caregiver or family member withholding privacy, and call lights left unanswered are all potential indicators that a resident is suffering from abuse or neglect.

NAs are mandatory reporters, which means that they are legally obligated to report suspected abuse or neglect. The NA can alert the nurse to their concerns with or without discussing it with the resident first. When reporting, the NA should tell the nurse and give as many details as possible; they should also assist the resident if the resident decides to make a formal complaint.

Remember, residents have a right to be free from retaliation; if a resident complains and a staff member appears to punish them for it, the nursing assistant should report this behavior as soon as possible.

What would you do?

Imagine that you are working as a nurse's assistant in a long-term care facility. You regularly care for Mr. Jones, and have a good sense of his personality. He is talkative with you, is forgetful but lucid most days, and is comfortable with a casual touch on the hand or the arm (you know this because he told you after you asked). However recently you have noticed some changes in Mr. Jones' demeanor. In the last month he has become more withdrawn and disoriented, less willing to eat and participate in social life, and he recoiled the few times you have touched his hand during conversation. Today he said something concerning: when you brought up the upcoming weekend, he said that he wished you would still come to work so he "wouldn't have to spend as much time with that other aide." You've observed him while assisting with ADLs and did not notice any marks or physical causes for concern. How would you proceed with this situation? Would you tell the nurse immediately, or try and talk with Mr. Jones first? How would you approach that discussion? Spend 5 minutes writing, and share with a friend or classmate.

Professional Communication

Professional communication for NAs looks different depending on the context it occurs in; professional communication means something different when talking with a nurse than when communicating with a resident^[11].

The communication that goes on as a function of caring for patients and residents is some of the most significant communication that happens in healthcare settings. In other words, the members of the care team have to communicate with one another in order to organize and provide care, and their ability to communicate effectively matters a lot for their ability to successfully care for someone. Professional communication between members of a care team about patient care will utilize three important frameworks and procedures: the nursing Chain of Command, the Nursing Process, and reporting and recording.

The Chain of Command

The Chain of Command refers to the authority and responsibility that different nursing staff carry relative to one another. NAs are at the "bottom" of the Chain of Command; this has nothing to do with how important they are to a person's care, and simply means that they are not permitted to delegate tasks to or supervise anyone. Rather, tasks are delegated to them, and they are supervised by a nurse with more responsibilities and liabilities who is "higher" on the chain of command.

A facility's Director of Nursing (DON) is responsible for the whole nursing staff. The DON has a team of staff involved at higher-order levels of staff development and care management, who have responsibility over nursing supervisors and charge nurses that manage many units or a single unit respectively.

Staff nurses, or RNs and LPNs, are next in the Chain of Command and are responsible over the nursing assistants. NAs report to the RN that they are assigned to.

It is part of the work of employers to provide their NAs with the education and mentorship necessary to do their work. NAs should always feel comfortable asking for help or additional instructions from people who oversee their work and training.

Delegation

When an RN gives the NA a request or an order, they are delegating something to them. This implicates them both in that care task. NAs are liable for their own actions; this means they are responsible for them. However, NA's actions are also a liability in the sense that other people, like supervising nurses, may be held responsible for them as well.

NAs must ask for help if they may need it. NAs should never do something they are less than comfortable with unsupervised, because many people rely on NAs to do their work correctly.

Delegation occurs when a particular member of the care team with a higher level of supervision and responsibility than the NA on the nursing Chain of Command asks them to perform a task. Tasks must be properly delegated, in the sense that they are delegated by the correct person to the correct person. An NA should only be delegated tasks that are within their job description and they can legally perform; NAs may also be asked to assist nurses with more complicated tasks. RNs can delegate tasks to LPNs and NAs, LPNs can delegate tasks to NAs, and NAs cannot delegate any tasks.

The National Council of State Boards of Nursing (NCSBN) describes the **Five Rights of Delegation**^[12] as:

- Right Task
- Right Circumstance
- Right Person
- Right Direction/Communication
- Right Supervision/Evaluation

These “rights” are in place to ensure that when a task is delegated, it is the correct care task, delegated properly by the relevant person, in the best interest of the patient, and is performed by the right person with the proper oversight. It is part of the NAs responsibility to know when they are being delegated a task that they should not perform. This is vital, because a NA, RN, or another member of the nursing team may be held responsible for improperly delegated tasks^[13].

NAs can either agree or refuse to perform a delegated task. Protecting the patient from harm is always the NA's first priority; if the NA does not feel they can safely perform the delegated task, they should refuse it so the nurse can delegate it to somebody who can safely and legally perform it.

NAs should only perform tasks that are within their scope of practice. The NA's scope of practice is determined by the state, the agency the NA works for, and the NA's supervising nurse. However, no agency or nurse can expand the NA's scope of practice beyond legal boundaries or beyond the boundaries of responsible caregiving.

It is important never to ignore a request. If a NA is not comfortable with performing a delegated task, it is important that they communicate with their supervisor or someone who can hear their concerns. Some reasons for refusing a task may be that the directions aren't ethical or are not within the legal boundaries of the NA role, the task falls outside the NA scope of practice, directions may go against agency policies, directions are unclear or incomplete, or a nurse may not be available to supervise the NA's performance.

Quick Question

Imagine that you are at work as a NA, and your supervising nurse asks you to perform a care task that is within the technical scope of your practice, but that you haven't been trained on how to perform. The floor is very busy right now, so when you raise your concern, the nurse says “It's a simple task, just go ahead and do it.” You are still uncomfortable with the situation. What should you do? Which of the Five Rights might be at jeopardy in this situation?

Query 7

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The Nursing Process: Assess, Diagnose, Plan, Implement, Evaluate

Nursing care is a highly organized process, which means that in order to do it well every time all members of the nursing team need to proceed methodically. The nursing process is a step-by-step method that nurses use to determine what may be wrong with a patient and how best to move forward with their care.

Assessment: Assessment means, in short, gathering information about the patient. Nurses or N.A.s may do this by reviewing a medical chart, talking with the patient, performing a physical assessment of some kind, and by using your five senses to take note and observe.

Subjective and Objective Information

Can you define the difference between subjective and objective information in a patient care setting? What is one example of objective information and one example of subjective information that a NA might take note of?

Nursing assistants play an important role in the assessment phase of the nursing process because they often have the most hands-on interaction with the patient, and are therefore best positioned to take note of changes in their condition.

NAs should take note of objective information by writing down what they can gather from their senses; they should also note any subjective information, or things they learn by speaking with the patient or their families. For example, objective information is noticing that a patient has jaundice; subjective information would be when they tell you that their stomach hurts.

When observing a patient as part of assessment, try and take note of their orientation (awareness and grasp of reality), vital signs, changes in ability, or any other changes in physical condition or mood. Assessment is an ongoing process, and continues for as long as the patient is in the nursing team's care.

Diagnosis: When a medical professional makes a diagnosis, they are making an official declaration of what they believe is wrong with the patient. Nurses can give diagnoses of problems that can be treated with nursing measures. Nursing diagnoses are not medical diagnoses, because a medical diagnosis must be made by a doctor. A nursing diagnosis can be made by a nurse, and describes a health problem that can be treated by a nurse. A nursing diagnosis may have to do with an issue of the body, but it may also address the emotional, social, or spiritual dimensions of a person's care.

Planning: Planning occurs when the nursing team decides how to proceed with care. Planning with the nursing team may involve the delegation of tasks and duties, prioritizing some aspects of care over others, and aligning your care goals as a team. While the RN ultimately decides on the plan, everybody's input (especially the patient and their family's) input is essential. Goals are what is desired for a person's care, and usually indicate an "if all goes well" mentality, aiming at a person's highest anticipated level of being and function. Goals are important because they promote healing and recovery. When prioritizing actions in the planning phase, consider which needs are most threatening, which steps are time-sensitive, staff availability to perform the tasks, and the holistic needs and wants of the patient. Prioritization is an exceptionally important skill for a NA to develop, because it is important to the organization of a patient's care and because it is essential for efficient time-management on the job.

Implementation: The implementation step is the action phase of the nursing process. It is when the interventions determined in the planning phase are put into effect. The tasks in need of implementation may range from basic and simple to highly complicated and requiring multiple people. Reporting and recording of the care should only occur after the care has actually been administered. It is important to continue observing and taking note throughout the entirety of the nursing process, because the assessment phase never ends. Continued observation is necessary in case any changes need to be made to the care plan.

How is critical thinking involved in each step of the nursing process? Spend five minutes writing, and share your response with a friend or classmate

Evaluation: Evaluation occurs when the care team determines how successful the intervention was. Goals set during the planning phase may be met completely, partially, or not at all. Once progress has been evaluated, the nursing team returns to the assessment stage to continue the patient's care and begin the process over again.

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Reporting and Recording

When an NA reports something to the nurse, they deliver information verbally. When an NA records something, that means the information was written and is included in the patient's chart. It is important to make sure that both of these steps are completed.

When reporting, a NA has only officially reported something when they speak to their supervising nurse, not simply another person above them in the Chain of Command.

When verbally reporting the NA should be prompt, thorough, and accurate. This means correctly noting all relevant information, without including so many unnecessary details that the record is burdensome and time consuming. All record entries should include the patient's name, room, and bed number, and the time that the observation was made or care was given.

The NA should report and record only what they did and the care they provided, as well as any noticeable changes to the patient's condition. The report should also include the time when the NA left the area.

When recording, an NA should write information in the patient's medical record. A medical record, or chart, is a permanent legal document that medical institutions keep on their patients. It contains descriptions of a patient's condition, relevant details of their medical history, notes on the care plan and treatment, consent forms, progress notes, and details of any changes the patient has undergone since entering into care.

The NA should record anything that they do to, with, or for the patient; this is an essential element of maintaining the continuity of care within the nursing team.

A patient's medical record is confidential, and should be handled on a need-to-know basis. Do not give the medical records to anyone, including family or legal representation, without explicit permission from the nurse or MD.

A popular saying in the nursing profession is that "if it wasn't recorded, it didn't happen." While ironic, this saying expresses the extent to which a nursing team relies on a patient's medical record to coordinate their care. All documentation should occur only after the care has been administered, neither during nor before.

Record-keeping may be different from one healthcare setting to the next. While most employers now use an electronic system, some may use a written or a mixed record-keeping system. When charting by hand, always use black ink, and only record facts rather than opinions. It is important to follow the agency's rules on documentation. If a NA make a mistake on a chart, they should never erase it or correct it, though they should cross it out and enter the correct information. NAs should follow their facility or agency's policy for correcting a mistake made on a medical record.

Incident Reporting and Recording

An incident is a problem, accident, or unforeseen event in a patient's care, or an accident or injury that impacts any employee or visitor. An incident report is a report that objectively documents what happened and what the response to the situation was. This is important so workplaces can be made safer, and so incidents do not further impact anybody's care.

NAs should never let anybody talk them out of filing an incident report. Incident reports exist to make workplaces safer, and to protect everybody's interests, including caregivers.

NAs should always fill out an incident report if they are injured while on the job; if an incident occurs in a patient's care, a nurse will usually fill out the incident report and may ask for input from the NA. The incident report should include only factual observations and events from an objective perspective. NAs should never let anybody talk them out of filing an incident report.

When completing an incident report, NAs should include exactly what they observed, list the time of occurrence, list any observations of the person and what state they are in, and describe the person's reaction to the situation. Facilities will usually have a specific form for NAs to fill out. NAs should report the incident to the nurse before filling out an incident report form, especially if the incident involves a patient, because the nurse may want to complete the form themselves.

Query 9

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Start and End-of-Shift Reporting

Start-of-shift reports are gatherings of the care team at the start of a shift to get up-to-speed on the patients in their care. NAs will be present at start-of-shifts reports, during which the nurse from the previous shift will discuss any changes to patients' conditions and updated care plans, as well as any discharges or new admissions. It is also where NAs will receive their assignments for that shift.

At end-of-shift reports, NAs should report any changes to their supervising nurse, so they can be included in the next start-of-shift report. Before finishing tasks and going to end-of-shift reporting, NAs should make sure that patients or residents have anything they may need. NAs can offer them the restroom, make sure that necessities are within easy reach, and reposition them. Shift changes will likely be the longest time patients or residents are left unattended during the day, so it is important to make sure that they will be safe and their needs taken into account for that time.

Critical thinking is an essential skill for nursing assistants. NAs will rely on critical thinking when making observations for reporting and recording. Why is critical thinking such an important skill when reporting and recording? Write for 5 minutes, then share your response with a friend or classmate.

Professionalism

It is essential that nursing assistants keep themselves well-groomed, diligently attend to their hygiene, and dress in accordance with the standards of their workplace. NAs should always be aware of their workplace's dress code. NAs should abstain from wearing large jewelry or any adornments, such as long nails, that could get in the way of performing hands on work or catch on an object unintentionally. NAs should remove unnecessary jewelry, but are encouraged to wear a small, waterproof watch to keep track of the time. Remove the watch when washing hands so that no areas are missed.

NAs should refrain from using artificial fragrances like perfume and cologne. Instead, consider a lightly or unscented deodorant. People receiving care may have sensitivities to smell, so refraining from fragrance is one way you can practice empathy and courtesy before even arriving at work.

It is important for NAs to conduct themselves in a professional manner. This can mean being punctual, limiting cell-phone use, never reporting to work under the influence, using appropriate language, maintaining positive relations with coworkers, and listening to and applying feedback. NAs should always discuss workplace standards of professionalism with their supervisor, as expectations can change depending on where one works.

Key Takeaways

- Nursing assistants (NAs) are the first line of care. NAs provide the most direct and daily care of the different members on the care team, so it is important that their caregiving be holistic, person-centered, and performed with empathy and conscientiousness.
- Residents have a set of specific and legally enforced rights, including rights to safety, dignity and respect, and participation and agency in their own care. When NAs observe the violation of Residents' Rights they should report this to their supervisor or a state ombudsman.
- NAs will have their tasks delegated to them in accordance with the facility Chain of Command. NAs are responsible understanding their scope of practice and determining whether delegated tasks are included in it. NAs should always ask for assistance if they are unsure about performing a delegated task.
- The Nursing Process: Assess, Diagnose, Plan, Implement, Evaluate, Assess again
- Reporting and recording are essential practices. NAs should always follow workplace reporting and recording procedures. The combination of critical thinking and observation skills are important for good reporting and recording.

Comprehension Questions

1) Which of these are ADLs? Select all that apply.

- a. Brushing one's teeth
- b. Showering
- c. Going to the movie theater
- d. Getting dressed
- e. Voting in a city council election
- f. Meditative breathing exercises

2) Which of these qualities are necessary for providing holistic, person-centered care?

- a. Respecting someone's personal choices and individuality
- b. Telling confessional stories in order to build rapport
- c. Attending to someone's physical, psychological, social, and spiritual needs
- d. Making somebody second-guess themselves about treatment the NA doesn't agree with

3) What are qualities that nursing assistants must cultivate? Select all that apply. With a friend or classmate, discuss what each (correct) answer means to you, and for your role as a nursing assistant.

- a. Funny
- b. Punctual
- c. Empathetic
- d. Accountable
- e. Creative

f. Attentive

g. Patient

4) Respond to the following sentences with T (true) or F (false).

___ Nurses make decisions about the care someone will receive and then delegate to NAs

___ If unsure about performing a care task, NAs should give it a shot and see how it goes

___ NAs should avoid telling a person's family about their loved one's diagnosis, and should instead leave it up to the nurse or doctor

___ NAs can decide whether or not they will respond to an order or request from the chain of command

5) Edna is an elder who recently needed to sell her house for her financial security. She also found it difficult to use the stairs, and reach everything in her kitchen. Edna's husband died five years ago, and her children live in different states. She has a good memory, but has trouble with cooking, and mostly stays in her home. What care facility would Edna benefit from the most?

a. A hospital

b. Hospice care

c. An assisted living facility

d. A nursing home

6) OBRA and NATCEP require which of the following?

a. NAs must shower before work

b. NAs must be registered with their state's Healthcare Worker Registry

c. NAs must report observations or suspicions of abuse and neglect

d. NAs must act within the clearly defined scope of practice

7) What are the "Five Rights of Delegation"? What does each "right" involve?

8) What are the four basic steps necessary for critical thinking? Why are they all important? Is critical thinking something that can be done with others? If so, how?

9) What does it mean for NAs to be understanding, empathetic, and accountable in their work? How do these qualities relate to the Big Three? Try to relate them to at least two elements of the Big Three.

10) What are the 5 steps in the nursing process? What does each step involve?

11) What does it mean for nursing assistants to practice professionalism? What is the connection between professionalism, providing good care, and being a good team member?

12) Cassandra is working as a nursing assistant; she is assigned to a new resident named Mrs. Gupta, who is known for her being chatty and enjoying company. Cassandra says "Couldn't I be assigned to someone else? I can never understand people with those accents anyways." Which qualities of a good nursing assistant does Cassandra's response *not* demonstrate? How could she have responded differently?

13) Drew, a nursing assistant, is helping a resident eat their dinner. Drew notices that his shift ends in 10 minutes, and he still has a lot of work to do before the shift change. He says to the resident, "Could you eat faster, please? Or maybe you could do the last bit here yourself? I have some things I need to do before my shift ends." How could Drew have demonstrated more patience and empathy in this situation? Does Drew's comment go against any of the Big Three?

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Module 2 – Introduction to the Patient

Learning Objectives

- Demonstrate understanding of Maslow's Hierarchy of Needs
- Demonstrate understanding of respecting people from various cultural, religious, and personal backgrounds
- Demonstrate understanding of good communication techniques
- Demonstrate understanding of some changes associated with aging

Person-Centered Care

In the last module we introduced the concept of holistic, person-centered care. What does it mean to care for someone holistically? To do something holistically means to guide one's actions and responses with attention to the whole, rather than to a part or a section. This translates to medical caregiving because even though residents or patients may have a specific problem or ailment, we recognize that a problem with one part of a person's body can still impact their whole experience, whether physical, spiritual, psychological, or social^[1].

For example, a person experiencing chronic pain may not be able to socialize as much as they want to, and so their mental and social wellbeing suffers along with their physical wellbeing. Similarly, maintaining one's mental, spiritual, and social health can be an important part of healing or managing a physical ailment. When we talk about holistic care, we recognize that caregiving is about the whole of a person, and that all aspects of a person are impacted by a medical condition.

It is important for nursing assistants to practice holistic care; failing to practice holistic care may result in a medical professional harming a person in one way at the same time as they try to help them in another. Holistic care understands that a person's physical, psychological, social, and spiritual needs are interrelated.

As a person loses parts of their normal functioning, whether due to illness, disability, or old age, anger can be a common response. It is necessary for NAs to treat everybody they care for with dignity and respect, and to keep them informed about their care as the NA provides it.

If a person being cared for becomes upset or angry, it is necessary to respond with a calm and professional demeanor; NAs should not argue, and make sure to listen and allow space for silence.

When caring for a person, NAs should emphasize their abilities in interaction, rather than disabilities. If a person can perform a task themselves, such as washing their hands or dressing themselves, that option should be made available to them. NAs should always allow time and be patient with the people they care for; even if a person can only do something at a much slower pace than the NA, the NA should still give someone the opportunity to complete the task themselves at their own pace.

Person-centered care and holistic care are closely related. While holistic care means caring for the entirety of a person (not just the part or system impacted by a diagnosed condition), person-centered care means that the person's care plan is guided by their own goals for treatment and that their desires for care and care outcomes are respected as much as possible. Person-centered care involves empowering a person to make as many of their own care decisions as possible; it means encouraging their autonomy and agency, and proceeding with the understanding providing care should always be meeting the goals and needs of the person themselves.

Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs is a framework for interpreting and understanding human needs, and is useful when applied to care in a holistic way. Humans have a wide variety of needs, whether they are basic physical needs or psycho-social needs. Basic physical needs include things like food and water, movement, sleep, freedom from pain, and shelter. Psycho-social needs are more varied, and include feeling safe and secure, feeling loved, and maintaining self-worth. Maslow's Hierarchy divides the schema of human needs into roughly five layers representing kinds of human need, each of which is necessary for the full experience of the next. These kinds of needs are basic physical needs, safety and security needs, the need for love, the need for self-esteem and self-

regard, and the need for self-actualization.



“Maslow’s Hierarchy of Needs” by Chiquo is licensed under [CC BY-SA 4.0](#).

In 1943, Abraham Maslow came up with a psychological theory of human need where our needs are structured like a pyramid, with more basic needs on lower (and hence more structurally necessary) tiers of the pyramid. “Maslow’s Hierarchy of Needs” can be a useful way of thinking about that some needs like having friends and having self-esteem depend on more basic needs like comfort, oxygen, or nutrients.

The bottom tier of the pyramid is **physical needs**. The physical needs Maslow has in mind here are basically things that a person could not survive without; food, water, air, movement, etc. NAs can make sure a resident meets their basic needs by encouraging and helping them to eat and drink, assisting them with eliminating waste, and making sure they rest and move enough.

The second tier of the pyramid is **safety and security**. A person needs an environment that is free from danger, and provides protection. It is important that a person has a consistent environment they can call their own. An NA can help a someone feel safe and secure in their new residence by being understanding if the person they are caring for displays anxiety or confusion; moving out of one’s home for long-term medical care is a stressful situation; NAs can be compassionate and patient, and do what they can to cultivate a home-like atmosphere for residents or patients. NAs can also provide a listening ear, and help to reassure residents that they are safe.

The third tier is Maslow’s pyramid is our **human need for love**. Our need for love includes other

Belonging

A nursing assistant can help a resident feel welcomed, listened to, and cared for; NAs can prompt a resident to socialize and take part in activities that help them cultivate a sense of belonging.

psychosocial needs, like our need for **acceptance** and a **sense of belonging**. When people enter an assisted-living facility, they may feel distant from their loved ones, or have recently lost a loved one. It can be difficult for a person to acclimate to a new living environment, particularly when it involves living amongst strangers. It is normal for someone to miss their established routines.

The fourth tier of the pyramid is a person’s need for **esteem**, both self-esteem and social esteem. People need to feel valued by themselves and feel that they are valued by others. It is important for a person to feel that their presence matters.

Nursing assistants can help residents meet their esteem needs by telling a resident that they think highly of them, spending enjoyable time with them, and praising their successes. NAs can also help residents maintain a sense of self-esteem by encouraging as much independence as possible, and praising a resident’s successes. Such comments can help someone maintain a sense of dignity and self-esteem.

The fifth type of need a human has on this model is for **self-actualization**. Self-actualization refers to a person’s striving to reach their “ideal self,” whether through acts of creativity, play, charity, socializing, or some other form of positive engagement with the world. Examples might include painting, dancing, or writing letters.

Self-actualization refers to our pursuit of the activities that we have chosen as expressions of our authentic self, or the activities that we engage in while pursuing an expression of our authentic self. NAs can help residents pursue self-actualization by encouraging and showing interest in their pursuits, and facilitating connections with other residents with compatible self-actualization activities.

It's all connected

When a person enters an assisted living facility, it can accompany a sense of loss of one's identity, independence, mobility, social connections, and sense of connection to the world. When a person's psychosocial needs go unmet, other aspects of their health can suffer. Nursing assistants should keep the full spectrum of human need in mind as they provide care, since it is necessary for providing holistic care and helping residents maintain their highest possible quality of life.

When somebody experiences disability, whether for the first time or because of a lifelong condition, their reactions may include angry, demanding, inappropriate, or aggressive behavior. NAs can't avoid residents, however if a resident acts in such a way that puts themselves or others at risk of danger then an intervention may be needed to correct the behavior. Until such an event, NAs should be patient and accommodating with residents who are angry with their circumstances, empower them with as much autonomy as possible, and meet any abrasiveness with a kind and dignifying demeanor.

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Respecting people from different cultures, religions, and backgrounds

Culture and language

When interacting with residents, it is important to approach them with a sense of basic respect. This kind of respect is considered “basic” because it will be consistent across all the residents an NA cares for. Always interact with residents as complex adult human beings; never infantilize them with one's words, tone of voice, or body language. Always provide them with courtesy and respect.

“Culture” refers to a group's shared behaviors, attitudes, assumption, beliefs, and values. Culture closely relates to the way that any person's worldview is shaped by the social context they grow up in. The world contains significant cultural plurality, and each culture shapes peoples' worldviews in unique ways. Culture can correspond to, but is not the same as, one's nationality, ethnicity, region, or even one's own friend group or family.

One's culture can impact things like how comfortable somebody is with eye contact, which forms of touch they find appropriate or welcome, their food choices, and their communication styles. Different cultures also have different beliefs about the sources of illness and the causes of death.

Cultural competency

Within an assisted living facility there may be a substantial amount of cultural diversity, or people from a wide array of different cultural backgrounds. Cultural competency refers to a person's ability to comfortably and skillfully communicate with people from different cultures; a lot of cultural competency comes down to being flexible, attentive, and nonjudgmental.

Culturally competent nursing is an important aspect of caregiving in a pluralistic community. A NA should be able to learn things about each resident's cultural background and apply that information to their caregiving.

YouTube Video

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Johnson & Johnson Nursing. (2018, December 3). Becoming a culturally competent nurse [Video]. Youtube. <https://www.youtube.com/watch?v=r62Zp99U67Y>

NAs must always interact with the people they care for with an attitude of *acceptance and nonjudgement*. Because culture influences the ways that people seek and discuss healthcare, NAs should try to become familiar with the cultural backgrounds of the residents they care for.

Some residents will be excited to share different aspects of their culture with you, so NAs can ask about family, friends, and cultural traditions; others may be more reticent or less enthusiastic, so sometimes NAs may need to do a little bit of research or use their critical thinking skills to understand how a resident's cultural background may inform their attitudes and preferences.

When NAs are culturally competent and sensitive to difference it improves the quality of their care and makes the experience of providing care to a diverse population that much more interesting and rewarding. Cultural competence is necessary because it improves patient care outcomes; providing culturally and linguistically appropriate services (CLAS) means providing care that is effective, appropriate, and understandable for the person receiving care^[2].

After watching the above video, consider your own relationship to culture, cultural humility, and cultural acceptance. What are some ways you can begin thinking through a lens of cultural humility? Are there any areas where you think this will be difficult for you? How will you try to move toward a place of cultural openness and acceptance? Write for 5 minutes, and share your response with a friend or classmate.

Resident Rights

Residents have a right to communicate with someone in their own language. If a facility does not have someone who is capable of communicating with a resident in the resident's own language, then they will need to hire an interpreter. If a facility fails to meet this requirement, then they will be in violation of OBRA.

If you feel that an interpreter or translator is needed for a resident to communicate with ease and convenience, they tell the nurse right away^[3].

Religion and spirituality

There are a wide variety of different religions in the world, and a modern day assisted living facility may represent a good number of them. NAs will interact with believers from many different religious traditions. A resident's religion and spirituality can be important to them, and may play a key role in maintaining a hopeful and positive attitude throughout the duration of their care. NAs must always treat residents' religious beliefs, needs, and practices with respect.



“ introduces bill banning religious symbols” by Prachatai is licensed under CC BY-NC-ND 2.0.

NAs should never adopt a judgmental attitude toward a resident’s religious beliefs or practices; an essential element of cultural competency is learning how humble oneself and practice empathy to better understand and accept the way someone from a different cultural or religious background experiences the world. Always be accepting and helpful about a resident’s religious needs.

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A resident’s religion may have an impact on how they receive care. For example, some religions like Islam and Judaism maintain a dietary code (called Halal and Kosher, respectively) that can impact what a resident will eat. Other religions may have other rules about the kinds of medical care someone is permitted to receive; for example, Jehovah’s Witnesses do not accept blood transfusions or products derived from blood.

Never make assumptions about somebody based on their religion.

The flip side of considering how a person’s religious beliefs can impact care is that not everyone practices their religion in the same way; even if the NA knows something about a resident’s stated religion, it is important not to make assumptions about a given resident’s personal relationship to religion and spirituality.

Knowing something about different religions such as Christianity, Islam, Judaism, Buddhism, and Hinduism can help NAs understand their residents’ worldviews and experiences.

Religious beliefs and death

Religious traditions think about death differently; Hinduism and Buddhism both believe in a process of reincarnation while Christians believe in an afterlife, however both Christians and Hindus believe in the existence of a soul while Buddhists do not.

It can also help them when conversing with residents, and in discussing spiritually laden topics like death and dying and the meaningfulness of life. Understanding some doctrinal aspects of a resident’s religion, such as beliefs after the afterlife or the existence of the soul, can be helpful in conversing with them and tending to their emotional and spiritual needs.

Religion can be an important source of community for people. Residents have a right to practice their own religion and, when possible, to practice it with others. If a resident needs help accessing spiritual resources, religious leaders, or a community of religious practice, the NA should tell the nurse so arrangements can be made to meet the person’s full scope of human needs.

NAs should never judge a resident for their beliefs or for how they choose to practice their beliefs. NAs should never try to change a resident's religious beliefs, push them into any kind of religious activity, discuss your own personal beliefs, or interfere with a religious practice in any way.

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Race and Ethnicity

Race is a form of classifying people based on shared observable characteristics like skin color. Ethnicity refers to grouping people based on a common heritage, language, social customs, and national origins. A person's race and ethnic background can have an impact on how they understand themselves and how they relate to other people. However, neither race nor ethnicity provide somebody with certain information. race and ethnicity should never be the basis of an assumption about a person.

Race and ethnicity can influence how a person relates to things like work and rest, and how

Everyone is unique

NAs should always interact with people as individuals, never merely as members of some particular race. In other words, while cultural competence requires taking a person's race and ethnicity into account as context, a person's race or ethnicity should never be the basis of an assumption about that person.

they speak and use language. A person's experience as a member of a particular race or ethnicity, especially if that race or ethnicity is regularly stereotyped by dominant cultural narratives, may condition how they interact with others.

Racism occurs when a racial minority is discriminated against or treated in a one-dimensional way based on their perceived race. Prejudice occurs when someone judges another person based on preconceived notions about a group that the person apparently belongs to. All racism is prejudice, but not all prejudice is racism.

Medical racism occurs when someone experiences a negative health outcome due to their race. Medical racism occurs at a personal level when an individual's racism or implicit bias negatively impacts someone's care. Medical racism occurs on a systemic level when a whole population's health and access to medical care is negatively impacted by racism. Medical racism is still a problem in the healthcare system today^[4]. Medical racism of both kinds remains a pervasive problem in healthcare today^[5].

NAs must be careful never to adopt a racist or prejudiced attitude about any of the residents in their care. NAs should make sure to see each resident as a complex individual, and not to make any assumption about residents based on race, ethnicity, or culture.

Implicit bias

Implicit bias refers to the unintentional biases that we all carry within us as part of living in an unequal society; people are unaware of their implicit biases, even as they impact their behavior and interpersonal interactions. Somebody can be consciously committed to social justice and still hold implicit biases, or unconscious negative attitudes and judgments, that cause them to behave in discriminatory ways.

NAs can make healthcare settings more socially just by attending to their own implicit biases. When having a negative response to a resident that occupies a marginalized social position, NAs can ask themselves "where is this response of mine coming from? what can I do to address these negative feelings in a way that lets me be more thoughtful and reflective?"^[6]. NAs should advocate for residents who they believe may be suffering from biased treatment.

People from different cultural backgrounds may want to talk about their culture, and even to share their culture with the NA.

NAs should feel comfortable asking polite follow-up questions with a genuine interest in learning more, especially since such knowledge can help NAs provide better and more individualized care. Understanding the role that a person's race, ethnicity, or culture play in their understanding of a relation to the rest of the world can be a useful perspective to bring to holistic caregiving.

Sexuality and Gender

Residents have a Right to be respected and affirmed in their sexuality and gender identities. This means that NAs must be equipped to respect, value, and interact in an affirming way with residents who occupy a variety of gender and sexual identities. NAs should learn something about the LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and more) community so that when they care for a member of that community they can do so in a way that is affirming. This is necessary when practicing holistic, person-centered care.

"Sexuality" refers to how one experiences physical, emotional, and amorous attraction to other

NAs should never shame residents for who they are attracted to, who they invite to their rooms for private visits, nor the ways that residents may choose to express their sexuality.

people. One is considered "heterosexual" if they are exclusively attracted to members of the opposite sex, and "gay" or "homosexual" when exclusively attracted to members of the same sex. "Bisexual" and "pansexual" are both terms that indicate attraction to people of multiple or all sexes and gender-presentations.

"Gender" refers to one's experienced sense of themselves in relation to other people and the world at large; some examples of gender identity categories are man, woman, and nonbinary, though terminology is broad and can vary from person to person.

Gender is distinct from one's sex organs – if somebody is assigned male or female at birth because of their sexual morphology, such assignment is ultimately unimportant to how that person may come to think of their own gender; a person's sexual morphology is *especially* irrelevant to anybody other than that person. Never ask a transgender person (or anybody) for details about their anatomy or comment on their anatomy.



"File:A TransGender-Symbol Plain2.png" is licensed under [CC BY-SA 2.0](#).

"Transgender" is the term used to describe a person who does not identify with the gender they were assigned at birth. If a person discovers that they are transgender, they may decide to transition and live their life in a way that reflects their inner truth. Nobody should ever use the term "transgendered," because being transgender is not a disease and is not something that happens *to* a person, but is one aspect of who a person *is*.

Transitioning can be a difficult process; it is also usually joyful and affirming. NAs should support transgender residents at any

stage of their transition, and always refer to residents using the language and pronouns residents choose for themselves.

Resident Rights: Dignity & Respect

Treating members of the LGBTQ+ community with dignity and respect in healthcare settings is an essential aspect of providing good holistic, person-centered care. When interacting with gay or bisexual persons, it is important to maintain the positive, accepting, and empathetic attitude that the NA adopts with all of their residents.



Sometimes, people may respond to differences in sexuality or gender in negative ways without meaning to or even realizing it, such as with feelings of annoyance or even unintentional disgust. These unconscious reactions are examples of feelings motivated by implicit bias, and everyone experiences implicit bias in some form to some degree. The important part is in how we all respond to our implicit bias – ideally, with critical self-reflection and by making sure that it doesn't find its way into our actions and behavior.

NAs can be respectful towards LGBTQ+ people in pretty much the same ways that they respect people of different religions, ethnicities, and cultural backgrounds. NAs must respect the rights of residents to lead a life that they identify with, and one that is really *theirs*. NAs should do everything they can to help residents adopt a sense of ownership and agency over their circumstances. Ultimately, NAs should interact with residents in a way that always emanates from the recognition of their inherent worth as a person with a right to make their own decisions.

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Ms. Rosa has a large family that loves to come and visit her every week. When they arrive they often bring food, some music that Ms. Rosa loves, and engage in enthusiastic conversation in Spanish. Ms. Rosa loves her family, and spends the week looking forward to their visit. Lately, another resident has been complaining about Ms. Rosa's family visits because they are "too loud" and "can't seem to speak English." How would you respond to this resident? Which elements of Resident Rights are in conflict in this scenario? What would a culturally competent response to the complaining resident look like? Spend 5 minutes writing, and share your response with a friend or classmate.

Changes associated with aging

The human life cycle, or the arc of olife cycleur lives from birth until death, is commonly thought of as occurring in different "stages" that connote changes in one's physiology, psychology, and sociality. Infancy, toddler, childhood, preadolescence, and

adolescence are all early stages of the human life cycle^[7].

The Human Lifecycle

- Infancy (0 – 2 yrs)
- Toddler (1.5 – 3)
- Childhood (4 – 10)
- Pre-teen (10 – 12)
- Adolescence (13 – 19)
- Young adult (18 – 40)
- Middle adult (40 – 65)
- Late adulthood (65+)

An adolescent becomes an adult around age 18, and is then considered a young adult until about age 40. Middle adulthood generally lasts from around ages 40 until 65. Once a person is no longer in the middle adulthood stage of the life cycle, they are elderly, or in late adulthood.

Different people respond to aging in different ways. How they respond depends on factors like their health, previous life experiences, financial circumstances, education, and social support network. Some people may find that old age suits them, while others may find themselves feeling lonely, alienated, or insecure. Many people experience both.

Elderly adults will likely work less or not at all, have less income, experience diminished mobility and energy, may require frequent medical care, and may need to enter an assisted living facility or move in with younger family members.

People at this stage of life may be coping with the deaths of friends and loved ones, and may be coming to terms with their own mortality. All of these factors can contribute to decreased life satisfaction and wellbeing.

To meet their holistic needs, elderly folks may have to put extra effort into a fulfilling social life by picking up new hobbies, volunteering, and staying active in community organizations. Staying connected to others is vital, especially because growing old sometimes involves diminished social connections, and can result in feelings of loneliness and loss of meaning. When caring for older adults in long-term care facilities, NAs should encourage them to be social and engaged in community activities.



“Senior couple having fun” by Be-Younger.com is licensed under CC BY-NC-SA 2.0.

Changes in a person’s physiological systems with age

As people age, their bodies undergo changes. These changes happen to “systems” in the body, such as the nervous system or the circulatory system^[8]. A bodily system is a set of body parts and processes that play a specific role in keeping somebody healthy.

Gastrointestinal system: The gastrointestinal system refers to how a body takes in food, processes it for energy, and expels what goes unused as waste. As a person ages, their gastrointestinal system undergoes changes.

- Their sense of taste becomes less sensitive, so they may prefer foods with salt and/or sugar. Good oral hygiene and denture

care can help to improve the taste of food.

- Chewing and swallowing may become more difficult (dysphagia), and the production of digestive fluids such as saliva decreases.
- The person's body may absorb fewer nutrients from the food they eat, and the whole process of digestion will be slower. Peristalsis, or the contracting muscular movement of food through the body from esophagus through waste disposal, decreases with age, which can slow or belabor the digestive process.

Urinary system: The urinary system is responsible for filtering the blood as disposing of the waste in liquid form. As a person ages, their urinary system becomes weaker and more susceptible to infection.

- Kidneys filter blood less efficiently, which can slow urinary output and increase blood toxin levels.
- The bladder muscle weakens, so it can hold less urine.
- Urination may happen more frequently, but the bladder may not empty completely.
- Older adults are at high risk for urinary tract infections.
- Older adults have to remain well hydrated to maintain a healthy urinary system. Good hydration is essential for preventing urinary tract infections.

Reproductive system: A person's reproductive changes as they age will depend on whether they have a penis and testes or a vagina, uterus, and ovaries. For someone with a penis and testes, normal age-related changes include...

- Enlargement of the prostate gland
- Decreased number and efficacy of sperm, and slowed sexual responsiveness.

For someone with with ovaries normal changes include...

- Decreased production of the hormones estrogen and progesterone, which leads to weakened bones and can result in more severe skeletal complications.
- Drying and thinning of the vaginal walls
- Menopause is the end of an ovulating person's ability to reproduce, and usually occurs between ages 45 and 55.

Integumentary system: The integumentary system refers to our outer layer of protection, composed of fat and living and dead skin cells. As a person ages...

- They have less fatty tissue, which can make them feel cold and result in sagging skin.
- Wrinkles form as the skin loses elasticity, and the skin can become dryer and thinner. This may cause a resident's skin to be particularly itchy.
- Because an elderly person's skin can tear or puncture easily, NAs should exercise gentleness and caution when handling bandages and wound dressings.
- As a person's hair distribution changes, perhaps losing hair on their head and acquiring it in other areas such as the face, back, and chest, they may experience a loss of identity or self-esteem. NAs should do what they can to help residents address these physical changes in the way they want, or talk about it with them in a kind and supportive manner.

Circulatory system: The circulatory system is responsible for pumping blood through the human body, which delivers oxygen and nutrients, and removes toxins and waste. As a person ages...

- A person's heart weakens and pumps blood less efficiently.
- The combination of less efficient blood pumping with narrowed and inelastic blood vessels, also due to age, results in decreased blood flow and diminished oxygen delivery.
- Weakened blood vessels mean that an elderly person may bleed more quickly and easily, and their blood may take longer to clot.

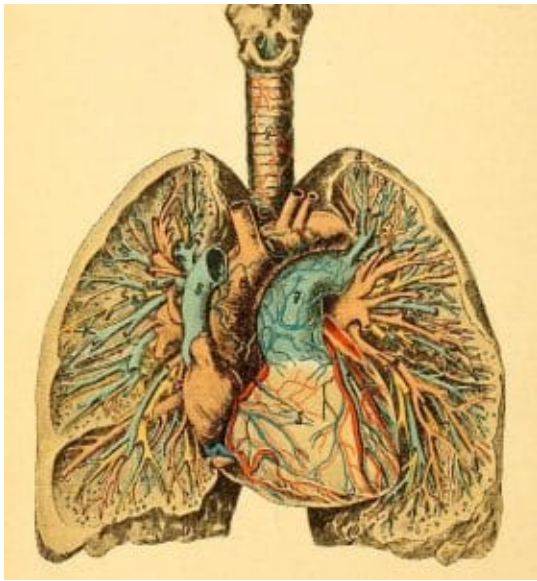


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Respiratory system: The respiratory system is responsible for taking in oxygen, distributing oxygen to the blood cells for distribution, and disposing of the body's carbon dioxide. As someone ages...

- Their lungs, diaphragm, and other components of the respiratory system weaken.
- They may have more difficulty breathing and experience increased susceptibility to respiratory illness.
- Their lungs and chest muscles become weaker and decrease in capacity, and their airways lose some elasticity.
- They may experience dyspnea, or difficulty breathing.

Musculoskeletal system: The musculoskeletal system consists of muscles, bones, tendons, and ligaments; tendons and ligaments are connective tissues that keep the muscles, bones, joints, and cartilage working together. As someone ages...

- Their muscles weaken, and their bones become brittle due to decreased calcium.
- They may literally shrink due to a contraction of the vertebrae and spine, and they will lose some range of motion as joints and muscles stiffen.
- As mobility decreases, regular activity and a nutrient-rich diet are especially important. NAs should encourage residents to be active, help prevent them from falling, and support them during ambulation.

Nervous system: The nervous system is the system of nerves that conduct our movements through their connection to the brain; it includes the brain, and everything the brain performs. As a person ages...

- They lose nerve cells, and their senses may weaken or become less receptive.
- Weakened senses can result in loss of vision, hearing, smell, taste, and a diminished sensitivity to touch.
- Memory loss occurs, especially short-term and task memory, sleep patterns change, and physical reflexes may also slow.
- Dizziness can occur as a result of diminished blood flow to the brain.

Visual and auditory systems: Older adults experience changes to their ability to see and hear. As a person ages...

- Their eyes tend to dry out because of decreased tear secretion.
- Vision becomes less clear, and it can be difficult to see without adequate direct lighting.
- Older adults tend to become more far-sighted with age; someone who didn't need glasses at all may find that they now require reading glasses.
- Our eye lenses all yellow with age, which can impact color perception and differentiation; as older adults lose color differentiation, they should be prompted to distinguish their medications by means other than color.
- The ear drum atrophies, which means it gradually becomes weaker.
- Less ear wax is produced, but it is harder and thicker than a young person's, and so may need to be removed by a nurse or a doctor to prevent hearing obstruction.
- Residents may require hearing aids; hearing aids must be cleaned and placed in the appropriate container.

Endocrine system: The endocrine system regulates a person's hormones. Hormones are involved in some way in most human health processes, from digesting food to regulating mood. A person's hormones alter as they age.

- People undergo changes in the production of testosterone, estrogen, and progesterone.
- Physical stress, in the form of cortisol and other stress-related hormones, becomes more difficult for a person to process. They may have increased difficulty regulating their emotions.
- The body produces less insulin, which makes it more difficult for a person to process and metabolize sugars.

Immune system: A person's immune system exists to clean the body of external stuff, such as microbes or viruses, some of which may be harmful to our organism. As a person ages...

- Their immune system weakens, which makes them less able to fight off infection and illness.

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Feelings about changes associated with aging

Some people enjoy the aging process. However, more commonly, someone may feel anxiety, dread, or loss of overall life satisfaction as their body changes. Some of the changes listed above produce physical and emotional discomfort, and present obstacles to spending time with loved ones or engaging in activities that give joy and meaning to one's life. An aging person may respond to these changes with frustration, depression, and even anger.

NAs should always respond to a resident's complaints about aging with kindness, empathy, and understanding. It may also be helpful to make sure that a resident's basic needs are always met. Ultimately the best thing nursing assistants can do is provide a listening ear, and make sure that the person has all of their basic care needs met.

Why might somebody's experience with aging cause them to feel frustration or despair? As a nursing assistant, how will you respond to residents' negative feelings about their own aging and potential disablement? Write for 5 minutes, and discuss your response with a friend or classmate.

Communication Skills

Communication is, at its most basic, the exchange of information. People exchange information in many ways, though most of the ways NAs will communicate is face-to-face and in person. When using verbal communication, or spoken and written communication, NAs should be as clear, direct, and kind as they can. Good communication improves patient outcomes, and makes someone feel cared for and attended to.

YouTube Video

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The ACH Online. (2014, April 24). The importance of communication in healthcare: The time is now [Video]. Youtube.

<https://www.youtube.com/watch?v=b7YwrHNylTg>

The importance of tone

Good verbal communication includes awareness of tone, particularly when communication with residents. NAs should try and sound engaged, upbeat and present when responding to residents, so residents feel comfortable and dignified while receiving care. An exhausted or hurried tone can make a resident feel like a burden to their caregivers.

NAs need to practice active listening, which means keeping one's full attention on the person they are communicating with and remaining fully present in that interaction.

Someone practicing active listening will show they are engaged with their body and eyes by leaning forward and being responsive through nods and smiles; they will also use responsive phrases ("I see," "Oh my," "So what happened?"), and will stay on topic. It is important for residents to feel that people are interested in what they have to say.

When communicating with residents, some general strategies will be useful:

- Always listen closely, and really listen in a way that brings an awareness of the whole person to the conversation.
- When practicing active listening, paraphrasing the other's response can be a helpful tool because it shows them you are attentive, and it can help to clarify exactly what each person means.
- Direct questions are often useful because they set an explicit subject of conversation, while an open-ended question may help begin conversation by letting the resident determine the topic. Yes/no questions should be avoided, since they tend to end rather than begin conversation.

Never assume they can't hear

Always assume that a resident can hear what is said around them, even if you suspect that they cannot. Even if someone appears unconscious, they may have some degree of situational awareness. When performing care tasks the NA should always describe what they will do prior to doing it.

When conversing with residents NAs should try and include everyone present in the conversation; if an NA is conversing with Mr. Johnson and Ms. Chou, then both residents should be regular participants in the discussion; staff should never conduct conversation amongst themselves while a resident is in the room, since it will come across as indifferent and uncaring. Instead, involve residents in conversation.

When communicating information to residents, such as the steps of a task or the items on a menu, NAs should ask follow-up questions, such as "Can you tell me what we're about to do?" or "What does poutine come with again?" to make sure the resident understands. Yes/no questions are not particularly useful for gauging someone's understanding, because they can respond "yes" without fully understanding the topic.

Communication styles vary from person to person

Everybody has different communication styles for verbal and nonverbal communication. The way a person communicates and wants to be communicated with is shaped by one's past experiences, their family, the environment they are in, their feelings and mood on a given day, and other things. NAs should be attentive to a resident's tone, mood, and body language when determining how a resident would like to be communicated with on that day.



Image by agilemktg1 is marked with Public Domain Mark 1.0.

Someone's culture can play an influential role in their communication styles. For example, the use of eye contact in communication is commonplace in some areas of the world, but in others direct eye contact can be taken as rude or abrasive.

Deference for elders is another culturally informed dimension of communication. In some cultures, young people are expected to show a high degree of respect for their elders, while other cultures may have less formal courtesy norms.

NAs should refer to residents by their last name preceded by Mr., Ms./Mrs., or Mx. (pronounced "mix"), until a resident requests or grants permission to be referred to by a different name. NAs should respect resident's wishes on what they would like to be called, and how they would like to be communicated with.

Take a moment to reflect on your own communication styles, and how they relate to your own cultural background. Do you prefer eye contact, or do you find it uncomfortable? How comfortable or uncomfortable are you with casual touch? Do you like to communicate in an excited and animated way, or do you prefer to remain more reserved until you know someone better? What formative contexts have shaped your communication style and preferences? Write for 5 minutes, then discuss your response with a friend or classmate.

Using touch in communication

NAs will touch residents as part of performing basic care tasks such as helping to wash, dress, or move. In addition to medical care, touch may be one way that NAs provide holistic care through comfort and emotional support.

Physical touch is an important example of interpersonal communication that varies with cultural background; it can communicate happiness, empathy, or a simple sense of presence. However, comfort levels with such touch vary. Some residents may appreciate touch on the hand, arm, or back, or may ask for a hug. Other residents may be uncomfortable with any social touch and would prefer to only be touched when necessary for care.

Asking "is it alright if I touch your hand or arm sometimes when we are speaking" is a useful step if the NA is unsure how a resident feels about casual communicabody languagetive touch. Paying attention to a resident's body language can also provide information on their comfort with touch; if someone becomes stiff or slightly pulls away when touched, they may be communicating their discomfort using their body language.



“Help giving” by BournemouthBC is licensed under CC BY-NC 2.0.

NAs should only engage in social touch that they can tell is wanted by both parties; that means that NAs should not engage in any forms of touch that make them uncomfortable or that make the resident uncomfortable.

Some forms of touch are never appropriate, such as sitting on laps, kissing, any touch of even remotely sexual nature, or anything that appears unwelcome and unprompted.

If a resident touches a NA inappropriately, the NA should set a clear and explicit verbal boundary and make sure that the boundary is understood by the resident. If the inappropriate behavior continues, the NA should alert the RN to find a workable solution. Touch should always be an expression of a friendly and professional connection NAs have with a resident, never something that produces feelings of discomfort or unease.

Barriers to communication

NAs may experience barriers to communication in their workplace, whether between themselves and a resident or between staff members. A barrier is anything that makes communication more difficult or impossible than it would be under ideal circumstances. Some barriers to communication between NAs and residents are environmental or medical, and some barriers are psycho-social or due to a mismatch of communication styles^[9].

Environmental and medical barriers

Environmental barriers are features of one's environment than can impact straightforward communication. For example, maybe the resident is on the other side of the room and the NA will need to move closer to have a clear conversation. Perhaps they forgot to turn their hearing aid on, or it has a low battery.

When speaking with older adults, it is helpful to stand directly in front of them, speak slowly and clearly, and make distinct mouth and facial movements. Never whisper, shout, or mumble – instead, enunciate words and speak at a clear (and reasonable) volume.

Hearing impairments

When a resident has impaired hearing, NAs may need to change the way they communicate with them.

- Never approach a hearing-impaired resident from behind. Place oneself in front of them and get their attention before speaking.
- Make sure that your own face is well-lit, and speak clearly and distinctly.
- Sometimes the NA may need to use written communication with hearing-impaired residents. When communicating with writing, it is best to use short sentences with yes/no answers and to print in large letters.
- Do not make exaggerated movements to explain something. Some gesturing is often helpful when communicating with anyone, but excessive gesturing when communicating with a person with impaired hearing can come across as condescending.
- Residents have a right to effective communication. If somebody requires an ASL interpreter in order to communicate effectively in a healthcare context, then an interpreter must be provided. When speaking to someone through an interpreter,

you are still having a conversation with the person (not their interpreter); look at the person directly and maintain eye contact throughout the conversation, and refer to them by name.

Visual impairments

People with visual impairments may need specific communication strategies.

- NAs should always identify themselves to the resident, and narrate the activities they perform before and as they do them.
- Visual impairment can make someone more susceptible to falls, so maintaining good spatial awareness is key. NAs should avoid moving objects around a room unless necessary, and should tell the resident when they do.
- When entering a new space, describe the room in terms of the face of a clock; “there is a plush chair in the corner at 1 o’clock, and a group of people playing cards at a table nearby at about 9 o’clock.”
- If a resident uses eyeglasses, make sure they are clean and fit properly. Be careful and gentle when handling a resident’s eyewear

Difficulties with speaking

Sometimes a resident may be difficult to understand, whether because of the words and phrases they use or because of some medical or physical obstacle to clear speech. Communicating with people who speak in ways one is unused to can take practice, but with careful listening and good communication practices it becomes easy with time.

NAs can ask such residents to repeat themselves, or to rephrase their meaning or explain in a different way. NAs can then reflect and rephrase what the resident tells them with responses like “so what I am hearing is...” or “I think you are experiencing..., does this sound right to you?” These are strategies that grow from an attention to active listening.

Residents with speech and language disorders may have difficulty forming words, or they may be unable to create or comprehend conventional language. A person with a speech and language disorder may use assistive technology, such as an augmented and alternative communication (AAC) device. NAs must take the time to learn the communication strategies that are most effective for residents, including the use of assistive devices.

Social barriers

Language barriers

Residents have a right to speak with someone in their own language. If a resident needs a certified interpreter to communicate, the facility is required to provide one in-person or by phone.

Clear & straightforward

NAs should not use medical terminology when communicating with residents; instead, NAs should use simple every day language they can be sure the resident will comprehend.

When an interpreter is not always necessary but the NA still needs to navigate a language barrier, they should speak slowly and as clearly as possible. They should note when the resident appears to genuinely understand as opposed to when they say they understand but still seem to experience some confusion.

NAs may need to utilize gestures, pictures, translation technology, and other ways of communicating in addition to spoken language. The NA should be patient and kind throughout the process, never condescending or frustrated.

Residents have a right to effective communication, even if they do not speak English. The right to effective communication obviously relates to the Big Three in terms of Resident Rights. Can you think of some ways that the right to effective communication also relates to Safety, another part of the Big Three? Write for 5 minutes, then share your response with a friend or classmate.

Effective communication

NAs should be conscious of appropriate, professional, and effective ways of communicating with residents^[10].

- Avoid using slang and profanity, even if a resident engages in those things. Such language is not in line with professional communication norms and expectations.
- Avoid using clichés and platitudes, such as “I’m sure it’ll all work out” or “it’s all part of the plan.” This shows that somebody is not really interested in listening.
- Residents will need somebody to listen to their concerns, fears, and worries; NAs should be a listening ear, ask how they can support the resident, and never belittle or minimize their worries.
- Avoid responding to resident wishes or requests with “why?”, since such responses can shut down conversation or make a respondent defensive. If a resident makes a choice about how they would like to spend their time, it does not necessarily need to be scrutinized.
 - Sometimes the NA will need to ask a follow-up question in cases where a resident’s behavior may be out of the norm or indicate an underlying change; for example, refraining from taking a walk may indicate fatigue, or choosing not to socialize may indicate a sense of loneliness. When the NA notices something like this, they should frame their question in terms like “I noticed you seem low-energy today, how are you feeling?” instead of “why aren’t you sitting with your friends?”.
- Avoid yes/no questions – questions that only have yes or no answers can shut down conversation, and prevent nuance. Instead, frame questions in an open-ended way. An example may be asking “what are your favorite fruits?” rather than “do you like blackberries?”

Residents may experience anxiety in long-term care. Anxiety is a non-specific feeling of dread that can feel similar to fear. Anxious residents may have elevated heart rates, persistently worry about things like their health or whether the care team, their family, and other residents like them, and may experience anger and irritation. When communicating with anxious residents, always speak in a calm voice and practice active listening. Often times an anxious person’s problems will not be solvable; instead of trying to solve the anxious resident’s problem, NAs can make residents feel heard, loved, and respected. Anxiety can come from an underlying sense of unsafety; NAs should do everything they can to make anxious residents feel safe and secure.

NAs should never offer a medical opinion or give medical advice. Always defer to the nurse. It is not within the scope of the NA practice, and could be dangerous and irresponsible.

Nonverbal communication

Nonverbal communication can be a barrier to communication when someone is unaware of their body language. NAs should exercise conscious body language to show the resident that they are being listened to.

- Leave arms uncrossed
- Lean in slightly
- Look at the resident when they are speaking
- Nod one’s head to indicate interest and engagement

NAs should also pay close attention to residents’ nonverbal communication; for example, even if a resident tells you that they are comfortable, their facial expression or constant shifting may indicate that they are in pain.

The opening and closing procedure

Residents have a right to be informed about their care, every time care is provided. Performing the opening procedure and closing procedure whenever you give care is an important part of effective communication with residents, and helps protect their rights to dignity and respect.

The opening procedure involves some steps NAs should perform every time they give care, to prepare themselves and to prepare the resident. The closing procedure is a process done after giving care that involves making sure the resident is comfortable and has their needs met, and that care is documented.

Opening procedure

Do these tasks every time you give care.

1. Wash hands for at least 30 seconds. Do not shake dry. Do not touch contaminated surfaces between washing hands and giving care.

2. Assemble the equipment. Make sure that you have everything you need within easy reach.
3. Knock and pause before entering the resident's room. This gives them a moment to prepare for an interaction.
4. Introduce yourself and verify the resident's identity. A resident's identity ought to be verified in multiple ways, such as by asking them their name and reading the name on their patient ID. This is to ensure that the right care is going to the correct resident.
5. Ask visitors to leave, unless the resident explicitly requests their presence.
6. Ensure privacy for the resident. This can be done by closing their door and closing the privacy curtain around their bed.
7. Explain the procedure, answer any questions, and make sure the resident understands the care they will receive.

After going through the opening procedure, NAs can proceed with their assigned care.

Closing procedure

After giving the assigned care, nursing assistants will go through the closing procedure to make sure the resident is comfortable and has everything they need before the NA leaves. After completing care, make sure to go through the following steps.

1. Position the resident comfortably in their chair or in bed.
2. Remove and discard gloves and other protective equipment, except your face mask.
3. Wash your hands.
4. Return the bed to an appropriate position, usually its lowest setting.
5. Place the signal cord/call light within easy reach.
6. Check the resident's room and general environment for safety concerns. Make sure the resident is safe and remove potential risk factors.
7. Open the privacy curtains.
8. Care for the equipment as needed, such as rinsing measuring cups or cleaning the bedpan.
9. Wash your hands (again).
10. Invite the person's visitors back into the room if it is appropriate.
11. Report the task to the nurse, if necessary.
12. Document all care given, the resident's response to care, and any other relevant observations in the patient's chart.

The steps of the closing procedure will be done at the end of every care task.



Making each step of the opening and closing procedure a habit will make good handwashing routine. Having a handwashing routine built into care tasks is an important measure towards preventing the spread of infections in the workplace.

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Communication on the Care Team

Compassion & Candor

“Whether you’re communicating with a resident or the nursing team, compassion is super important. Compassion for residents lets them know that you’re there to care for them, and makes them feel safe. Compassion for other people on the nursing team helps you work well together, and be honest with each other.”

– Kandice B., graduate of Illinois Central College’s CNA training program

Good communication is essential between all members of a care team, staff, and facility^[11].

Good communication is necessary for giving high-quality care. Consistent dialogue and careful documentation amongst the care team leads to more attentive caregiving and better quality of life for residents

Good communication is essential for coordinating care because everyone needs to be on the same page about a lot of important information that they can only learn from each other, and from the resident. In some cases, good communication and documentation is also ethically and legally required. For example, care teams must hold care conferences

Regular and detailed communication between NAs and other nursing staff is necessary because they are always working together with common goals and shared responsibilities.

Candor is a person’s ability to speak comfortably and directly, and all members on a care team should be able to speak to one another with professional candor. Candor is important for holding one another accountable to a high standard of professionalism, especially when someone needs to advocate for a patient’s best interest amongst the care team. Examples of candor are feeling comfortable pointing out when someone is handling a procedure incorrectly, or asking for help when you have handled a procedure incorrectly. Candor requires a sense of trust.

When communicating about care or reporting one’s observations, NAs should try and speak in terms of fact statements. Fact statements are declarations of things that are definitely true; an example of a fact is “Mx. Gupta weighs 150 pounds; she is two and a half pounds lighter than she was last week” or “Mx. Gupta usually drinks tea in the afternoon.”

An opinion is something someone thinks, and that may be true or false or a matter of personal taste. Examples of opinions are “Mx. Gupta looks like she may need to use the restroom” or “Ms. Gupta has seemed more tired than usual lately.”

Both factual and opinion observations are useful for a care team. NAs have a valuable perspective that RNs, doctors, and other medical professionals will want to take into account beyond strictly fact statements. NAs should be careful to distinguish when they are providing an opinion from when they are providing a fact.

Query 6

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Key Takeaways

- Maslow's Hierarchy of needs provides a useful framework for thinking about what goes in to making a person safe, happy, and fulfilled. Holistic care addresses all aspects of Maslow's hierarchy. While Maslow's hierarchy places physical needs like food, water, and basic health on the bottom, and most fundamental, tier and psycho-social needs higher on the pyramid, all of the needs are interconnected and influence each other.
- Everybody has a right to effective care, no matter their cultural background. Recognizing this means that healthcare providers are responsible for developing cultural competency. Cultural competence involves humility because it requires recognizing that one's own cultural background isn't the only way of doing things or seeing the world; it requires openness because providers must change their practices to best suit the cultural needs of those they care for, even if they disagree with the person's beliefs or lifestyle.
- As someone ages their bodily systems undergo changes. Some of these changes result in a weakened immune system, fatigue and decreased mobility, difficulty hearing and seeing, and other effects. Their social and financial circumstances may also be in a period of disrupt. Some people respond to aging with positivity and a sense of security, while others find the process disturbing and worry about their future. Nursing assistants should be compassionate and attentive listeners when discussing resident's feelings about aging.
- Good communication is extremely important. Communicating clearly, calmly, and thoroughly with residents and with healthcare team members is necessary for good care. Good communication improves patient outcomes.

Comprehension Questions

1) Please list the different kinds of needs discussed in Maslow's Hierarchy of needs in their order of fundamentality, or from the bottom – up on the pyramid. After listing the need, please provide two examples of each kind of need. Think about the way that you meet these needs in your own life, and how you can meet them in others' lives.

2) Respond to the following sentences with T (true) or F (false).

___ A person's physical needs must be met before psychosocial can be fully met.

___ Needs listed higher on Maslow's hierarchy do not impact the needs below them.

___ Feeling a sense of safety and belonging is not important to healthcare outcomes.

___ Feeling secure in one's identity and social esteem are important needs.

___ Aging and moving into an assisted living or long-term care facility can make it difficult for someone to independently meet all of their psychosocial needs.

3) Is a person's right to effective communication in their own language a physical need, a psychosocial need, or both? Why?

4) What is culture? Select the correct answer for the context.

- a. A colony of growing bacteria
- b. Diversity
- c. Shared beliefs, attitudes, values, and behaviors in a group or subgroup

d. A person's nationality

e. The way someone sees the world

5) What goes in to giving culturally competent care? Select all that apply.

a) Actively listening to someone and asking what they need, instead of making assumptions about them.

b) Being really good at guessing where someone is from.

c) Adopting an attitude of acceptance and nonjudgment.

d) Loving Mexican food.

e) Advocating for a person's right to access culturally appropriate food, language services, religious services, and culturally relevant community.

6) Respond to the following sentences with T (true) or F (false).

___ A person's religion is irrelevant to providing them with effective care.

___ Healthcare team members must be accepting of residents' religious beliefs.

___ If you know of a superior religion, it is good to try and convert the residents in your care. They'll be better off for it.

___ Everybody has implicit bias; the important part is to reflect on your own biases, and approach care from a place of acceptance and compassion for everyone.

___ When a transgender resident decides to transition, NAs get to decide if they will call the resident by their chosen name and gender pronouns.

___ A resident's right to dignity and respect includes a right to equitable care, to have their identity honored, and to have their individuality cherished by the people caring for them.

7) What are some psycho-social changes commonly experienced by older adults? Select all that apply.

a. Less income due to leaving the workforce or working less

b. Increased activity levels due to more free time

c. Coping with the deaths of friends and loved ones, and reckoning with one's own mortality

d. It becomes easier to meet one's holistic needs by participating in the community

e. Decreased independence due to financial circumstances, losing a spouse, or moving into a family member's home or an assisted living facility

8) What are some physical changes commonly experienced by older adults? Select all that apply.

a. Sense of taste becomes more sensitive

b. The bladder muscles weaken, which means someone may have to urinate suddenly and urgently

c. The skin becomes thinner and more fragile

d. The heart becomes stronger and pumps blood more efficiently

e. Mobility decreases and muscles weaken and bones become more brittle

f. Eyesight and hearing become less sensitive

g. The immune system becomes stronger and more capable of fighting infection

9) Respond to the following sentences with T (true) or F (false).

___ Active listening requires giving someone your full attention.

___ Yes/no questions are useful for determining whether someone understands what you're telling them. The best question to use is "do you understand?"

___ NAs should always avoid touching a resident on the hand or shoulder during conversation. Friendly touch is never appropriate or useful during care.

___ Writing in a patient's chart is one important form of communication.

___ Nonverbal communication usually does not provide someone with useful information.

___ Candor is an important quality to have in communication amongst the care team. Candor means that you tiptoe around difficult topics to keep everybody in a good mood.

___ Effective communication on the care team, both written and verbal, is essential to providing high-quality care.

10) Please list the steps of the opening and closing procedures.

11) You think a resident may be in pain; she is making a strained facial expressing, clenching her teeth, and clutching her shoulder. You are hurriedly tidying the resident's space when you ask "are in pain right now?" The resident slightly smiles, shakes her head, and says "I'm fine." You say "okay," gather your things, and leave. What barriers to communication are present in this interaction? How could you have handled things differently?

12) What are some potential sources of anxiety for a resident in long-term care? What are some ways that anxiety presents itself? What are some strategies that you can use as a nursing assistant to communicate effectively with an anxious resident? Discuss at least three different approaches.

13) Compassion is obviously necessary in all of the healthcare team's interactions with patients. Why is compassion necessary in a nursing assistant's interactions with other members of the care team? How should you balance compassion and candor when communicating with your colleagues? What is the relationship between compassion and being a responsible team member (ie, showing up on time, completing your assigned tasks, asking for help)?

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Module 3 – Safety

Learning Objectives

- Identify situations that put residents at risk
- Demonstrate understanding of how to keep oneself safe
- Demonstrate understanding of how to keep residents safe
- Demonstrate proper body mechanics
- Understand the use of equipment to protect resident and staff safety

Safety is part of the Big Three

Safety is included in the Big Three because safety is a basic human need. On Maslow's hierarchy of needs, "safety" is both a physical and a psychosocial need.



In long-term care, practicing Safety minimizes the risk of accidents and injuries without further limiting the resident's mobility and independence.

The care team must be proactive in protecting a resident from potential accidents in their environment; for some people, an incident like a fall, burn, or scald can cause deadly complications^[1].

The best way to avoid accidents is to proactively remove accident risks from a person's environment.

Slipping on some juice and breaking a hip can be the adverse event that begins a sharp decline in health and quality of life; a small scrape or scald can become a wound with an uncontrolled infection. Avoiding accidents and practicing safety is important for everybody, and it is especially important when caring for vulnerable adults.

NAs must practice safety measures to protect patients and residents. NAs must also take steps to protect any visitors, their coworkers, and themselves. Many of the risk factors for patient and residents are also risk factors for everyone else. For instance, NAs can help prevent slips and falls by reporting any spills as soon as they notice them; slipping and falling is an accident risk for everybody.

When NAs take measures to promote residents' safety, these measures cannot infringe on residents' rights. For example, if a resident wants to go on a walk, then their NA should not stop them from going on a walk because going on a walk can be dangerous. Instead, the NA should do everything they can to make the resident's going a walk as safe and accident-risk free as

possible.

What is the relationship between Resident Rights and Safety as parts of the Big Three? Write for 5 minutes, and discuss your response with a friend or classmate.

Accident risk factors

A risk factor in general is anything in one's environment or life that increases the likelihood of physical or psychological harm. Accident risk factors are features of a person's way of being in the world or their environment that can make them more prone to accidents like falls, bumping into things, dropping things, taking the wrong medication, etc. Age, agitation, sensory impairments, decreased mobility, and prescribed medications are some common risk factors^[2].



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Age: As a person ages, their reflexes can slow, their muscles can weaken, and their situational

Residents may experience diminished awareness of their surroundings, so it is important for NAs to be hyper-aware and maintain a constant state of observation to avoid accidents.

awareness may decrease. When we are aware of our surroundings, it is less likely that we will slip and fall, stumble on an object, or bump into something.

The surrounding environment itself can be a risk factor to both the resident and the NA, especially when drawers are left open or clutter is allowed to accumulate on the floor.

Agitation: When somebody acts in an agitated way, they are more prone to accidents than when they are calm. This goes for both facility staff and for patients and residents.

NAs should always maintain a sense of calm; if they feel themselves getting agitated, they should turn to breathing techniques and other forms of self-regulation. If NAs are distracted by their own feelings of agitation and frustration, they will be less prepared to respond to situations that put residents at risk.

Residents being agitated or acting aggressively is an accident risk factor; overstated hand and arm movements can cause harm to the person gesticulating, and an agitated resident may be more likely to perform difficult maneuvers unassisted and may even become an elopement risk. Frustration and agitation cloud everyone's thinking by limiting our perspective and inhibiting our capacity for careful and reasonable thought.

NAs should work with residents who experience agitation to develop self-regulation techniques so that unpleasant feelings do not become a source of physical danger or injury. Always report resident agitation to the nurse so they can develop techniques to include in the resident's care plan.

Vision loss: A resident experiencing vision loss may not see obstructions in their path, may have a difficult time reading labels on medicine and food, and are less likely to have a keen awareness of their surroundings to help them avoid potential injuries. Residents need to know their surroundings to be safe; NAs should describe the layout of a room to residents with vision loss upon entry. NAs can assist residents around a space by offering up their arm for the resident to take, but should never take a resident's arm.

Hearing loss: Residents may not hear a verbal warning from a NA about safety precautions or the presence of other accident risk factors.

Impaired sense of touch: Residents may not realize when something, such as bath water, coffee, or a food item is dangerously hot. If a dangerously hot liquid come into contact with human skin, it can cause a scald. A scald is a burn caused by liquids, and they can worsen, become infected, and lead to severe complications.

Impaired mobility: Residents with impaired mobility are more likely to fall, and are less likely to catch themselves or fall safely. NAs should assist residents with mobility impairments with any ADLs that can lead to accidents such as getting dressed, or moving between bed and a chair. Always lock the wheels of the bed and chair when transferring somebody between their bed and their wheelchair.

Medication: Medication poses a risk factor, particularly for residents with vision impairments or unreliable memories. In some circumstance residents will be responsible for their own medication, while in others their medication will be administered by facility staff. Residents with vision loss may not be able to administer their own medications because they run the risk of poisoning themselves.

New medication can pose a risk factor because of side effects. Some medications will have behavioral side effects, while others may induce vertigo. NAs should be aware of any medications that residents are taking and familiarize themselves with potential side-effects to be aware of, particularly those that pose additional accident risk factors.

Query 1

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What is a safe environment?

A safe environment is one in which a person's risk factors have been minimized. A safe environment involves basic physical safety, in that the risk of injury from infection, falls, burns, poisoning, and other accidents is low. A resident has a right to a safe environment, which means that residents' rights and safety are closely intertwined.



Sensory safety

A safe environment is a comfortable environment. It produces feelings of safety and security, in addition to minimizing accident risk factors.

- The temperature of the room should be comfortable for the resident and set between the required 71 - 81 degrees Fahrenheit.
- Noise should be at a reasonable level that does not impede communication, or pose an unwelcome distraction.
- Any smells in the space ought to be pleasant to the resident when possible.

The resident's room

Safety concerns relate closely to a resident's physical environment.

- Spaciousness is an important dimension of safety. If a room is too cramped for someone to move around comfortably and freely, then it is not safe, especially for those with a heightened risk of falling.
- Keep the room free of clutter. A cluttered space is a fall risk.
- The room should be well-lit so it can be maneuvered easily and safely.
- A person in a long-term care facility has a right to their own possessions, and it is the responsibility of everyone involved to help keep resident possessions safe from theft, intruders, and fire. This is often accomplished by placing a small safe in resident's room.
- NAs should always respect residents' privacy. If someone does not have access to privacy, they will not feel safe.
- NAs should *never* lock a resident in their room. This is a violation of residents' rights and poses a danger in the event of a fire.

Emotional wellbeing

A safe environment includes emotional as well as physical features.

- Residents should not feel afraid in a safe environment. If a resident is expressing ongoing fear and concern about being in a particular space, the NA should inquire further.
- Persistent feelings of fear and anxiety may be a result of disorientation. If a resident's fear or anxiety persists beyond managing risk factors, the nurse should be notified.
- If a resident expresses fear or anxiety around particular staff members, other residents, their family, or specific spaces in the facility, the resident may be experiencing abuse. NAs should report suspected abuse to the nurse immediately.
- Residents have a right to a home-like environment. NAs should listen attentively when discussing how they can make the resident feel most comfortable and at-home in their space.

What are common accidents? How can we avoid them?^[3]

Falls

Falls are the most common form of accident in assisted living facilities. They usually occur during the hours of 6 and 9 p.m. in resident rooms and bathrooms during the staff's shift change. The most common causes of falls are poor lighting and cluttered floors, although many things can cause someone to fall.



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- Before their shift change, NAs should always assist residents with using the restroom and any other activity that requires movement.
- Help residents keep a tidy space, remove clutter and cords from all walkways, and keep frequently used objects within easy reach.
- Never move a resident alone. Attempting to move a resident by oneself can result in serious harm to the resident and the NA. When helping residents in and out of bed or in and out of a wheelchair always lock the wheels first.
- Residents must wear non-skid footwear.
- If raising a bed to provide care, make sure the bed has been returned to its lowest position after giving care. Non-skid bath mats should be used when helping residents bathe and shower.
- If the NA notices any unsteady objects like rugs, loose handrails, or damaged walkways, benches, or ramps, they should report it immediately.
- When helping a resident to stand or walk transferring from a horizontal position, NAs should give them a moment to sit upright as a transitional posture. Sitting upright in between laying down and standing up can help prevent lightheadedness, and preventing lightheadedness can help prevent a fall.
- NAs should assist residents with bathroom needs promptly, and offer residents the bathroom often. This will prevent residents from needing to attempt to use the bathroom on their own, and can help avoid the risk of a fall on the way to or while inside the bathroom.
- NAs should never move furniture without being told to do so by a nurse, and they should always tell the resident before moving the furniture.
- Long-term care facilities should perform fall risk assessments on all of their residents. NAs should make sure they consult the care plan for any specific fall-prevention measures.

YouTube Video

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Responding to a fall

If a resident is falling, the proper way to minimize damage is not to try and completely stop the fall. Instead, the NA should use their body as leverage to gently lower the resident to the floor.

Bring the resident's body close to one's own and slowly and carefully lower the resident to the floor. The resident cannot get up until a nurse has arrived and checked them for injuries. NAs should sit with the resident until a nurse arrives.

Even if a resident has a fall and is uninjured and says that they feel fine, always report it by completing an incident report form.

Burns and scalds

Burns and scalds can be caused by hot electrical appliances or hardware, hot liquids, or dangerous chemicals. Burns can happen quickly, are extremely painful, and may require complicated interventions like surgery and long-term wound treatment. A burn can be the event that causes a downturn in a resident's physical condition. Elderly people are at the greatest risk of injury from burns due to a less sensitive sense of touch.



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- Always check bath water temperature with a thermometer; bath water should not exceed 105 degrees Fahrenheit. Always check the water temperature before a resident enters the bath.
- Make sure hot beverages have cooled before prompting a resident to drink; older adults' skin is fragile, and spilled coffee or tea can cause a harsh scald. Always be careful when pouring hot drinks, and be conscious of where hot drinks are placed on a table.
- Be conscious of the harmful capabilities of the sun. Do not leave use-objects such as wheelchairs in the sun for long periods

of time; if a use object has been left in sunlight, NAs should check the temperature of the object before allowing residents to use it. Residents should also not be left in the sun; when going outside, have residents use sunscreen and wear hats.

Poisoning and choking

Poisoning is a risk for residents because there is a high concentration of toxic materials in facilities. Glue, cleaning products, paint, soap, perfume, and medication are all things that be dangerous or deadly if consumed or consumed improperly.

- Items like plants, fragrances, soap, hair products, and nail polish and nail polish remover should all be kept away from disoriented residents. Such products should be stored in a locked place or kept outside of the resident's room.
- Poison Control's phone number should be posted wherever there is a telephone.
- Make sure there is proper ventilation in every space, since chemical products can release fumes that residents may find unpleasant or overwhelming.
- NAs should check resident drawers or stowing locations for rotten or spoiled food.

Always verify a resident's identity using at least two different forms of identification. Some acceptable forms of identification include a verbal response, a resident's ID bracelet, or a name listed on their room.

- NAs should closely observe residents when they eat and drink; some residents may be at high risk for choking due to weakness or dysphagia.
- Dysphagia can lead to choking on food, drink, or another foreign substance. The inhalation of matter into the lungs is called aspiration, and can lead to severe medical complications. Dysphagic residents may require prescription diets of naturally viscous or thickened liquids.
- Residents should have their bed in an upright position when consuming food or drink. When assisting a resident with consumption, NAs should proceed slowly and switch between solids and liquids. All food should be cut into small, bite-sized pieces that will not be laborious to chew.
- Dentures must fit properly and securely.
- Know residents' specific swallowing needs and precautions. If a resident would have an easier time eating with a different diet, NAs should report this insight to the nurse.

Always make sure that the right resident is getting their own, and only their own, medication and food. A resident being given the wrong food or medication could result in poisoning, illness, or death.

The Safety Data Sheet (SDS)

The Safety Data Sheet (SDS), formerly referred to as the Material Safety Data Sheet, is a resource that provides information on specific chemicals and chemical products, why and how each is dangerous, how to properly handle and dispose of them, how to use them, and which emergency actions are necessary once in direct contact or ingested.

OSHA, the Occupational Safety and Health Administration, requires that facilities keep a copy of the SDS on hand and readily available at all times.

Facilities must have SDSs for every dangerous chemical used.

Sign up for any SDS training opportunities at your place of employment.

NAs must be able to read and understand the information represented on an SDS, and apply it to their circumstances. Always ask for help. if unsure about something on the SDS.



“physical hazard label” by The EnergySmart Academy is licensed under CC BY-NC-SA 2.0.

Check the SDS before cleaning chemical leaks or spills. Any hazardous substance must have a warning label on its container; if an NA notices that a container for a hazardous substance looks damaged, they should immediately alert the nurse.

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Ally Safety. (2021, September 29). Safety data sheets training video by Ally Safety [Video]. Youtube. https://www.youtube.com/watch?v=_yWF-w3CwmU

General guidelines

- The danger of skin tears

Older adults are at a high risk for accidents like cuts, scrapes, and tears because human skin weakens and thins as a person ages. Preventing skin tears is an element of Safety; it is also an element of Infection Control.

Avoid leaving any sharp items out, like razors, after they are used. Sharps must be disposed of in a specific “sharps” container labeled with a biohazard symbol.



Created by Dmitry Vasiliev
from Noun Project

Biohazard by Dmitry Vasiliev from [Noun Project](#) (CCBY3.0)

- Prevent skin tears by interacting with residents in a careful and thoughtful way; dress residents slowly and smoothly, and always be conscious of their limbs and hard or rough surfaces. It won't take much more than a brush against a rough surface for a resident's skin to break; NAs should proceed with a heightened degree of caution whenever there is a risk of a resident's skin tearing.
- Don't run.
- Pay attention to the environment. Keep an eye out for spills or wet surfaces, and address spills and clutter.
- Don't overburden extension cords, as this can lead to fires.
- Don't overuse plugged-in items; electrical devices should be unplugged when not in use. Unplug something if it becomes overheated, stops working properly, or causes a spark. Alert management immediately about frayed cords or wires, and stop using them.
- Always ask for help when moving a resident, in addition to utilizing proper lifting techniques and equipment.

Always report and fill out an incident report form for any injuries or workplace violence.

- Get to know each resident, and learn which residents are more likely to become combative or aggressive. Know what triggers this kind of behavior, and be prepared to respond calmly. Notify the nurse of aggressive or combative residents so you can develop a response plan together.
- If exposed to a dangerous chemical, rinse skin with water immediately and follow facility procedures for chemical exposure. The same applies when anything splashes in one's eyes; thoroughly rinse, and report the incident to the nurse. An emergency eye flush may be necessary, as will a visit to a doctor.

Residents rely on the nursing team to meet their basic needs, and a person must be safe to have their basic needs met. The needs and rights of facility staff members must also be taken into consideration. The whole team has to exercise care, caution, and proactive thinking about risk factors to protect the safety of everyone at the facility.

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Disaster Preparedness

Fire safety

Fire is a constant danger in assisted living facilities. All a fire needs to occur is heat to produce the flame, fuel for the fire to burn, and oxygen to maintain the fire.

What is a fire hazard? A “fire hazard” is something in an environment that has a higher likelihood of causing a fire.

Smoking is a major fire hazard. If a facility allows any smoking indoors, smokers should never be left unattended.

- Always check ashtrays and put out anything that is still smoldering. Check the surrounding area to make sure no smoking materials have become lost.
- Always double check an ashtray before emptying it to avoid the risk of starting a trash fire.
- If residents use vaporizers or e-cigarettes, make sure the battery does not overcharge or become overheated. Remove the battery at night.

Frayed or overused **electrical infrastructure**, such as outlets and cords, are fire hazards.

- Don't use cords that have been wrapped in electrical tape.
- NAs should report any damaged electronics as soon as they see them.
- Don't overburden power strips.

Oxygen tank safety

Some things to keep in mind when a person is on an oxygen tank.

- Flammable liquids, such as alcohol and nail polish, should be removed from the vicinity of oxygen.
- Do not burn candles, flick a lighter, or make any open flame near oxygen. *Do not smoke near oxygen.*

If you smell gas, report it immediately.

Oxygen tanks are fire hazards because they contain large of amounts of compressed fire-fuel. Since fires burn on oxygen, compressed oxygen tanks are notable fire hazards. Oxygen tanks must always be stored properly when not in use. Never smoke, or allow anyone else to smoke, near an oxygen tank.

Responding to a fire

Fires do occur in medical facilities. It is extremely important for NAs to prepare, and keep their wits about them when they do occur^[4].

- Everyone should know where a facility's fire evacuation plans are kept. If a fire occurs, stay calm – calmness allows for clear and critical thinking.
- Rescue residents in immediate danger while following the evacuation plan.
- If a building is on fire, check doorknobs and under doors before opening them, and remain low to the ground to minimize smoke inhalation. Make sure exits are clear and free of debris.
- Do not use an elevator during a fire.
- Close all doors and windows to keep the fire contained.
- Turn off any oxygen or electrical equipment in the fire's area.

It is important to know the location of all of the facility's fire alarms. If the NA wonders what to do in case of a fire, they can remember the acronym “RACE.”

Remove anyone in danger, unless you are actively in or escaping danger.

Activate the alarm and call 911

Contain the fire; close all doors and windows.

Extinguish the fire if you can do so safely. If not, **evacuate** and the fire department will extinguish the fire.

Using a fire extinguisher can be nerve-racking, especially in a stressful situation like a fire. Remember the acronym “PASS” to know the steps for successfully using a fire extinguisher.

Pull the pin

Aim at the base of the fire (not the middle or top of the flames)

Squeeze the handle

Sweep back and forth at the base of the fire.

Disaster response

A disaster is a sudden catastrophic event. Nobody likes to think about the possibility of disasters, whether natural or man-made, but they do occur, and it is important to be prepared for them. Natural disasters include floods, earthquakes, tornadoes, and some fires, while man-made disasters include events like things like shootings and acts of terrorism.

When disasters occur, NAs must respond calmly and intentionally. Facilities will have plans in place for disasters; NAs must closely follow facility protocol in the event of a disaster.

In any disaster, NAs must...

- know the plan
- stay calm
- know the layout of the building including all exits and stairways
- know where fire extinguishers and alarms are found

Planning for disaster

Facilities will have plans and drills in place for specific kinds of disasters.

A facility's disaster plan necessarily involves steps to protect the safety of both staff and residents.

A facility's plan will outline the process for discharging those who are able to go home, and using the facility's designated emergency areas. Off-duty staff may be called in for extra assistance if possible.

All evacuation procedures should be followed when initiated.

Always remain calm – calmness allows for clear and critical thinking.

Disaster response can be chaotic, which means it is an optimal time for an intruder or security risk in the hospital. If the NA sees someone in the facility who they don't recognize and doesn't seem like they are supposed to be there, the NA should report it immediately, especially during disaster response.

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Understand how to keep yourself safe by identifying situations that put NAs at risk

Workplace Violence Prevention

Workplace violence refers to any situation in which an employee has attempted harm enacted upon them. This harm could either be physical or psychological. Threats and bullying are forms of workplace violence, in addition to physical violence.

Someone does not have to successfully harm an employee for it to be an instance of workplace violence. Actual physical violence and verbal threats to violence are both instances of violence, as is harassment and other forms of violent behavior that do not always involve physical contact.

Workplace violence occurs more frequently in healthcare careers than in any other industry. The vast majority of healthcare workplace violence comes from patients or residents who act aggressively towards staff members. NAs are at particular risk of experiencing workplace violence because they have the most direct contact with patients and residents^[5].

Workplace violence can also come from co-workers. Such workplace violence is referred to as “lateral violence.”

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American Nurses Association. (2023, March 24). ANA workplace violence defining scope of violence [Video]. Youtube. <https://www.youtube.com/watch?v=8tvM...Xz0Qei&index=3>

According to Schub and Karakashian, the majority of incidents of workplace violence in hospitals were against staff by patients or visitors. Relatedly, NAs’ rates of workplace violence were 2.8 times higher than the national average^[6]. NAs should recognize that their safety is at stake in conversations about workplace violence.

OSHA publishes guidelines for workplaces to follow that can help to decrease the risk of workplace violence. OSHA recommends that workplaces maintain a written program for workplace violence prevention. Make sure that you know what your facility's workplace violence prevention plan involves.

It is essential that all NAs understand and follow their workplace’s violence prevention program. These plans are in place as a result of careful analysis of threats and the best responses to them^[7].

- Always voice concerns. If you are concerned about a potential risk, whether regarding an aggressive resident, a suspicious and unknown person in the facility, bullying, or something else, speaking up could make the difference between resolving the risk and a workplace violence incident. Early awareness of a potential threat can provide an opportunity to intervene, and

helps staff be prepared in the occurrence of violence.

- Always report incidents of violence promptly and accurately. Violent incidents require an incident report form.
- NAs can take extra steps to help ensure their safety and the safety of those around them by signing up for any extra safety trainings offered. Special trainings on workplace violence can help employees recognize and manage aggression, agitation, assaultive behavior, and intent to commit violence.
- Consider joining the health and safety committee that reviews information on workplace violence and implements procedures to minimize it.

Risk management

Almost everything discussed thus far, from proactively preventing common accidents to navigating the possibility of workplace violence, falls under the idea of risk management.

Risk management refers to identifying and managing the risks and safety hazards that impact a healthcare agency. Managing risks is about protecting everybody's safety from accidents, risks of violence from patients or visitors, and risks of violence from other staff members.

Facility risk management deals with:

- Accidents and fire prevention
- Preventing negligence and malpractice by medical staff
- Preventing abuse of patients
- Preventing workplace violence
- Always meeting federal and state safety requirements and quality of care standards.

If these things are going to be done effectively, then plans and decisions must be made according to data collected from within the facility. Incident report forms are vital to a facility's ability to manage risks.

Incident Reports

An incident is an event that has harmed or may have harmed a patient, resident, visitor, or staff member. When an incident occurs, an incident report will need to be filled out^[8].

Incident reports are compiled and reviewed as data by facility risk management personnel and committees. The risk management team analyzes the incident data to look for trends and patterns in the reported accidents, errors, or violent incidences.

Fill out incident reports as soon as possible. It is important to remember details accurately and completely, so filling out the incident report form quickly will allow for a clear and detailed memory.

What kinds of incidents require an incident report form?

- Any and all accidents involving patients, residents, visitors, or staff. Anything from a resident falling and breaking a hip to the scheduler getting a papercut warrants an incident report.
- Incidents of workplace violence.
- Errors in care require incident report forms.

For example, if Mr. Jones was supposed to get a bath, but Ms. Smith is bathed instead by mistake, report the incident.

Errors in care include *giving the wrong care* to someone, giving care to the *wrong person*, and *not giving care* to someone who was supposed to receive it. Tell the nurse if an error in care occurs so everyone who needs care still receives it properly.

- Broken or lost items, money, or clothing
- Incidents involving hazardous substances such as chemicals or cleaning solutions
- Sentinel events are unexpected events that result in a person's severe injury or death, and require immediate investigation.

When reporting an incident, stick to facts. Include exactly what happened and peoples' responses to it, the time, and date.

Incident report forms are confidential and intended for internal use only. NAs should never make a photocopy of an incident report form, and should not include statements like “incident report filed” in a patient’s medical chart since this might lead to a breach in confidentiality.

At some point an NA may have a colleague try to talk them out of completing an incident report form. Never give in to this kind of pressure – incident report forms exist to protect everyone in a facility, including staff members. Always complete an incident report form when you believe one is called for. Always follow facility procedures on incident reporting and documentation.

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Movement and body mechanics

Body mechanics refers to the way that the different parts of our body work together; good body mechanics refer to ways of performing motions like lifting, bending, and running that maintain the physical health of the body. For example, sitting up straight and tall is an example of good body mechanics because it helps maintain spinal health over time.

Good body mechanics are necessary for the long-term health and functioning of all human bodies; NAs really have to consider body mechanics to protect themselves from injury, and to protect the people they care for from injury as well. Musculoskeletal injuries are a common issue in healthcare, and can be debilitating.

Alignment

A person’s body is in alignment when a vertical line can be drawn from the tip of their head to their tailbone. Humans should try to maintain alignment whenever possible, whether they are laying down, sitting, or standing.

The left and right sides of one’s body should be mirror images of one another, particularly when carrying something heavy, large, or awkward.

When carrying a heavy object, maintain bodily alignment by keeping the object close to one’s body and avoiding twisting or hinging one’s body at the waist. If lifting a heavy object, a person should keep the back straight and lift with their legs. Use the thighs, upper arms, and should to lift, as these are some of a person’s strongest muscles. Never lift with your back.

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Base of support & center of gravity

The base of support for any object refers to an object’s foundation^[9]. For most humans, one’s feet will be their base of support.

Widening the base of support by spreading one's legs further apart and bending one's knees can help to maximize stability. Standing with feet at shoulder-width will allow stability and balance; keeping one's feet together narrows the base of support and leaves you prone to imbalance.

A person's center of gravity is the point in their body where the most weight is concentrated;

The center of gravity changes depending on positioning and weight distribution.

the placement of a person's center of gravity depends on how their body is positioned. Standing normally, the center of gravity is around the pelvis.

Hold the objects or people you lift close to your body. Holding objects or people away from one's own body can cause a person to strain and injure their muscles, especially their back.

Good body mechanics are Safety

Assisting with ADLs and nursing tasks involves a lot of moving and lifting, as well as other care activities that, if done without good body mechanics, could cause a musculoskeletal injury. Such activities include lifting and moving residents, tidying a bedroom and doing laundry, helping a resident move in or out of a facility, taking out the trash, moving equipment such as a bed, and even simply cleaning the floor. Try to make good body mechanics a habit.



Any activity that involves lifting and bending carries a risk of injury if the person does not consciously practice good body mechanics.

Keep these tips in mind:

- Raise the bed before making it or replacing the linens, and lower it again afterwards.
- Always keep the lifted object close to oneself and stand with a wide base of support. Lift with the legs. If possible and safe, slide heavy objects across the floor rather than lifting them. When lifting, always bend at the knees and not at the waist.
- Maintain alignment by facing the object or person being lifted.
- Pivot, don't twist.
- Always use both arms and hands when moving objects.
- Get help from coworkers when moving a heavy object or a resident.
- Always talk to residents before attempting to move them. Explain what is going to happen, discuss any ways that the resident can help or make the movement more easy and comfortable, and coordinate your movements by counting to three so that everybody moves synchronously.
- Always bend a resident's knees before moving them in bed; if their knees are not bent, then residents are more likely to sustain a back injury

Ergonomics

Maintaining good posture in the residents one cares for is an important aspect of a NA's job. Ergonomics refers to the practice of creating equipment that suits the needs of human bodies, or modifying work procedures and motions to promote the health of the body. Examples include devices like ergonomic chairs and eating utensils, or practices like adjusting beds to a good working height instead of bending down.

Medical equipment to be ergonomically sound. Beds and chairs need to be supportive, and mobility devices need to keep a person's body safe and secure. Canes and walkers need to be designed with aging human hands in mind. Medical equipment needs to have high ergonomic standards because the likelihood and consequences of injury are raised in healthcare contexts, especially when caring for elderly people.

Ergonomic equipment, particularly assistive devices that are used to safely transfer and move residents, is necessary to protect both caregivers and the recipients of care.

Healthcare workers also need to have good ergonomic work practices. Ergonomically sound body movements help protect staff members from back injuries.

The Right to Safety

OSHA mandates a safe work setting. Part of maintaining a safe work setting is minimizing activities that put staff members at risk. Musculoskeletal injuries are a high risk for direct care staff because of the frequent lifting, moving, and range of motion the job requires; musculoskeletal problems account for over half of NA's days away from work^[10]. OSHA guidelines require that employers take measures to avoid or minimize the conditions that result in back and muscle injuries.

Back injuries can occur from a motion repeated over time, or from one adverse event. Even though a single movement, such as twisting while carrying an object instead of pivoting, may not feel like a strain when done once, it may cause a back injury when done repeatedly.

Symptoms of back injuries include:

- pain when sitting or standing
- decreased mobility and range of motion
- pain when rising from a seated position

Report the symptoms of a back injury right away. Assistive technology such as over-the-counter back braces can help staff members practice good body mechanics on the job.

To protect the staff from injury, some facilities have implemented no-lift policies, also called zero-lift or lift-free policies. These policies adopt rigorous standards for how residents are allowed to be lifted or moved, and sometimes ban lifting without an assistive device altogether. The more tightly lifting is regulated, the more protected facility staff will be from injury. NAs should closely follow facility policies, and should always ask for help when unsure about performing a task.

Lifting an uncooperative or unsuspecting resident poses a risk factor. It is pertinent to both Safety and Resident Rights to communicate effectively with the resident before lifting them and while lifting them.

- Whenever lifting or moving a person, or when helping a person move, always remember to be gentle and respectful of the person's body.
- Tell them exactly what is going to happen before performing the task; if it would be helpful, involve them in the task by coordinating so they help execute the maneuver; for instance, by saying "push up with your legs on three."
- The important part is to keep communicating through the whole process, from entering the person's room until the move has been completed.
- Always check in with the person afterwards to make sure they are stable and comfortable.

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Equipment and techniques for promoting safety

Various pieces of equipment, like transfer belts and wheelchairs, can help keep both staff and residents safe. However, if safety and assistive equipment is going to keep people safe, it needs to be used properly. Improperly used safety equipment quickly becomes a risk factor.

Transfer/gait belt

Transfer belts are thick belts made of strong material that facility staff can use to help residents get from their bed and into a chair or wheelchair. Transfer belts are also used to assist a resident with ambulation, and in such cases may be called a gait belt. NAs can grasp the belt firmly and use it to help move the resident.

- Transfer belts are used to help people who are unsteady or disabled.
 - Tighten the belt around the resident's waist until it is snug but not tight – the NA should still be able to fit all four of their fingers under it.
 - Grasp the belt on either side with fingertips upwards and spread out. Never place the transfer belt over a resident's bare skin.
 - The resident should not hold onto the NA for extra support, since doing so could take both the NA and the resident off-balance.
 - If a resident is wearing a transfer belt, they should not stand without assistance. Do not take your hands off of the transfer belt when the resident is standing.
 - Always raise the resident's bed to help them into a seated position to assist them out of the bed. NAs should raise the resident's bed whenever providing care to maintain good posture.

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- If a person is falling while being assisted, the NA should not attempt to catch the resident. Instead, the NA should use the gait belt (another word for transfer belt) to ease the resident slowly to the floor.
 - The NA can brace the resident against their body; as they lower the resident to the floor, they should remember to maintain good alignment, keep their center of gravity low, and bend and lower from the knees rather than the back.
 - A resident that has fallen should not be allowed to get back up until a nurse checks them for injuries. Always complete an incident report right after a resident falls, even if they appear to be uninjured.

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Wheelchairs

Practicing thoughtful wheelchair safety is important to keeping residents and oneself uninjured. Some wheelchairs are motorized, while others are propelled by the person using the wheelchair or by another person using the chair's push handles.

(ICC video how to transfer someone into a wheelchair)

- Before transferring a person into a wheelchair, make sure that the wheelchair's brakes are activated. The wheelchair needs to remain stationary while the transfer is performed.
- Make sure that the tires are sufficiently inflated and properly secured to the wheels. Check the wheels for any damage.
- When positioning a resident in the wheelchair, it will be helpful to situate their hips in the back of the chair by having the resident move themselves backward into the wheel-locked chair while bracing themselves on the chair's arm rests. After the resident is situated, help them get comfortable.
- Once the resident is in position, make sure that all four wheels are pointed forward. Next, position the person's feet squarely on the footplates, and double check that they are in place before unlocking the wheels and pushing the chair forward.
 - Always push a wheelchair forward, unless going through a doorway or entering an elevator. When going through a doorway or entering an elevator, it is appropriate to pull the person in the wheelchair in reverse.
 - Never let the person stand on the footplates.
- Some people may need accessories added to their wheelchairs. For instance, somebody who needs to be kept on oxygen will have a specific accessory that affixes the oxygen equipment to the chair. A person who uses a catheter bag will also have a specific wheelchair accessory that allows them to easily and discretely travel with it. Always make sure that a person's necessary wheelchair accessories are in place.

If a wheelchair is stationary, lock the wheels.

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Stretchers

If a resident cannot sit up or must remain laying down as part of their care, then they will not be able to use a wheelchair. In such cases, NAs will likely need to use a stretcher. A stretcher is a small platform, like a very narrow bed, with four wheels.



Image by [Dan Zen](#) is licensed under [CC BY 2.0](#).

- Stretchers come with safety belts to make sure that the person does not fall out of the stretcher. Make sure that the stretcher's safety belt and straps secure the patient.
- Always ask at least 2 or more colleagues for help when moving someone from their bed to a stretcher.
- Make sure that the stretcher's wheels are locked before and after the transfer occurs.
- Before unlocking the stretcher's wheels, raise the side rails and keep them raised for the duration of the transport.
- Keep talking with someone who is being moved, first by narrating what is going on, and then by continuing the conversation if the person seems open to it. Transportation via stretcher can be uncomfortable and vulnerable, and people may appreciate an attempt at casual human connection through pleasant conversation.
- Always keep a person on a stretcher covered so they remain warm, and to minimize unpleasant feelings of exposure. Blankets and coverings can help someone feel more secure.

Bariatric equipment

Bariatric equipment is any medical equipment that is designed to have a higher weight capacity than standard versions. Beds, wheelchairs and chairs, stretchers, toilets, commodes, and other equipment usually have a weight capacity of 250 to 350 pounds. However, some people who need care will exceed the standard weight capacities of most equipment.

Always know the person's weight and be aware of the weight capacity of the equipment. Do not use an item with a weight capacity that is exceeded by the person.

Never exceed the listed weight capacities on equipment; the equipment used must be able to safely support the full weight of a person. Bariatric equipment is built with weight capacities between 250 and over 1,000 pounds. This equipment is labeled with "expanded capacity," and will be labeled with the suggested weight limits.

NAs should always ask themselves whether they are doing something in the safest way, or whether there are any safety concerns that are being overlooked. The safety of everyone, residents, patients, staff, and visitors, is the utmost priority. NAs should always ask for help if they need it or if they are unsure of correctly and safely performing a task.

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Restraints and restraint-free care

Restraints are either physical or chemical; a physical restraint is any method or equipment that restricts or limits a person's capacity for movement, such as special straps, belts, and mittens. A chemical restraint is a medication used to manipulate mood and behavior^[11].

Restraints can only be used when they are determined to be medically necessary, usually by a doctor's order, and/or by consent of the person. A person can consent to restraint in advance – in these cases, such information will be included in the person's care plan.

If a resident cannot remove equipment designed to enable them, then the enabler may become a restraint; an example would be a laptop tray on a wheelchair that, if it cannot be removed without assistance, traps the resident in their seat and restricts the movements they can perform from that position.

Make sure that residents can easily remove enablers; if they cannot, the NA should remain with the resident to provide assistance for the duration of the enabler's use^[12].

Bed rails

Patients' raised bed rails may be either an enabler or a restraint depending on their use. The NA should always lower the bed rails after completing care tasks. Leaving the bed rail raised increases the risk of entrapment.

Entrapment occurs when a person becomes physically trapped in a physical structure, such as their bed's headboard or bedframe. A resident can easily trap their arms, legs, or head in the spaces provided by a fully raised bed frame.

Avoid leaving patients or residents in situations that could result in their entrapment. Bedrails can only be used when they are necessary for care. Raised bed rails are sometimes needed by unconscious, sedated, or disoriented people.

Resident Rights

Before the passage of OBRA, restraint use was common for everything from fall prevention to keeping confused residents in place, or to prevent people from removing their own tubing and IV lines. This environment created conditions where the irresponsible use of restraints was normalized for caregiver convenience, rather than the wellbeing of the resident.



Restraining people for convenience leads to injuries and abuse, so the federal government determined that restraints need to be limited to specific, proper uses. Now, restraints can only be used when they are medically necessary, and the least restrictive effective restraint must be used. Restraint application as discipline, punishment, or convenience is illegal and abusive.

Whenever a restraint is being used to care for a resident, strict guidelines must be followed involving close monitoring of vital signs, mental condition, and skin health. Close monitoring is required because residents can suffer complications from restraint use that can result in injury and death.

Complications

Complications from restraint use can be extensive and varied^[13].

Restraints, when used improperly or for too long, can cause:

Restraints can only be used when they are in the best interest of the resident, and after considering alternatives. Only the least restrictive restraint necessary for care can be used.

- bruising and other skin contusions and damage
- suffocation
- negative impacts on the circulatory system and heart health
- decreased mobility from muscle atrophy
- musculoskeletal complications and nerve injuries.
- falling
- entrapment
- strangulation
- poor nutrient consumption
- urinary tract infections
- incontinence
- constipation

Restraints can also have negative effects on a person's mental wellbeing, including:

- depression
- poor sleep
- loss of independence and dignity
- increased anxiety and agitation
- social isolation
- confusion

In severe cases, restraint use can result in death.

Using restraints carries high-stakes risks, so many workplaces aim toward restraint-free care, or at least emphasize finding alternatives to restraint before deploying it as a last resort.

Facilities are legally required to take restraint use seriously, and can only use one "if it is the least restrictive means necessary to attain and maintain the resident's highest practicable physical, mental, or psychosocial wellbeing," as found in the Illinois Nursing Home Care Act^[14].

Restraints can only be ordered by specific personnel such as medical doctors, medical social workers, nurse practitioners, and in some cases RNs. If a person poses an immanent physical threat to themselves or others a restraint may be ordered immediately.

A resident must be monitored regularly while restrained, and must be able to access their call light. Persons being restrained must have their call lights answered immediately.

From the perspectives of Resident Rights and Safety, why is it important to answer a restrained resident's call light immediately?

NAs must let a person out of their restraint every two hours (at least) to receive care and perform basic ADLs, and to check in on their physical and psychological comfort. NAs should make sure to check for discoloration or swelling of the skin and notify the nurse of any abnormalities, especially in the areas making contact with the restraint.

Adverse side effects like sedation, confusion, and disorientation often accompany chemical restraints. Such side effects may cause or constitute harm, and should be avoided when possible.

Documentation

Documentation is an important dimension of using restraints, and is required by federal and state law. Once someone makes the decision to use a restraint, multiple parties must be notified, including members of hospital administration and any individuals or organizations the person being restrained had officially indicated.

NAs must document certain things in a person's chart while caring for them during restraint use. Always document:

- what type of restraint was used
- how it was used
- the time it was applied
- each subsequent removal
- Document any care given in between or after restraint use, including a person's vital signs. Make sure to take note of any circulation, skin, or behavioral abnormalities.

Restraint alternatives

All patients and residents have a right to be free from restraint. This right can only ever be infringed upon when it is in conflict with their right to safety. The right to be free from restraint has led many facilities to adopt a restraint-free care policy.



A facility uses restraint-free care when they never use restraints for any reason. Not all facilities have restraint-free policies, but those that do set the standard and help to advance the use of restraint alternatives. A restraint alternative is a measure or adaptation a facility makes to minimize or eliminate the need for restraints.

Understanding the underlying reasons for a dangerous behavior or condition allows for the possibility of addressing them in a way that avoids the need for restraints.

If a resident is agitated, NAs can try and redirect their attention and energy towards engaging activities, or calming them with breath work. It is also a good idea to make sure residents are physically comfortable by offering a snack, inquiring about pain levels, or offering assistance with the rest room.

Agitated people often experience irritation as a result of understimulation. Providing interesting things to do, opportunities for physical exertion, and people to talk to can help. Sometimes people experience irritation instead as a result of overstimulation and tension; NAs can prompt the resident to engage in relaxing activities, or use their knowledge of what relaxes the resident to create a soothing environment.

Always follow facility guidelines, training, and protocol on best practices to use regarding restraint and restrain-free care.

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Hartford Institute for Geriatric Nursing. (2013, September 20). Avoiding restraints for elderly dementia patients [Video]. Youtube. <https://youtu.be/wiJUKLfISQU>

Key Takeaways

- Safety is part of the Big Three. Both residents and facility staff have a right to a safe environment. Accident risk factors need to be proactively considered and avoided to ensure a safe working and living environment.
- Keep residents safe by following facility safety policies, maintaining continuous communication, and always asking for help when unsure. Always file an incident report form when accidents occur.
- Keep yourself and fellow staff members safe by remaining vigilant about safety concerns and potential for workplace violence. Participate in risk management.
- Always use excellent body mechanics when lifting and moving, and doing any task that requires the body. Use assistive equipment and ask for help when needed.
- Avoid restraint use when possible. If restraints must be used, always protect resident rights.

Comprehension Questions

1) Respond to the following sentences with T (true) or F (false).

___ Safety, Resident Rights, and Infection Control are all closely connected.

___ The best way to avoid accidents is to proactively remove them from a person's environment. If they can't be removed, the nursing team should have a plan in place to manage accident risks.

___ Age is not an accident risk factor.

___ Diminished awareness is an accident risk factor. Nursing assistants must remain observant and vigilant to protect residents from risks, especially if the resident tends to lack situational awareness.

___ Psychological and emotional factors, such as orientation and emotional regulation, are not considerations in risk management.

___ Falls are rare in healthcare settings.

2) What are some things NAs can do to help create a safe environment? Select all that apply.

a. Make sure the temperature is between 71 and 81 degrees; if the Resident is still cold, use blankets and dress them in warm,

soft clothing.

- b. Regularly have loud background noise on to drown out the other sounds in the facility.
- c. Keep the room free of clutter and make sure the resident has adequate space to maneuver.
- d. Keep lights dim and low to create a calm and comfortable ambience.
- e. Observe residents closely for indications of discomfort or anxiety. Talk with residents to see what makes them feel comfortable and at-home.

3) Which of the following actions can NAs take to help prevent falls? Select all that apply.

- a. If there is loose, unsteady, or broken equipment, say nothing and let someone else take care of it.
- b. Make sure the resident wears non-skid footwear.
- c. Answer call lights immediately for residents who are at high risk of falling.
- d. Rearrange the resident's room often to keep things fresh.

4) What is the Safety Data Sheet? Select the most correct answer.

- a. Information on protecting patient's electronic health information.
- b. Facilities are required to have a Safety Data Sheet for every chemical they use.
- d. A color-coded sheet with lots of symbols on it.
- e. A resource that all facilities must keep on hand that provides information on specific chemicals, how each is dangerous, how to properly handle and dispose of them, how to use them, and which emergency actions are necessary once coming into direct contact or ingested.

5) Respond to the following sentences with T (true) or F (false).

- ___ The presence of oxygen does not require heightened awareness of fire safety.
- ___ Staying calm is an essential part of good disaster response.
- ___ Facilities mostly rely on good improvisational thinking during disaster response.
- ___ NAs must make sure they know all facility disaster response plans, including evacuation, lockdown, and shelter procedures.
- ___ If a power strip sparks when you plug something into it, that just means it's working.

6) What qualifies as workplace violence? Select all that apply.

- a. You are filing paperwork and get a papercut.
- b. A coworker calls you an offensive name because of the way that your lunch smells. Even though you know it was immature, your feelings are hurt. When you talk to her about it after your shift, she tells you she isn't joking and that you'd better bring something else for lunch tomorrow.
- c. You are helping a confused resident eat his lunch. He forgets where he is and, due to poor vision, thinks that someone is trying to hurt him. He knocks the spoon out of your hand and pushes you away.
- d. Your supervisor critiques your job performance without offering any constructive feedback.

7) Please list at least 5 situations that would require an incident report form.

8) Respond to the following sentences with T (true) or F (false).

___ Keeping your back straight when you lift heavy objects is an important part of good body mechanics.

___ Someone's center of gravity is always in the same place.

___ NAs should raise the bed to a safe working height when changing linens or providing care, and return the bed to its lowest setting when complete.

___ Communicating with residents before, during, and after transferring them is an important part of practicing Safety and protecting Resident Rights.

___ Nursing assistants, like everyone, have a right to a safe working environment.

9) When is it acceptable to use restraints in a resident's care?

a. When it will be most convenient for the nursing team.

b. When the facility does not have a restraint-free care policy.

c. Only when they are ordered by qualified personnel, are necessary for the person's care, are used as a last resort, and are removed as soon as they responsibly can be.

d. If the resident becomes combative and issues threats to the care team.

10) Why is it so important that a resident have easy access to their call light while under restraint? What does this have to do with the Big Three?

11) You show up to work in your favorite new pair of scrubs. However, the scrubs are just an inch too long; but they fit great otherwise, and you don't have any other clean uniform clothes to wear. Your day is going well, and you are assigned to give a resident a sponge-bath in bed. You heat the water and pour it into the basin without checking the temperature. On your way over to the resident your pant leg snags on a zipper from the resident's handbag that is laying on the floor; you stumble, and spill water on the resident. The water was 130 degrees Fahrenheit, and causes a scald that requires treatment and infection control measure. The resident's condition worsens and their quality of life goes down. How could this situation have been prevented?

12) You regularly care for a resident with dementia who often becomes absorbed in puzzles and word games. You notice that he has been becoming increasingly frustrated over small things, and has been quicker to anger. Recently, while confused, he tried to hit after you startled him by interrupting his activity to suggest he use the bathroom before a meal. He profusely apologized, and you were taken aback because this resident normally is kind and gentle with you, so you forget to tell the nurse about the incident at the end of your shift. The next day, he successfully hit a different nursing assistant. What is one thing you could have done to prevent this from occurring? Why is the prevention of workplace violence important for both staff members and residents?

13) Why should restraint free care always be a goal, even if the facility does not have a formal restraint-free policy? What are two restraint-alternative strategies the nursing team can use when a resident acts agitatedly or aggressively?

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Module 4 – Infection Prevention

Learning Objectives

- Differentiate between medical & surgical asepsis
- Demonstrate proper handwashing technique
- Develop understanding of Standard Precautions, Bloodborne Pathogen Standard, & types of Isolation
- Demonstrate understanding of Chain of Infection

What is an infection?

An infection is a disease that results from the invasion and growth of microbes in the body. It is a major safety and health hazard, and if unnoticed or left untreated can result in serious complications or death.

Infection control refers to the set of practices and procedures that individuals and facilities use to protect patients, residents, visitors, and staff from infection. Infection control is exceptionally important, and should be something that NAs always have at the forefront of their minds.

Microorganisms are extremely small beings such as bacteria and viruses. Microorganisms are everywhere; they are on every surface we touch, in the air we breathe, in various sources of water, and in our bodies. Microorganisms tend to prefer areas that are dark and damp.

A person's microbiome is the ecosystem of bacteria that help us live. Human beings need our microbiome bacteria for gut health and other beneficial functions. Some people take pro-biotic medicine or foods to foster their microbiome.

Microorganisms that cause harm to people are called pathogens.

When pathogens, or dangerous microbes, are consistently exposed to anti-infection measures, they can adapt and become resistant. Antibiotic resistant bacteria are a serious problem in healthcare facilities.

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Infection control terminology

Infection control terminology usually fall under three general categories: words describing the body's defense system, words describing microorganisms and infections, and words discussing asepsis^[1].

Words describing the body's defense system:

- Antigens are foreign substances that initiate an immune response in the body. Antigens include pathogens, toxins, and any foreign substance that can be harmful to one's body and ought to activate an immune response.

- Antibodies are proteins deployed by the body's immune system that bind to and destroy antigens.
- Normal flora is a term for the normal microbes that live in certain areas of a healthy human body. For instance, the discussion above about the human microbiome is in reference to our normal flora.

Words describing microorganisms and infections:

- An object or space is contaminated when it contains potentially harmful microbes; contamination is the opposite of asepsis. Not all microorganisms are harmful; in fact, some are essential to human health. Non-harmful microorganisms are nonpathogenic.
- Contaminated surfaces should be cleaned and disinfected. One cleans a surface by applying products and friction to reduce the presence of microbes. Disinfecting a surface involves destroying the bacteria with chemicals like bleach, alcohol, and peroxide.
- An infection is an invasion of human tissue by pathogenic microbes. Most pathogens are combatable with disinfection techniques.

Spores are bacteria that are protected by a hard exterior shell, and are thus not killed with disinfectants

Sterilization techniques will be necessary to adequately combat spores and other hearty microbes that aren't killed using standard disinfection.

- Pathogens will have varying degrees of virulence; virulence is a pathogen's relative ability to cause disease.

Words describing techniques to combat infection:

- Sterilization refers to practices that destroy all microorganisms on a given surface using high temperatures, auto-clave pressure, and steam. "Sterile" is a difficult standard to reach. NAs will not be able to work in a completely sterile environment, but they should make sure that surfaces and hands are disinfected.
- Asepsis is the process of keeping surfaces and hands free of microorganisms. Aseptic practices are essential to safety and infection control. Part of maintaining asepsis is always applying Standard Precautions in the workplace.
- Standard Precautions assumes that all bodily fluids are contaminated. Anytime an NA comes into contact with a bodily fluid, they should automatically treat it as if they know for a fact that it contains dangerous pathogens. An example of a Standard Precaution is to always wear gloves when providing hands-on care, even if the person does not appear to be sick. This ensures that potential infection risks are immediately treated with a high degree of caution, and routinizes practices meant to minimize the spread of pathogens.

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Communicable diseases

A communicable disease is a disease that can be spread from one person to another. Spread occurs through direct contact with the person, such as by being in physical contact or by breathing the same air as they do. Spread can also occur through indirect contact, such as by touching objects recently handled by the infected person^[2].

A contagious disease is a communicable disease that spreads easily and quickly. Non-communicable diseases are diseases that can't spread from person to person, such as diabetes.

A body has a natural set of defense mechanisms to prevent and combat infections. The body's skin, mucous membranes that

protect our eyes, nose, and ears, and other defense mechanisms are in place to stop, trap, or remove pathogens to keep them from entering the body, or to kill them quickly once they do. Tools like fevers, the deployment of white blood cells, and other immune responses are to fight the infection once the pathogen has started reproducing within the person's body.

If someone has a bacterial infection, they may be prescribed anti-biotics. Anti-biotics target some microorganisms. However, if anti-biotics are ineffective, it is likely that the person is suffering a viral infection, for which antibiotics won't be an effective treatment.

Asepsis

NAs can work to minimize the spread of communicable diseases by practicing good asepsis technique. NAs should utilize medical asepsis techniques to minimize the risk of spreading infections from person to person, or from one part of a person's body to another part of their body. It also works to reduce the risk of reinfection, which occurs when one person becomes infected multiple times with the same pathogen^[3].

Medical asepsis refers to the set of techniques healthcare staff use to keep a facility as clean and sanitized as possible. Techniques like regular handwashing, disinfecting surfaces, and wearing personal protective equipment (PPE) are all part of medical asepsis.

Medical asepsis cannot make an environment totally free of potential pathogens, let alone microorganisms. To make an object or area completely free of microorganisms involves sterilization, or the getting rid of all microorganisms, which is a technique used as part of surgical asepsis.

Surgical asepsis is different from medical asepsis in that it gets rid of *all* microorganisms, while medical asepsis gets rid of most microorganisms. Surgical asepsis is difficult to maintain, and requires that specific steps be taken. Sometimes procedures requiring sterile technique will require that NAs receive special training before they are allowed to assist.

Handwashing

Handwashing is essential to good asepsis technique. It is the most important thing you can do to practice infection control. Washing one's hands is something most people do regularly, but it is important to know how to do it well. Good handwashing will involve:

1. Make sure to remove rings and jewelry prior to washing one's hands to ensure a thorough clean. Items like rings and watches may also harbor bacteria and can be disinfected with hot soapy water.
2. Rinse one's hands under warm running water.
3. Use antimicrobial soap and scrub one's hands, including one's fingernails and any other surface area where bacteria could accumulate. Scrubbing should last for at least 30 seconds – 1 minute.
4. Rinse one's hands under warm running water, and dry them.

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Infection control is part of the Big Three



SMART CHOICE



Infection Control is the third pillar of the Big Three, in addition to Residents' Rights and Safety, because NAs should always keep it in mind while they are working. It closely relates to the other two pillars of the Big Three.

Residents have a right to a comfortable and safe environment, so they also have a right to be free of infection to the extent that it is possible, and to have their infections promptly noticed and treated should they occur. Similarly, a resident who is regularly at a high-risk for potentially dangerous infections cannot be considered safe. Infection control is an essential aspect of providing effective care.



SMART CHOICE



Noticing and treating infections

Noticing, treating, and minimizing the further spread of infections are parts of infection control. How can NAs observe and notice infections?

Inflammation occurs when tissue swells, and becomes discolored. Inflammation can occur because of damage to tissue, or as an immune response^[4].

There are many symptoms of inflammation beyond observable redness and swelling, such as:

- Mild fevers
- Pain, tenderness, and limited use in the impacted part of the body
- Nausea
- General aches and discomfort

The above symptoms may indicate an immune response to the presence of infection.

The presence of infection symptoms

Everybody responds to pathogens differently, and the symptoms of a person's infection and infection response can vary depending on multiple factors.

The virulence of microbes can vary. Virulence is a word that refers to how harmful different pathogens are. The more virulent and highly concentrated a pathogen is, the more likely it is to produce a harmful infection.

The overall health of the person and the general condition of their immune system impacts their susceptibility to infection. Proper nutrition and hydration are necessary for maintaining a robust immune system. Age, genes, and comorbidities are also relevant factors.

Emotional stress and emotional or physical exhaustion can have significant impacts on the immune system. It is important that residents do things that they enjoy, and find engaging and relaxing. This has a real impact on the immune system's ability to fight off infections.

Symptoms of infection

The signs and symptoms of infection vary widely. They include:

- fever
- chills
- increased pulse and respiratory rate
- pain and tenderness
- fatigue
- loss of appetite
- nausea
- vomiting
- diarrhea
- joint pain
- confusion
- rashes
- sores on mucous membranes
- redness or swelling
- discharge from an infected area
- heat or warmth emanating from a body part
- the limited use of a body part
- headaches

Report any of these symptoms to the nurse and record them in the chart.

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Some different kinds of infection

A localized infection is an infection that impacts a specific area, such as an infected wound. Localized infections can sometimes spread to other parts of the body. Microorganisms that are normal flora in one area of the body may be pathogenic in another.

A generalized infection is an infection that broadly affects a specific area, such as pneumonia, a rash all over the body, pink eye in both eyes, or an infection in the brain.

A systemic infection is an infection that has entered the blood stream and is therefore being carried throughout the body system; septicemia, or sepsis, is an example of this type of infection.

Healthcare-Acquired Infections (HAIs)

Healthcare-acquired infections (HAIs) are infections that develop while a person is being cared for in a healthcare facility or home-care setting. HAIs are common and dangerous, with roughly 1.7 millions and infections and 99,000 associated deaths each year.

32% of HAIs are urinary tract infections (UTIs). Residents or patients that use urinary catheters are at heightened risk for UTIs. NAs can help minimize the risk of UTIs by not leaving urinary catheters in place for extended periods of time, and by keeping the catheter and surrounding area clean. Catheter-associated urinary tract infections have the acronym CAUTI.

22% of HAIs are surgical site infections. NAs can help minimize surgical site infections by observing the site closely and closely following medical sepsis when caring for the site as it heals^[5]. Other HAIs include developing pneumonia by using a ventilator, and some blood infections that result from surgeries or medical equipment.

The CDC now estimates that as many of one-third of US hospitals fail to follow the CDC's guidelines for handwashing and other basic infection control measures, even though universal strict adherence to clean-hand policies could prevent roughly 20,000 HAI attributed deaths each year^[6].

Healthcare facilities should be a place of care and healing, and it is devastating and ironic when the care someone receives results in the infection that kills them.

Multi-drug resistant organisms (MDROs)

Some HAIs are caused by multidrug-resistant organisms (MDROs), which are microbes capable of resisting the effects of antibiotics. This occurs when an organism is capable of adapting quickly in response to antibiotic treatment; rather than the antibiotic getting rid of the organism, the organism adapts so the antibiotic is no longer effective.

MDROs are rampant in healthcare facilities, and pose serious health risks to patients and residents. Three MDROs NAs should be familiar with are MRSA, *c. diff.*, and VRE^[7].

MRSA

MRSA, pronounced mer-za, is an acronym for methicillin-resistant *Staphylococcus aureus*.

MRSA is capable of withstanding the effects of the powerful antibiotic methicillin.

- MRSA usually manifests as a skin infection, but can also infect surgical wounds, the bloodstream, lungs, or urinary tract. It is usually either a generalized or systemic infection.
- MRSA is spread by direct contact; since the bacteria lives on our skin, touch tends to be the medium of contagion. People can contract MRSA through skin to skin contact with an infected person or by touching a contaminated object.
- MRSA changes and mutates all the time to remain resistant to antibiotics. The people most susceptible to severe MRSA are the elderly, people with weakened or compromised immune systems, and people who use tubing and implanted devices. Tubing and implants increase risk of severe MRSA because they give the bacteria a clear portal of entry into the bloodstream.
- *Treatment and guidelines:* A person with MRSA will be treated with an antibiotic therapy. When caring for a person with MRSA, NAs should make sure to keep any drainage from the infection contained and not let it spread to other areas of the skin or to surfaces or objects in the room.

Use a 1:10 bleach solution to wipe contaminated surfaces.

- Exceptional hand hygiene is required, including the use of gloves when touching a patient or contaminated surfaces, and a gown when there is potential for any contamination of one's clothing. A person infected with MRSA should not share any of their items with anyone.

C. diff

Clostridium difficile, or *diff* for short, is a bacterial pathogen that can develop when someone is taking anti-biotics. *C.diff* is a naturally occurring gut bacteria that is usually kept in balance by other bacteria in the gut microbiome. When someone takes an antibiotic that throws the gut biome out of balance, concentrations of *c.diff* can reach dangerous levels and cause serious illness.

According to the CDC, likelihood of reinfection with *c.diff* is high, and one in eleven people over the age of sixty-five who contract *c.diff* will die within one month^[8].

C.diff is contagious. Wash your hands often, shower after your shift every day, and do not use a shared restroom while experiencing diarrhea. *C.diff* spores can lie dormant on a surface for five months and are not killed by alcohol hand sanitizers. Soap and water are the best defense against *c.diff*.

Symptoms of *c.diff* include:

- frequent diarrhea
- fever
- stomach pain
- loss of appetite
- nausea

If these symptoms are observed in a patient or in oneself, alert a nurse immediately.

Treatment for *c.diff* may include a fecal microbiota transplant (FMT). A FMT involves transplanting stool from a healthy individual into the colon of the person with the infection. This counteracts the *c.diff* by reintroducing necessary normal flora back into the colon.

VRE

VRE is the acronym for Vancomycin resistant *Enterococcus*. *Enterococcus* is a species of bacteria that are part of the intestinal tract's normal flora. VRE can enter the bloodstream and cause meningitis, pneumonia, or an infection in the heart.

The symptoms of VRE manifest differently depending on the location of the infection. General symptoms of VRE include:

- drainage from a wound
- fever
- chills

- fatigue
- redness and swelling

VRE is spread via direct contact between people or between a person and a contaminated object. NAs can help prevent the spread of VRE by practicing meticulous hand hygiene and disinfecting surfaces with a bleach solution. NAs should wear protective items like gloves and gowns whenever they are at risk of contamination.

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The Chain of Infection

The Chain of Infection is a way of thinking about how disease spreads from one person to the next. It is a sequential loop that starts with a harmful bacteria and ends with a person's infection; the cycle then starts again, since the infection will allow the pathogen to proliferate and spread.

The chain of infection progresses: 1. Causative agent > 2. Reservoir > 3. Portal of exit > 4. Mode of transmission > 5. Portal of Entry > 6. Susceptible host



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- Causative agent: the pathogenic microbe that infects a person and causes illness. Causative agents could be bacteria, fungi, or viruses.
- Reservoir: surface or host where causative agent lives. The reservoir for a pathogenic microbe could be the surface of a piece of equipment or furniture, or in the food, water, and air. Animals and humans can also be reservoirs for pathogens. Microbes tend to prefer warm and oxygen-rich environments, and tend to grow better at body temperature. Many are capable of surviving on hard surfaces and in linen. Treat contaminated surfaces and linen with care.
- Portal of exit: the pathogen's means of exiting the reservoir. In the case of human or animal reservoirs, portals of exit can include things like mucus, waste, spit, breath, and blood. A portal of entry is a pathogen's means of entering a new host.
- Mode of transmission: the means the microbe uses to travel from a reservoir to a host, or from one host to another host. Different pathogens travel via different modes of transmission; some require contact, while others may be airborne or travel through the different medium of respiratory droplets.
 - Vector transmission of a pathogen occurs when an infectious agent transfers a pathogen to another host, while vehicle transmission occurs when a pathogen enters a host from a substance or surface.

- Host: a hospitable environment for a pathogen to reproduce in, and a launchpad from which it can travel and infect other hosts. A human body can spread pathogens more efficiently than pathogens can spread themselves by interacting dynamically with their environment (breathing, coughing, touching things).
 - People who are immune-compromised, elderly, or experiencing a health condition (whether chronic or acute) are at increased risk of becoming a host to an infection.
 - People who live in nursing homes are at an increased risk of infection because of the higher amount of pathogenic microbes contained in the facility; because of the high concentration of people and microbes in such facilities residents are more likely to come into contact with pathogens, and are less likely to be able to successfully defend themselves against the infection.

Try out this interactive infection control game: <https://www.wisc-online.com/learn/career-clusters/health-science/nur1603/chain-of-infection>

Breaking the chain

There are many different things healthcare staff can do to “break the chain” of infection. When we break the chain, it means we take steps to interrupt the spread of pathogens; if one link in the chain is broken, it can prevent someone from contracting (and then spreading) what might otherwise be a harmful infection.

Here are some basic precautions that facilities and facility staff should implement:

- Wash hands before and after every care task
- Use personal protective equipment (PPE)
- Deploy isolation techniques when a person develops an infection
- Identify the infection and the type of microbe that causes it
- Facility staff should keep themselves generally healthy; overall health in the form of nutrition, hydration, sleep, and exercise is important for maintaining a robust immune system.
- Cleaning and disinfecting all equipment
- Always use aseptic technique
- Make sure residences have good airflow
- Keep hands moisturized so they do not crack and create a portal of entry

Query 5

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Standard Precautions

The Center for Disease Control (CDC) is an organization in the federal government that performs a variety of public health functions. The CDC researches and publishes information on diseases and issues guidelines on how the public should respond to disease. The CDC has an infection-prevention system used in healthcare facilities meant to minimize the risk of infections spreading^[9].

The CDC has guidelines on the kinds of precautionary measures that must be taken to prevent infection. The two levels of precautions are Standard Precautions and Transmission-based Precautions.

Standard Precautions are a set of precautions that healthcare staff use all of the time, with all of their patients or residents. The basic idea behind Standard Precautions is to always treat blood and other bodily fluids, nonintact skin, and mucus membranes (eyes, nostrils, mouth, sex organs, and rectum) as though one is certain they are infected.

Gloves: Standard Precautions require the use of gloves whenever there is the possibility of coming into contact with bodily fluids,

nonintact skin or other tissues, and mucus membranes.

- Always wash your hands immediately before and after putting on gloves; only use a pair of gloves for the procedure, and then quickly remove them.
- Do not touch dirty objects with clean gloves, or clean objects with dirty gloves.
- Wear gloves whenever using objects like razor blades, needles, or anything else that might cause a person to bleed.

PPE: Other personal protective equipment (PPE) such as gowns, face shields, face masks, protective goggles may be required in addition to gloves if staff members may get bodily fluids on their clothes or face while administering care.



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Bloodborne Pathogen Standard: An important aspect of Standard Precautions is to also follow OSHA's Bloodborne Pathogen Standard. As part of the Bloodborne Pathogen Standard, employers are required to keep labeled "Hazard" bins for needles and sharps, as well as to provide employees with training and information on how to avoid an accidental needle stick, and other aspects of keeping oneself safe from bloodborne infections like HIV and Hepatitis B and C. As part of OSHA's Bloodborne Pathogen Standard, employers must teach employees how to handle bloodborne pathogen exposure, maintain an exposure control plan, universally implement Standard Precautions, and utilize PPE.

- **Biohazards:** A biohazard is any substance or object that carries a risk of infection, especially infection with a bloodborne illness. NAs must always put needles and other sharps into the labeled biohazard bin. Biohazardous non-sharp objects, such as a bloody or soiled piece of linen, will also have specific containers. NAs should always follow their facility policies on waste disposal, and should dispose of hazardous waste, or potentially contaminated objects, quickly in accordance with facility policies.
- If an employee has an exposure to blood or another bodily fluid, also called an exposure incident, they will have to fill out an exposure report form and follow up on any necessary medical tests.

YouTube Video

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Montana State Fund. (2020, March 2). Health care bloodborne pathogen safety [Video]. Youtube. <https://www.youtube.com/watch?v=j2favjW1GqQ>

Transmission-Based Precautions

Transmission-Based Precautions are deployed when a patient or resident is sick or has had an exposure and is suspected

to become sick. They are precautions meant to prevent the transmission of illness once it is present and use isolation and heightened anti-infection techniques to limit its spread.

Transmission-Based Precautions require the use of specific pieces of PPE depending on the kind of pathogen or illness the person is exhibiting. Nurses will tell the NA what kind of PPE each person's transmission precautions require; some facilities have signs on patients' doors that describe the transmission precaution and PPE required.

All Transmission-Based Precautions also include Standard Precautions and washing one's hands before entering and after leaving the room.

The three different kinds of Transmission-Based Precautions are airborne, droplet, and contact precautions.

- **Airborne:** Airborne Precautions are put in place for people who may spread pathogens that are expelled into the air and may remain there long enough to be inhaled by or land on a new person. Airborne infection isolation rooms (AIIR) are necessary for people under airborne precautions; AIIRs have increased air circulation and filtration to dispose of infected air quickly and to make sure no other parts of the facility are infected. Staff must wear a N95 respirator mask, and keep the door and windows closed at all times.
- **Droplet:** Droplet precautions are applied for people with pathogens that transmit through droplets of moisture that are expelled and either remain in the air or settle on surfaces. Droplet precautions require a respiratory mask be worn in the room at all times. Droplet precautions may require a restriction on visitors.
- **Contact:** Contact precautions are used when a person has an infection that is spread by direct or indirect contact. Contact precautions require the use of gloves and a gown. People requiring contact precautions cannot share equipment or linens with others; if two people must share a piece of equipment then it needs to be thoroughly disinfected between each use.

Isolation

All transmission-based precautions include isolating the person. If a person needs to be isolated due to transmission-based precautions, NAs should be aware of the negative impact that isolation can have on a person's wellbeing, especially when it comes to their psychosocial needs. The experience can be taxing on a person.

Isolation makes somebody more vulnerable to infringements on their rights as patients and residents. NAs should always recognize that residents in isolation are at greater risk of having their rights infringed upon; when someone requires isolation, never let their call light go unattended and make sure to check in on them frequently to provide care and moments of human interaction.

YouTube Video

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Fronheiser, A. (2017, June 15). Transmission based precautions [Video]. Youtube. <https://www.youtube.com/watch?v=qL-Eyq62-zc>

PPE

The CDC and OSHA recommend the use of personal protective equipment (PPE) for Standard Precautions, the Bloodborne Pathogen Standard, and for Transmission-Based Precautions. PPE is used to protect care team members from acquiring any of the communicable diseases that they work hard to treat. Some different kinds of PPE are gloves, gowns, goggles and face shields, and masks and respirators.

If a patient requires a specific piece of PPE the nurse will usually say something, but it is important for NAs to be able to identify risk levels themselves and be able to apply the appropriate response. Different conditions will require different pieces of PPE – for instance, a person with pneumonia will require different kinds of PPE than a person with chicken pox.

Different isolation precautions will require different kinds of PPE. Discuss such precautions with the nurse, and when in doubt *always ask*. PPE protects both its wearer and every person they interact with afterwards; if you think it might be necessary, then it is. Employers are obligated to provide staff with PPE.

What PPE would you need when: transporting someone in a wheelchair? Responding to an emergency involving spurting blood? Cleaning a patient who had experienced diarrhea? Taking someone's vital signs? Providing perineal care, or care of the genital and anal region? While emptying a catheter drainage bag? Consider the kinds of risk these activities put someone in, and the PPE someone could use to protect themselves. Write for 5 minutes, and discuss your response with a friend or classmate.

Donning and Doffing: When donning, or putting on, a full set of PPE, one should go in the order of gown, then the mask/respirator, then the goggles or face shield, and finally the gloves. When doffing, or removing, PPE one should go in the order of gloves, then goggles/face shield, then gown, and mask last.

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[View this YouTube Video online](https://www.youtube.com/watch?v=iwvnA_b9Q8Y)



Registered Nurse RN. (2020, May 29). PPE training video: Donning and doffing PPE nursing skill [Video]. Youtube. https://www.youtube.com/watch?v=iwvnA_b9Q8Y

Disposing of waste

Healthcare teams use many objects that, after their use, need to be disposed of. Always practice Standard Precautions while handling contaminated material. However, some material is considered more contaminated or more dangerous than others.

Healthcare facilities use a two-bag system for disposing of waste. Biohazardous waste is disposed of in “red bags,” bright orange trash bags labeled as containing biohazards. Non-biohazardous waste is disposed of in clear waste bags.

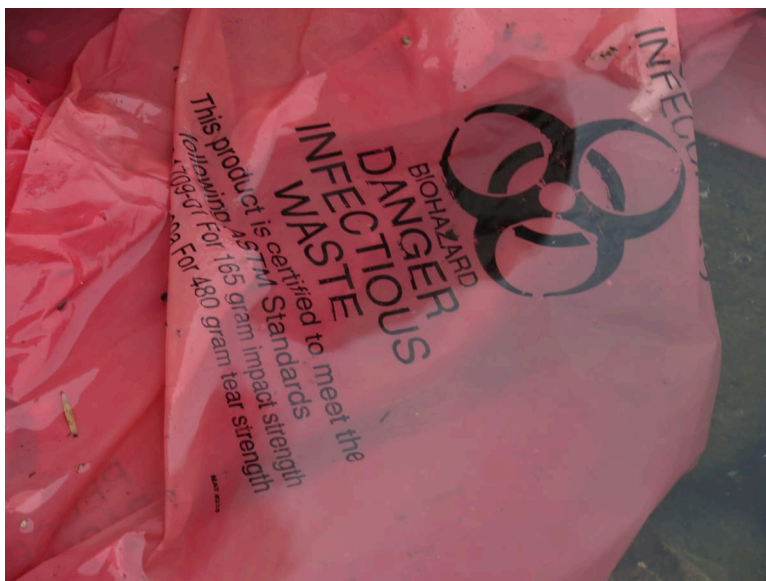


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Non-biohazardous waste is still considered contaminated or “dirty.” The items that can be disposed of in clear waste bags (non-biohazardous) include household waste such as food and food containers, paper products, non-bloody PPE, and IV bags.

Bio-hazardous materials require a bit more of a multi-step process to be properly disposed of. Because even the outside of the bag of biohazards is considered contaminated, biohazardous materials need to be double-bagged.

The double-bagging process involves one person who bags the material inside the room and one who stands outside with a red bag, or a labeled biohazard bag, folded over their hands. The bag from inside the room is placed inside the red bag, and is then transferred to the dirty utility room or the hazardous waste container.

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Key Takeaways

- Infection control is part of the Big Three. NAs should think critically about applying infection control measures in everything they do.
- Medical asepsis is used all the time, and refers to techniques like regular handwashing and disinfecting surfaces and equipment. Surgical asepsis is used to remove all microorganisms from a surface; surgical asepsis often employs sterile technique, for which NAs will need special training to perform.
- The Chain of Infection refers to the cycle of pathogens from living on a surface or in a host, to entering a new host, to creating an infection and spreading through the host's activities. Healthcare staff are responsible for breaking the chain of infection.
- Standard Precautions and the Bloodborne Pathogen Standard should be applied all the time; the gist of these frameworks involves considering any and all bodily fluids as contaminated, and protecting yourself accordingly. During transmission-based precautions, a resident may be placed in either airborne, droplet, or contact isolation; different kinds of isolation require different kinds of PPE, though they all require heightened caution. Isolation is hard on a person; watch out for the negative psychosocial impacts of isolation precautions.

Comprehension Questions

1) What sort of environment is best for pathogens to live and reproduce in?

- a. An icy area
- b. A cup full of bleach
- c. A damp and dark area
- d. A hot, dry, and sunny area

2) Respond to the following sentences with T (true) or F (false).

- ___ Pathogens are microbes that can cause infection.
- ___ Antibodies are foreign substances that activate an immune response.
- ___ A person's gut biome is one example of their normal flora.
- ___ If a resident's napkin falls off their meal tray and onto the floor, it is contaminated.
- ___ Medical asepsis requires sterile technique.

3) Medical asepsis includes which of the following? Select all that apply.

- a. Regular handwashing
- b. Isolation
- d. Standard Precautions

e. The Bloodborne Pathogen Standard

4) Which of the following are symptoms of an infection?

- a. Inflammation and redness in an area
- b. Bruising
- c. Mild fever
- d. Confusion
- e. Changes in personality
- f. Headaches
- g. Dry skin

5) Respond to the following sentences with T (true) or F (false).

___ A systemic infection only impacts a specific area of the body.

___ An infected wound is an example of a localized infection.

___ Healthcare-acquired infections (HAIs) are serious problems in medical facilities.

___ Normal flora are never harmful to human bodies.

___ MDROs are pathogens that develop resistance to drugs and become even more dangerous.

6) Which of the following PPE is required for Droplet Precautions?

- a. Frequent hand hygiene
- b. An Airborne Infection Isolation Room
- c. A mask or respirator
- d. A gown

7) Please put the links of the Chain of Infection in order.

8) Why is it important for NAs to spend extra time with people in isolation rooms due to infection precautions?

- a. Because the more time exposed patients spend with healthy staff, the less likely they are to become sick.
- b. NAs need practice being around sick people.
- c. Isolation makes it difficult for someone to meet their psychosocial needs; NAs can offer some human connection when visitors are otherwise restricted.
- e. NAs should spend time around sick people to build up their own immune system.

9) What are some techniques NAs can use to break the Chain of Infection? Select all that apply.

- a. Keep themselves in good health so they have a robust immune system.
- b. Use regular hand hygiene.
- c. Treat sick patients kindly so they are motivated to get better.
- d. Closely observe residents and patients for signs of illness and infection so they can be caught early.
- e. Covering your mouth when you cough.

10) Respond to the following sentences with T (true) or F (false).

___ MRSA requires airborne transmission precautions.

___ VRE is sometimes treated using a fecal microbiota transplant.

___ *C. diff* is an MDRO that is usually part of the human gut biome's normal flora.

___ Only nurses and doctors are responsible for breaking the Chain of Infection, because it requires specific training.

___ Standard Precautions are practiced as a way to make breaking the Chain of Infection a habit for all healthcare staff.

11) Imagine that you see a fellow NA administer a routine injection for a resident. You notice that they do not use gloves to administer the injection, and then set the needle on a countertop while performing some more care tasks. What safety precaution does this violate? How would you perform this care task differently?

12) Why is Infection Control included as part of the Big Three? What do Infection Control measures have to do with Resident Rights and Safety? Try to come up with at least two connections for both Resident Rights and Safety.

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Module 5 – The Patient’s Unit

Learning Objectives

- Demonstrate understanding of what makes a safe and healthy environment
- Understand what pieces of equipment are always present in a resident room
- Demonstrate understanding of positioning techniques
- Demonstrate proper placement of linen on bed
- Understand the nursing assistant’s role in admissions, transfers, and discharges

What makes for a safe and healthy environment?

Physical & emotional wellbeing

This module is all about what makes a resident or patient’s environment safe, healthy, and comfortable. All three points of the Big Three will be necessary.

It is helpful to consider Maslow’s Hierarchy of Needs. What is Maslow’s Hierarchy of Needs? How can NAs use Maslow’s Hierarchy to help ensure that residents are comfortable and have all of their needs met? Revisit module 2 to jog your memory.



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A person is comfortable at a basic level when they are physically safe, free from pain, and emotionally well.

There are many things that go in to making a person’s environment comfortable. NAs should make environments as comfortable as possible and give people agency over aspects of the room like temperature, lighting, and airflow.

Emotional comfort and safety can be as impactful as physical comfort on a person’s overall wellbeing. This is an especially important consideration for NAs working in long-term care facilities. Unsettling and difficult changes can occur when moving into or remaining in a facility, and the decision to do so was probably difficult and may follow an adverse medical event.

Having lots of pillows and blankets on hand can help provide a comfortable environment conducive to sleep.

Sometimes people have been separated from their loved ones. Most people moving into a care facility will need time to process

this drastic change. Perhaps they fear loss of independence, or a sense of loneliness.

NAs can help make a person's environment comfortable by being available to talk and to keep them company. NAs should emphasize that they are a kind presence and are excited to form a caring and friendly relationship with the person.

Comfort and Resident Rights



Residents have a right to a comfortable and home-like environment.

Temperature, ventilation, noise levels, and lighting are part of the patient's unit that directly impact their basic comfort^[1].

- Is the room too hot or cold? It must be between 71 and 81 degrees.
- Is there adequate air circulation and fresh air?
- Does the resident need more sound isolation, or perhaps would they like some music? Is the overhead lighting too harsh or can it be dimmed?

Temperature: Rooms must be kept at a comfortable temperature. OBRA requires that all rooms be kept between 71 and 81 degrees Fahrenheit^[2], and residents should decide to where in that range the thermostat is set.

If someone is still too warm at 71 degrees, or too cold at 81 degrees, other strategies such as fans or layering clothes and blankets may be necessary. If someone is sick, elderly, or an infant, then they are susceptible to drafts, or cold breezes; they should be clothed to offer some protection from chill, offered robes, blankets, and moved to warmer areas of the facility.

Odor: Unpleasant odors are common in healthcare settings; bodies themselves produce materials that can exude offensive odors (waste, wounds, and vomitus), and some people may find peoples' body odors, breath, or lingering smoking odors difficult to be around.

NAs that smoke should not smoke in their uniform. They should keep their hair odor-free, and consider a solution such as gum or mouthwash to assist with breath odor.

To reduce other odors, provide attentive care, and maintain good ventilation and housekeeping practices. For example, to reduce odors in a room with someone who is incontinent, change the resident's incontinence briefs regularly.

Soiled linens and unclean objects should be changed or cleaned as quickly as possible to prevent the buildup of unpleasant odors. If possible, NAs can open a window to improve ventilation and let in some fresh air. If nothing else seems to be working, facilities may keep spray deodorizer on hand for tenacious odors.

Noise: When someone is not feeling well, is trying to sleep, or is undergoing any form of emotional stress, then loud or unexpected noises can pose a disruption. For example, imagine being desperately tired and not being able to fall asleep, and then just when you are starting to doze off, a loud beeping sound from outside your door jolts you awake.

Keeping a controlled noise level in medical facilities can be difficult, but it is important to peoples' care, especially when they are

trying to rest. To minimize unwanted noise, speak conscientiously and at a measured volume.

Equipment can also be a source of unwanted noise; NAs should always handle equipment carefully and keep it in good working order so the machines don't make unnecessary disruptive noises.

Answer the phone, patient call lights, and intercoms promptly; this is both because patient needs should be met with haste, and because addressing these indicators promptly prevents anybody from needing to hear them a second time.

Lighting: Lighting is an important feature of overall comfort. If a room's lighting doesn't meet a person's needs, it can be frustrating and stressful. Rooms should be well-lit and kept cheerful and engaging during the day, especially if the room's resident is hard of sight at all. People with poor vision need clear and bright lighting. Lights should be dimmed when the resident is trying to rest.

Temperature, odor, noise, and lighting are part of Resident Rights because OBRA requires that residents have a home-like and comfortable environment^[3]. How could these things relate to Safety and Infection Control, the two other dimensions of the Big Three? Write for 5 minutes, then share your response with a friend or classmate.

Equipment in residents' rooms

Residents' rooms are their rooms, and they have a right to privacy. These rooms are their living spaces and must be treated as such.

- Always knock before entering a resident's room.
- Announce your presence clearly.
- Never rearrange any of the room's contents without discussing it with the resident first. Residents should be encouraged to fill their space with personal belongings to make them happy and feel at home.

Residents' rooms always come equipped with some basic equipment. It is important for NAs to know what each piece of equipment is and what it is for. While some pieces of equipment will differ from facility to facility, these basic items will be present in all healthcare facilities^[4].

- **Bedside stand:** For storage, and a table surface. Urinals and bedpans are kept in the lower compartment of the bedside stand, while personal care items like toothbrushes are kept in the top shelf or the drawer. It is very important that personal care items are kept separate from the items used for waste elimination and disposal. Items such as the telephone or personal objects like a book can be kept on the surface of the bedside table.
- **Dresser/closet:** Residents have a right to free access to a closet and drawer space. They must always have free access to the space and all of its contents. Always ask the resident's permission to open and search any closet and drawer space.
- **Overbed table:** This is a tall table surface, usually on wheels, intended to help people remain in bed while eating. The surface may also be used for another activity like using a laptop computer, reading a book, or providing personal care like brushing one's teeth.
 - The overbed table is a clean surface, and should be disinfected and kept free of clutter. Bedpans, urinals, and used linens should never be placed on the overbed table because people use the overbed table to eat. Clean the overbed table before a meal.
- **Chair:** Each unit has a chair for the patient and their visitors to use. The chair must be sturdy, stable, comfortable, and relatively easy to get in and out of. Residents in nursing centers can also bring furniture from home.
- **Privacy curtain:** Privacy curtains should be pulled all the way closed whenever administering care, when the person is sleeping, whenever the person is exposed or vulnerable, and whenever the person wants it closed. Sometimes it is okay to leave the curtain open halfway upon the person's request.
- **Personal care items:** Personal care items are items that are used for hygiene and elimination.

Respect the person's choice in personal care products, like toothpaste and shampoo. If they have a hygiene product preference that the hospital isn't able to meet, then they are encouraged to bring their personal care products of choice.

All agencies provide a bedpan and urinal, in addition to wash basins, an emesis basin, water pitcher and cup, soap, and a soap dish. Some agencies may also provide lotions, toothbrush and toothpaste, mouthwash, tissues, or a comb.

- **Call light:** A call light is a button that a patient or resident can press that alerts the nursing team that they need assistance. It is also called a signal light. NAs need to think of the call light system as a patient's lifeline; they may be calling because they are in pain and need to be repositioned, or they could be calling because they are having an immediate medical emergency and require prompt assistance.
 - Never ignore call lights, even from someone you're not assigned to care for; ignoring a call light can be considered an abusive or negligent behavior, and can result in administrative trouble, as well as serious medical consequences for the person calling.
 - Call light buttons should always be left within easy reach while the NA is out of the room.
 - Bathrooms and showers have specific call lights that must be answered immediately, because they may indicate that a person has fallen and needs assistance right away.
 - Depending on the person's hand and wrist mobility, special signal lights may be required. Some people are unable to use call lights; NAs should make sure that they are up-to-date on the care plan for patients like this, and should make sure to check on them often.
- **Bed:** Beds are the place where residents will spend the most amount of time. A clean and well-made bed prevents skin breakdown and pressure injuries because a smooth bed minimizes friction and helps to evenly distribute pressure. All beds will be able to move and be height-adjustable; some beds may have additional capabilities^[5]. This makes bed-making an important dimension of infection control; by minimizing skin contusions and sores, there are fewer points of entry for pathogens.

Personal possessions

Residents may have their personal possessions with them in long-term care. NAs must always treat these personal items with the utmost respect; never handle them without asking.

These items may be a resident's only daily connection to their life before or outside of the nursing facility. NAs can use these personal items as conversation starters when appropriate.

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(Re)Positioning

The importance of repositioning

Repositioning a person is necessary for maintaining basic physical health. It promotes circulation, comfort, and helps prevent pressure injuries. It is essential for holistic, person-centered care^[6].

A person needs to be repositioned at minimum once every two hours when are in a bed, or once every hour when in a chair.

Regular repositioning of residents, particularly those that are incapable of repositioning themselves, is necessary for promoting comfort and overall wellbeing.

Repositioning prevents any one part of the body from having an undue level of pressure or friction on it for extended periods and becoming sore. Repositioning also promotes good breathing and general body alignment.

- It is necessary for healthy blood-flow
- Prevents the forming of pressure ulcers
- Promotes muscle health by preventing contractures, and protects mobility when contractures do occur.

Safety

Safely positioning someone requires good body mechanics. Review the section on body mechanics in Module 3 for more information on the importance of body mechanics and alignment (Safety is one of the Big Three!). Always ask for help if unsure that you can reposition someone safely and comfortably.



While repositioning someone, keep in mind the possibility of unintentionally producing feelings of psychological discomfort, vulnerability, or simply awkwardness. Always explain the procedure in detail before and as you are doing it.

It is important to reposition people slowly and gently. Be cautious and don't make sudden or unthoughtful moves. Always provide for privacy by using the privacy curtain.

Make sure that the person is comfortable once they have been repositioned by asking if there is anything you can get them, or providing an adjustment if the person could be positioned more comfortably; sometimes assistive devices will be used to help keep a person in the proper position, but only at the direction of a nurse.

Always keep the signal light within the person's reach. Different positions can create different ranges of motion. It is the NA's job to make sure that whatever position the person is in that they always have easy access to the signal light.

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Positions

Positioning someone in a way that is as comfortable as possible for them will likely require some fine adjustments. However, there are seven basic positions NAs will use to keep circulation flowing and minimize the risk of pressure injuries for people who spend most of the time in bed.

- **Fowler's:** Fowler's position is a semi-sitting position where the person's bed is inclined to between 45 and 60 degrees, and the person's legs may be elevated with a pillow or a rolled blanket. The person may also just keep their legs flexed. Semi-Fowler's is a position where the bed is only slightly angled.



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Maintain good alignment in all positions by keep the person's spine straight.

- **Supine:** Supine position is when someone is lying on their back with their calves supported by a pillow or blanket so the heels remain slightly elevated. NAs can use supports under arms, legs, ankles, and hands for people with weak muscles. Always maintain healthy alignment.



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- **Prone:** Prone position is when a person lies flat on their abdomen and front with their head turned to one side and their arms palms-up at their sides. Only place people in this position as directed by them, since it can be uncomfortable or painful for some people.
- **Lateral:** Lateral position is when someone lies on their side. This position is variable and allows for various different positions. Usually, a person's top knee will be bent and supported by a pillow. Their top arm will likely fall over their front side, and can also be supported. Pillows or blankets can be used to separate the legs and ankles to prevent any friction and skin breakdown.



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- **Sims':** Sims' position is a semi-prone, left-side lying position where the right knee is bent towards the person's chest and supported with a pillow. Their lower arm is bent slightly behind their back at the shoulder and is left palm-up. Toes and ankles should be elevated from the bed using pillows.
- **Trendelenburg:** Trendelenburg position is when someone's body is lying flat, but the surface they lay on is angled so their head is lowered and their feet are raised. This position is only used according to doctors' orders.
- **Reverse Trendelenburg:** Reverse Trendelenburg is the same as the Trendelenburg position, except the feet are lowered while the head is raised. This position can only be used according to doctors' orders.

Repositioning in chairs

People who sit in chairs must be able to hold their head and upper bodies upright. If a person cannot support their own body weight then their alignment will be compromised and they may be injured. If a person cannot support their own weight due to age or disability then assistive devices may be put in place to maintain their alignment and posture.

Always communicate throughout the whole process. Continue to ask questions about the person's comfort.

- A person's feet should be flat, placed either on the floor or, if using a wheelchair, on the wheelchair's footplates. The person's calves and backs of their knees should fall slightly away from the seat.
- Always optimize the resident's safety, dignity, and functioning in repositioning people.
- Use time spent repositioning someone as an opportunity to check in about how they are feeling, provide some company and human support, and tend to the holistic dimensions of the person's care.

Query 2

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Admission, transfer, and discharge

NAs will play particular roles during the admission, transfer, and discharge of people within healthcare settings. Admission, transfer, and discharge are three common instances when a person's administrative status changes^[7].

Admission occurs when someone enters a facility for care, transfer occurs when a person changes facilities or changes their room within a facility, and discharge is when a person leaves the facility to continue care at home. While these all require different processes, there are points of similarity across all three. Admission, transfer, and discharge all require:

- Privacy and confidentiality throughout the process
- Meticulous reporting and recording
- Understanding the person and their needs, and knowing how to communicate with them effectively
- Consistent communication with the rest of the health team
- Respect for the person and their property. Whether facilitating an admission, transfer, or a discharge, the person's belongings should be treated with the highest level of respect. These belongings may be the person's primary way of feeling connected to their life outside of the healthcare facility.
- Being kind, courteous, and respectful of all participants at all times, especially the person receiving care. NAs should always take the time to explain what is happening, to offer moments of human connection and conversation, and to answer any questions (that they can or are permitted to answer) that the person may have.
- Patience and empathy are key considerations during admission, transfer, and discharge.

Admission

Admission is the official entry of a person into a healthcare setting in the position of a patient or a resident. Healthcare staff must be welcoming and kind during all of their interactions, but it is especially important during admission.

During admissions patients, residents, and their families are likely in a new setting that may be strange to them; perhaps they have concerns and fears about the quality of care or the social environment that they are entering into. They are likely there because of an adverse event, or because of an increasing loss of independence. The admission process should be conducted kindly and with a positive and welcoming tone.

The process

Admission will usually begin in the admitting office and will include obtaining the person's full name, age and birthdate, their regular doctor's name, their Medicare and/or insurance numbers, and their religion. NAs should prepare the person's room before they arrive, so that all that is left is for the person to move in.

A nurse will greet and escort the person and their family to the person's room, though the NA may be asked to admit them if they are all doing well. The nurse or admitting person will complete the admission paperwork with the person and/or their family, so there is no confusion and so the paperwork does not become its own source of stress and anxiety.

Admission is the NAs first chance to make a good impression, and first impressions only happen once.

- Always greet the person by their name and title (i.e. "Mr. Jones" or "Miss Gupta" or "Dr. Ali").
- Introduce new patients or residents to their roommates if they have them.
- Always treat the person with dignity and respect throughout the admissions process; newcomers in a care setting are experiencing a complicated array of emotions, and it is an important aspect of holist care for someone to feel comfortable and at-home.
- It is important to properly orient the person to their room, the nursing unit, and the general agency or facility. Provide newly admitted residents a tour of the space and facilitate introductions to other patients, residents, and staff.

Collecting basic information

Admission will involve collecting some basic medical and personal information. For instance, NAs will measure the person's weight and vital signs. They should also complete a list of the person's personal belongings and clothing items. Any valuables should be listed and either sent back to the person's home or placed in a safe in their room.

- When taking a person's height and weight measurement, it is important to be as respectful as possible. Many people do not like having measurements taken, as it can produce feelings of vulnerability and scrutiny. Always treat the person with dignity and a professional demeanor, and honor any of their wishes about how they would like their height and weight taken.
 - It is unnecessary for the NA to announce anybody's physical measurements of any kind, as they can observe and take note without saying anything out loud. Just take the note and move on, unless they specifically ask "how much do I weigh?"
 - A person will be weighed at different intervals depending on their care plan to measure any weight gain or loss, since weight gain or loss is a relevant change in a person's condition.
 - Different scales will be used depending on the person's mobility; for example, scales are often made to be stood upon, but there are also scales specifically designed to be used in a chair, wheelchair, bed, or mechanical lift. Some beds even come with features to measure their occupant's weight.

While obtaining a persons' weight, follow these guidelines to ensure accurate readings of weight gain or loss:

- Have the person wear the same or similar clothing they wore when weighed prior, and have them remove their footwear.
- Use the same scale.
- Weigh the person at the same time of day.
- Have the person void before being weighed if they can. If the person wears an incontinence brief, make sure that it is dry.

Care planning

Once a person is admitted there will be a care planning process where they set care goals in communication with the health care team members. Care plan re-evaluations will occur periodically throughout the person's stay in the facility.

Care planning involves all members of the care team developing a plan for the person to meet their health goals; care goals should be attainable and possible to achieve within a reasonable time frame. Residents have a right to participate in all care conferences.

Care planning follows the Nursing Process (assessment, nursing diagnosis, goal, implementation, evaluation). While NAs are necessary at every step, they are most essential to the assessment phase because they are in the best position to gather information and notice subtle changes in a person's condition day-to-day. Assessment is an ongoing process, and never ends no matter which phase of the nursing process the team is also working on. Getting to know residents on an individual level is

essential for accurate assessment.

Transfer

Transferring a person involves moving them to another healthcare setting, such as from the hospital to a transitional care facility before they can go back home. In some agencies, transfers will occur when a person is moved to a new room or a different area of the facility; an example might include an assisted living resident being transferred from their usual unit to a unit of the facility dedicated to memory care and residents with dementia and Alzheimer's.

Another example may be transferring someone into hospice care once a doctor determines that their condition is immanently terminal. Transfers can occur because of a change in someone's condition, or because there has been a change in someone's care needs. They can also occur because the person requests a new room for their own reasons, or if the roommates in a given room do not get along.

The process

Transfers between rooms or facilities can be quite the operation; in addition to moving the person, all of their objects will also be moved. The person's family can assist with this, especially if the person being transferred is moving from one elder care nursing facility to another.

NAs can use thoughtful communication skill to support and reassure the person during transfer. People can become stressed and anxious during transfer, especially if they are already prone to confusion or disorientation. Avoid clichés like "it's going to be okay" when responding to patient's or resident's worries. Such responses can feel prepackaged, belittling, and designed to appease. Instead, genuinely listen to the person's concerns, and validate their concerns without telling un-truth or increasing their worry. Sometimes it can help a person just to know that the NA is there and is caring for them, while others may need more involved conversation to be put at ease.

When the person is in their new room or unit, NAs orient them to the physical and social space. They can give the person a tour, introduce them to their roommate, and introduce them to the other facility staff.

Some transfers will involve the person leaving the agency and being transferred to a different agency. In such cases, the person is always involved in the transfer planning process, and the transfer-plan is discussed and laid out by the healthcare team in advance.

The nurse will alert the NA as to when it is time to start the transfer process. Only a doctor can give the order for somebody to be transferred out of the facility. If the person wants to leave the facility, the NA should tell the nurse as soon as possible. The nurse or a medical social worker will handle situations where a person is requesting or demanding to leave before the doctor has issued the order.

Discharge

Discharge occurs when someone is officially released from the care of the hospital or medical facility. This is usually a happy time for people and their families. The person may have reached their care goal. Sometimes a person will be released home and need continued home health care.

When a person is discharged, the healthcare team will give the family any information about diet and nutrition, exercise and activity, medications, and required procedures and treatments so that the person maintains continuity of care between the facility and their healthcare at home.

If necessary, discharge time is when home healthcare assistance is arranged for, as well as any special medical equipment and therapies the person requires. A follow-up doctor's appointment will be scheduled at the time of discharge.

When a person is discharged, all of their belongings are placed in a bag that goes with the person. NAs should make sure that all of the person's belongings and anything else they entered the facility with make it into the bag. If the person's family cannot transport them, the nurse or social worker will have transportation arrangements made. Many facilities, especially hospitals, have their own vehicles and transportation services available.

Once the person has moved out of their room, NAs may be requested to remove all linens and any care items from the room before housekeeping arrives to clean it for the next occupant.

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Bed linens

Beds are extremely important places for residents in long-term care facilities; some of them will spend all or most of their day in bed. In most nursing centers, a complete linen change will be done 1 – 2 times per week, usually on the day that the person is bathed. A person's linen is usually changed on the same day that they take a bath because if an unbathed person gets into a clean bed then they will speed up how quickly the linen becomes dirty; similarly, if a bathed person gets into dirty linens, then their bath will have been less cleansing.

Always change a wet, damp, soiled, or wrinkled bed as quickly as possible. When beds are wet, damp, or soiled they can become repositories for harmful pathogens; they can also cause skin irritation and produce rashes and sores. Wrinkled beds can result in pressure injuries and exacerbate skin breakdown^[8]. When changing linens, NAs must follow Standard Precautions and the Bloodborne Pathogen Standard.

A wet bed is a dirty bed. Never let a wet bed go unchanged. Which of the Big Three does this relate most closely to? How might it also relate to the other two? Write for 5 minutes, and share your response with a friend or classmate.

Bed linens consist of a fitted sheet, a flat sheet, a top sheet, pillow cases and draw sheets. People may have blankets, which also need to be washed if the bed was wet^[9].

A draw sheet is a small sheet placed over the middle of the bottom, or fitted, sheet so it sits between the fitted sheet and the flat sheet. The draw sheet may be either cotton or a waterproof material, and is intended to help keep the mattress and bottom linens clean and free from dampness and soiling. Draw sheets can also help when repositioning someone in bed.

Many agencies use incontinence products, waterproof pads, or disposable bed protectors to help contain spills or accidental elimination in bed.

Types of beds

There are a few different kinds of beds that NAs will need to know how to make.

A **closed bed** is a made bed with the sheets and covers pulled all the way up to the pillow, and is usually only made when the person will be out of bed all day. For instance, when a resident in a long-term care facility has an active day planned and likely won't return to bed until the late afternoon or evening, the NA would make a closed.

Beds should be adjusted to waist-height to be made, and then returned to their lowest setting. NAs should always make sure to use proper body mechanics when they replace linen.

When removing linens, roll them so the soiled side is on the inside of the roll. Remake the bed with fitted sheet first, then the flat sheet (seams down with the crease at the center), the draw sheet (make sure it is centered on the bed), and then the top sheet (seams up).

It is important that the linen's seams won't come into contact with the bed's occupant, as this can cause friction and irritation. Make sure the bed is free of wrinkles before performing the closing procedure.



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Open beds are similar to a closed bed, except the flat sheet and blanket is folded down to the foot of the bed. This type of bed will be made when a person will be returning to bed shortly after it's been made.

The steps to making an open bed are the same as making a closed bed, except at the end of the process the top sheet and blanket, and any other surface linens, are folded down to the foot of the bed. The top cuff of the linen should be left 6 – 8 inches from the bottom so the person doesn't wrinkle the bed upon entering it.



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Occupied beds are beds that must be made with somebody in them. NAs will have to make occupied beds when somebody is on an “absolute bedrest” order from a doctor.

Occupied beds must be made one side at a time; NAs should raise the bed rail on one side of the bed (remember the risk of entrapment associated with bedrail use) and gently turn the person in bed to their side facing the bed rail. NAs should request assistance from a coworker if they feel unsure about making an occupied bed alone.

One side at a time; roll the bottom used linen (soiled side in) towards the person and tuck the roll against their back. Then make

the first half of the bed.

After the first side of the bed has been made the NA can now raise the bedrail on the clean side of the bed before helping the person roll over onto the clean side of the bed. Once the person has rolled onto the clean side of the bed, the rest of the soiled linens can be removed and placed in the laundry bag.

The NA can gently grasp the rest of the clean linens and finish making the bed. Make sure the bed is wrinkle free and that the person's comfort needs are tended to before leaving.

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A **surgical bed** is specifically designed for people returning from surgery on a stretcher to make the transfer from stretcher to bed as smooth as possible.

To make a surgical bed one can first make a closed bed, and then fold linens down from the head of the bed and fold up the linens at the foot of the bed. Once this fold has been completed, fanfold the linens by making pleated layers on the side of the bed opposite from where the person will transfer from the stretcher.



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Key Takeaways

- A safe and healthy environment for a patient is one in which all of their physical and psychosocial needs are met. They are comfortable in terms of temperature, odor, light, and sound. They are emotionally calm, and experience a sense of security.
- A patient's room will always include a bedside stand, a bed, basic equipment such as a bedpan and emesis basin, a dresser and/or closet, an over-bed table, a chair, a privacy curtain, and a call light. Rooms may have additional features depending on the facility and the needs of the patient. Always respect a patient's personal belongings and treat them with care.
- During admission, transfer, and discharge nursing assistants are responsible for maintaining a friendly, supportive, and attentive atmosphere. They may assist the patient with becoming oriented to their new space, perform basic intake paperwork and obtain weight and vitals, and assist the patient with their personal belongings.
- Repositioning a resident appropriately is key to their health, especially when it comes to promoting circulation and preventing pressure injuries. Always communicate with a resident throughout the repositioning process. Follow the care plan.
- Beds must be smooth and wrinkle-free. Different bed-making strategies will be used for different circumstances; for examples, an "occupied bed" will be used when someone cannot get out of bed, while a "surgical bed" will be used when someone is returning from an operation. Always change wet bed linens immediately.

Comprehension Questions

1) A person is considered comfortable when they are...

- a. Depressed but sleepy
- b. Physically safe, free from pain, emotionally well
- c. In a big soft sweater
- d. Physically well but nervous about their circumstances

2) Respond to the following sentences with T (true) or F (false).

___ A resident's room must be kept between 75- and 85-degrees Fahrenheit.

___ Odors and noise levels can have a notable impact on someone's comfort.

___ NAs should decide how a room is lit, even if the resident disagrees. NAs know what lighting is safe and comfortable for someone.

___ All resident rooms will have a television.

___ Call lights are an important piece of equipment and must be kept within reach of the resident at all times.

3) Which pieces of equipment are always in a resident's room? Select all that apply.

- a. Dresser/closet
- b. Remote control
- c. Privacy curtain

d. Artwork

4) What are overbed tables used for?

- a. For a convenient place to put bedpans and used linens while providing care
- b. To help a person eat and drink, or do activities like use a laptop or read
- c. As a decorative object
- d. To give residents something to lean on when they get out of bed

5) Why is repositioning necessary for holistic person-centered care?

- a. Because preventing pressure injuries and circulatory musculoskeletal complications is convenient for the healthcare team
- b. Because preventing pressure injuries and circulatory musculoskeletal complications is required by law
- c. Because preventing pressure injuries and circulatory musculoskeletal complications is part of meeting the full scope of a person's needs in an attentive and dignified way
- d. Because preventing pressure injuries and circulatory musculoskeletal complications can be fun

6) Which description below describes the Fowler's position?

- a. The person is lying flat on their abdomen with arms palm-up at their sides
- b. The person is lying flat but they are angled so their head is lower than their feet
- c. The person is lying flat on their back with their heels slightly elevated
- d. The person is semi-sitting at about a 45 – 60 degree angle

7) When assisting with admitting a new resident, NAs should...

- a. Exude a sense of pleasant calmness by chit chatting for a while in the intake room, especially on busier days
- b. Practice kindness, patience, and empathy while taking the resident's basic information, showing them around the facility and their room, and introducing them to neighbors
- c. Practice kindness and curiosity by asking personal questions about the person's objects
- d. Keep the care planning meeting a secret so as not to worry the resident

8) A resident is expressing worry and anxiety about transferring out of the facility. How should you respond?

- a. Keep saying "it's all going to be okay"
- b. End the conversation quickly because you are very busy
- c. Listen thoughtfully and empathetically, be honest, and offer a comforting touch on the hand
- d. Play them your new favorite song

9) A person's bed linens are changed ...

- a. Only once they are too smelly for comfort
- b. Every 1 – 2 days, usually on bath day, or whenever they are damp or soiled
- c. When the NAs don't like the pattern on the sheets

d. Every day no matter what

10) Respond to the following sentences with T (true) or F (false).

___ Bed linens consist of a fitted sheet, a flat sheet, a draw sheet, an aerial sheet, and sometimes a blanket.

___ Incontinence pads, waterproof pads, and disposable bed protectors can be used to minimize the impact of spills.

___ Beds should be adjusted to waist-height before being made to protect NAs' alignment.

___ Occupied beds should be made when the person is in the shower or bathroom.

11) Write a paragraph describing the relationship between physical and emotional needs as they pertain to the resident and their room. What are some ways NAs can help residents meet their full scope of needs?

12) Mr. Jones is a new resident and is trying to get some rest. He is most comfortable with a cup of green tea after dinner to help his digestion, so after drinking his tea he retires early. Outside his room in the hall, members of the healthcare team chat because it is not yet lights-out time. Mr. Jones' wife has recently passed away, which is why he decided to move into the residence facility. Mr. Jones sometimes needs to sleep with a light on because of regular urges to use the bathroom; sometimes he soils the bed, but rather than disturb the healthcare team he chooses to change his own clothes and sleep in his chair, and let the team address the linens in the morning. What are some factors negatively impact Mr. Jones' comfort as he tries to rest? What are some things that NAs could do to help make Mr. Jones more comfortable?

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5. There are multiple different kinds of beds. For example, an electric bed is a bed that allows for controlling the head and knee positions of the bed using a remote. Alternating pressure beds help to relieve and redistribute pressure because they are built with a series of air-sacs that can be repositioned. Alternating pressure beds can help alleviate pressure on specific areas of the body should sores or skin contusions develop, and are especially useful if a patient is difficult to reposition. High-low beds are fully adjustable beds with head, foot, and height adjustability; while all hospital beds will be height-adjustable to a degree, high-low beds are specially designed for maximum accommodation depending on the person's care needs and the staff's ergonomic safety. ↵
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Module 6 – Lifting and Moving

Learning Objectives

- Demonstrate understanding of the complications of inactivity
- Describe effective ways to move a person safely
- Demonstrate understanding of active and passive range of motion
- Demonstrate appropriate use of assistive devices

Complications of inactivity

Persons who require nursing care may be immobile for long periods of time. A person is immobile when their bodies cannot be active or can only perform very limited activity, such as when a person is on an order for bedrest. However, remaining active is an essential part of human health and wellness. When a person remains inactive for an extended period of time, it can have negative impacts on various different bodily systems^[1].

- **Eating and digestion:** Activity is important for gastrointestinal health because it helps stir up an appetite and move waste through the intestines. Activity promotes healthy digestion, which promotes healthy elimination. Lack of activity can result in constipation, or inability or difficulty with regular elimination.
- **Urination:** Regular activity improves urinary elimination by helping a body to regulate its hydration and thirst; hydration and regular urinary elimination can help prevent UTIs. A result of inactivity thus may be increased UTIs as a result of inadequate hydration and thirst regulation.
- **Skin wounds:** Inactivity can result in integumentary pressure wounds, or pressure wounds on the skin that do not heal quickly. Activity improves the overall health of the skin; as a person remains inactive for a long period of time, their skin will break down, especially around the areas that remain in contact with the bed or chair.
- **Circulation:** Activity is important to healthy circulation, or the flow of blood through the body. When someone is inactive, it can produce blood clots. Humans should stay active to help keep their blood moving easily and normally.
- **Breathing and respiratory health:** Inactivity impacts a person's respiratory system by making them more susceptible to respiratory infections like pneumonia. Activity helps us breathe more easily, increases our lung capacity, and helps us fight off infections in the lungs.
- **Muscle health:** Activity increases blood flow and improves the strength and conditioning of our muscles. Without activity, a person's muscles can atrophy and develop contractures. This means that they weaken as they get smaller and softer. A contracture occurs when a muscle shortens and tightens, which can makes the muscle less effective.
- **Mental and brain health:** Activity is important for our nervous system because it makes us relaxed and sleepy afterward. A lack of activity and sleep can lead to mental health problems, compounded issues with sleep, and difficulty focusing.
- **Hormonal balance:** Activity is important for our endocrine system because it help our body keep its dietary hormones in balance. Without activity, the hormonal aspect of digestion and nutrient processing will be thrown out of balance. This can result in weight gain and diminished absorption of nutrients from food.

YouTube Video

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Assisting and moving a person safely

Body mechanics and safety

Always keep safety at the forefront of your mind while transporting, ambulating, or lifting a resident. Activity is essential, and getting injured by pulling muscles or spraining joints will only make both the NA and the residents they care for less active. NAs can protect themselves and residents by always thinking of good body mechanics, posture, and maintaining alignment^[2].



NAs should *never use their back* when lifting and moving residents. Always use assistive devices and mechanical lifts whenever possible; if the movement cannot be completed with an assistive device, NAs should always lift with their legs and ask for help from their colleagues.

Protecting one's back is an essential aspect to continuing to provide good care. Remember, good body mechanics are healthy ways of moving and lifting things; alignment refers to keeping a person's back, and one's own, straight and strong.

Determine the resident's independence

Always determine the person's level of independence while planning a movement or transfer^[3]. Independence in this case refers to a resident's ability to assist you during a movement or transfer, such as by pushing against the bed or chair to stand, or using their legs to help you help them to stand up.

Ask for help from another team member if a person's level of independence does not allow them to participate helpfully in the moving and lifting.

Determining a person's level of dependence is a necessary step in planning a transfer, or the movement of a person from one surface or place to another, such as a transfer from their bed to a wheelchair, or from their bed to a stretcher^[4].

- Consider your own abilities; if you are the NA, it is important to consider how strong you're feeling on that day, and how much practice you have performing the motion or transfer in question.
- Consider the size of the person being moved; a heavier person will require more staff members, or the use of an assistive device or mechanical lift to be moved safely. In addition to considering how many care staff will be required to move someone safely.
- Consider what sort of equipment will be most helpful in completing the task; for instance, does the move require a mechanical lift or would a transfer belt be more useful?
- Consider the person's own ability to assist the NA with the move or transfer. How cognitively present is the person? Would they be able to follow any instructions about the motion that the NA gives them? What are their physical limitations? Are they experiencing any physical limitations that would make the motion difficult or risky for them? Has the doctor ordered any restrictions on their movement, such as an order for bed rest or limiting their range of motion? The person's cognitive capability, physical limitations, or any doctor or nurse ordered restrictions are all important considerations when planning a move or a transfer.

Common assistive devices

Transfer/gait belt

Transfer belts are a common piece of assistive technology in healthcare settings. Transfer belts are thick belts made of a strong material, usually canvas, with a metal buckle. Transfer belts are used in care facilities to help transfer residents from their bed to chairs, and to assist them with ambulation^[5].

Transfer belts are applied around the person's waist or under their arms. NAs should always apply transfer belts over the person's clothing; transfer belts that are making direct contact with skin can cause chafing, rashes, and general discomfort.

The buckle on a transfer belt should always be on the person's side, never on their front or back. The belt should be tight and secure, but loose enough for the NA to still fit their fingers between the belt and the person's body. This is to maintain a stable grip while performing a transfer or assisting with ambulation.

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Bed and bedrails

Beds and bedrails are assistive devices because they can be used selectively and temporarily to help position a person for care, such as while making an occupied bed.

Bedrails for children and infants will be different than bedrails for adults, because children and infants are more likely to fall through standard bedrails. The rails will each be placed closer together.

Bedrails are danger and pose the risk of entrapment. If left up the bedrails are considered a restraint, which may pose some legal or ethical problems if they are used improperly or thoughtlessly.

Always make sure that beds are in the lowest position unless someone is actively performing a care task. NAs should always return a bed to its lowest position when they are finished with the care task. Always check the care plan before using bedrails with a patient or resident.

Lifts

Facilities may have various types of lifts. A lift is a device designed to gently lift a person to aid in their transfer from one position to another. Lifts can be used to move someone in bed, such as moving them up in their bed or moving them to the side. Lifts are also used to reposition someone in a chair, and to lift them up from the floor if they have fallen.

There are some different kinds of lifts. For example, there is a difference between a manual lift and a mechanical lift. A manual lift is a lift that is powered by humans and will operate through a mechanism that doesn't involve a motor or a battery. Mechanical lifts use a motor to assist in transferring residents.

The two most common kinds of mechanical lifts are the Hoyer lift and the ceiling lift. A Hoyer lift is a portable lift with two legs

mounted on wheel for portability. A ceiling lift, by contrast, is embedded into the ceiling above the bed. Only operate lifts that you have been trained to use.

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Assisted Home Health and Hospice. (2019, August 20). Hoyer lift [Video]. Youtube. <https://www.youtube.com/watch?v=jLetizMjNHg>

Ceiling lifts are often preferred to Hoyer lifts because they do not take up any floor space and thus do not present a physical obstacle to work around during transfers; Hoyer lifts can be preferred to ceiling lifts in situations where portability and the sharing of resources between patients is a necessity.

Transfers

Transfer refers to changing a person's location from their bed to a chair, from a stretcher to a bed, from a chair to a different chair, from a chair to the tub, or any other purposeful assisted movement from one location to another.

- Never support the resident under their arms; this is not a safe way to move an adult, and lifting in this way can strain the NA's back muscles and produce injury.
- The resident must never put their hands on the NA for support; instead, they can be given a solid object to hold onto for support, or can trust the care staff to perform the transfer; residents should never stabilize themselves upon another person during transfer, since this can throw people off balance and compromise the motion.
- Make sure any device's wheels are locked during transfer, such as when transferring using a wheelchair or stretcher.
- If side rails or bed rails are required for care, they must be lowered once the care task is complete. When the guardrails need to be raised for a care task, the NA should always lower the rails on the side of the bed they are working; NAs should never lean over a guardrail to provide care^[6].
- When transferring residents with a strong and weak side, it is important for the NA to work from the resident's weak side, and to begin the motion with the person's strong side by moving it first.
- Use a "stand and pivot" method where the person stands and the NA helps them pivot around until they either sit in the chair they are being transferred into, or take a seated upright position on the bed they are being transferred into. The stand and pivot method can only be used if the person's legs are strong enough to bear some or all of their weight, the person is lucid and cooperative enough to follow directions closely, and the person is otherwise capable of assisting with the transfer. If these three conditions aren't met, avoid using the stand and pivot method.

Stretcher

When transferring a person to or from a stretcher, the stretcher should be covered with a folded flat sheet or a bath blanket to minimize shearing and friction.

A lateral (side-direction) transfer device along with a slide board is used, or something similar to it such as a drawsheet, turning pad, or slide sheet, to move the person to the stretcher. When performing a transfer to a stretcher, at least two or three staff members must be present for safety.

Once the person has been safely transferred, and only with the nurse's permission, raise the head of the stretcher so the person is in Fowler's or a semi-Fowler's position so the person is as comfortable as possible.

Wheelchair

When transferring people into or out of a wheelchair always make sure the wheels on the chair are locked in place.

Adjust the height of the chair appropriately for the person who will be transferred to it, and that any straps, cushions, and rails are all positioned to make the transfer as smooth as possible. Make sure the person is securely seated all the way back in the chair.

(Re)Positioning

It is important for people who spend a lot of time in bed to move around in their bed to maintain comfort; moving in bed and adopting different positions to maintain comfort can help prevent bed sores and other pressure injuries^[7]. Moving in bed is also necessary for a person to maintain good bodily alignment. Some people will be able to reposition themselves in their own bed, however others will need assistance.

People who are weak, unconscious, paralyzed, in casts, or otherwise have their movement inhibited in some way will need help moving in bed. If the person weighs less than 200 pounds they will likely need 2 – 3 staff members and the use of a friction reducing device, such as a draw sheet. Depending on the person's mobility and ability a mechanical lift may be necessary. However if the person weighs more than 200 pounds at least 3 staff members should assist with the move while using a lift or friction reducing device.

Always communicate with the person being repositioned throughout the whole repositioning process. This helps to put them at ease and keep their body relaxed, which is an important part of moving a person safely. It is also an important dimension of person-centered care, because the person should know what is being done to/for them before it happens. Communication is important to creating a sense of agency for the person receiving care.

Friction and shearing

When moving someone in bed, minimize friction and shearing as much as possible. Friction occurs when two surfaces rub against one another, such as skin on a sheet. Shearing occurs when one's skin moves while their bone either stays in place or moves in the opposite direction, or when the skin is stationary and the bones and muscles move, and can happen when someone slides down or is moved up in bed. Shearing can be painful and may cause skin damage. Both friction and shearing cause skin infection and pressure ulcers.

- To reduce or eliminate friction and shearing, use friction-reducing devices such as a lift sheet, a cotton draw-sheet, sliding boards, and slide sheets.
- To prevent shearing and friction, always use a lift sheet or a mechanical lift with two people to move someone in bed.
 - The angle of the bed should be kept at less than 30 degrees unless the patient is eating; a less steep bed angle can help prevent the person from sliding down. While moving the person, the angle of their bed should be zero, or flat.
 - Another way to prevent friction and shearing is to have the person lift their legs during the move if they are able.

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Positioning

A person needs to be repositioned at minimum once every two hours, or when they become uncomfortable. NAs must always remember to chart when they have moved a person so the rest of the staff are up-to-date on the person's positioning.

When repositioning people some essential things to keep in mind are their comfort, skin health, and their alignment. NAs should always reposition people in a way that minimizes friction and shearing, and maintains the person's healthy alignment through the moving process. Use pillows and other supports to prop up a person in a way that is comfortable and maintains their alignment.

People may need to be moved into various positions such as Supine or Fowler's, covered in Module 5. Turning is one common form of repositioning. Some people can reposition themselves in bed, while others need help to do so safely.

Turning and logrolling

Sometimes a person will be turned onto their sides. This lateral positioning can help prevent complications from bedrest or may be the best position for recovery. A resident may require a specific repositioning procedure depending on their condition; always check the care plan or check with the nurse to see how a person needs to be moved.

A lift sheet should be used to put the person on one side of the bed before they are turned. Once a person has been turned onto their side pillows and other supportive devices can be used to prop them up to maintain their position comfortably.

One technique for turning a person while maintaining their alignment is logrolling. Logrolling involves two people (or more) using an assistive device like a lift sheet to turn someone on their side while keeping the back and legs perfectly straight. One might use logrolling when the person's spine needs to be kept straight at all times, such as after a back injury or while recovering from spinal surgery^[8].

Dangling

Another common positioning technique is called dangling and involves residents sitting on the side of the bed with their legs dangling. Dangling is used for many reasons; perhaps somebody is becoming uncomfortable lying down and wants spend some time upright without moving out of bed.

Dangling is also used as an intermediary step between lying down and standing up. In this case, dangling is used to help someone maintain balance and prevent dizziness; dangling helps to equalize blood flow and stabilize blood pressure, which can help a person keep their bearings when moving from lying down to standing up. Dangling is an important posture for residents who are prone to lightheadedness.

When a person is dangling, have them cough and breath deeply, and move their legs back and forth in a circular motion. These activities contribute to good blood flow and the regulation of blood pressure that helps prevent dizziness and lightheadedness.

Multiple staff members may be necessary when helping a person dangle. For instance, if the person has any issues with balance or coordination, they may need additional support to prevent a fall or accident. If any dizziness or fainting does occur, the person should lay back down until it subsides.

Reporting and recording

Report and record carefully when repositioning residents, helping them with care tasks, and observe for any changes in their condition. If the NA repositions someone it should be charted; if they transfer them to a chair this should be chart; if the person uses the bathroom and the NA assists them with perineal care before or after, this should be charted. Always chart care provided, and any relevant observations about the resident's condition or symptoms. Always chart carefully and thoroughly.

Bed rest

Sometimes a doctor will order bedrest for an elderly person when they are recovering from an injury or surgery. Bedrest can be useful, though it is also associated with declines in a person's body's muscle mass, immune health, cardiac and respiratory systems, and general ability to perform the tasks of daily living^[9].

People on bedrest are susceptible to dysphagia; to help prevent dysphagia, make sure that persons are angled highly enough in bed while eating to offset some of the difficulty of swallowing in Fowler's position.

There are three different kinds of orders of bed rest.

- The strictest prescription is "strict bed rest," where the person is not allowed out of bed at all. The NAs and other nursing staff assist them with all of their ADLs, including bathing and elimination.
- The next is bed rest with commode privileges, when the person remains in bed except to use the commode, which is a kind of free-standing device into which a person eliminates. Commodes are easier to transfer onto than toilets, and can be moved

so they are right next to someone's bed.

- The third is bed rest with bathroom privileges, when a person remains in bed except to get up and use the bathroom.

Bed rest can be beneficial for somebody who needs a substantial amount of rest or needs to recover from a major medical event, like a fall or surgery. Bed rest can help a person control their pain, regain their strength, and lets their body devote all of its energy to healing.

Complications

Bed rest has a deleterious effect on almost all bodily systems, and can result in muscle atrophy. Not only can bed rest result in serious medical complication, it reduces social interactions and ability to meet one's self actualization needs, and has a broadly negative impact on a person's mental health.

Some complications from bed rest include:

- Bed sores, pressure ulcers, and other forms of skin breakdown
- Constipation and fecal impaction
- UTIs
- Thrombus
- Orthostatic hypotension

Complications resulting from bed rest can make a person's recovery extremely difficult; the good news is that effective nursing care can prevent the complications that may follow periods of bed rest.

Some of the most important things to include in a person's bed rest care plan are maintaining good alignment and performing frequent position changes. Range of motion exercises help a person maintain muscle capabilities and mobility.

Assistive devices

Various assistive devices may be used to help people maintain their health while on bed rest. For example, a bed board is a hard surface placed under the person's mattress to make it further and to prevent the mattress from sagging.

- A foot board is a padded board used to keep a person's feet in place and in alignment.
- Trochanter rolls are similar to foot boards in being a padded object intended for alignment, except trochanter rolls are usually a set of rolled bath towels that keep a person's hips aligned. Abduction wedges (hip wedges) also keep hips in place, usually following a surgery, to promote proper healing.
- Hand rolls/grips and orthotic splints help keep a person's hands in place and in a natural position. Splints are useful in preventing contractures and other complications of underuse.
- Bed cradles and foot cradles are used to minimize the amount of time a person's legs and feet spend in direct contact with bedding.

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Active and Passive Range of Motion (ROM)

Exercise is important for a person to maintain a high quality of life; this goes double for older adults whose muscles are at risk of atrophy and contracture if they do not perform their exercise regularly.

NAs can help residents incorporate muscle-maintaining movements into their ADLs, or encourage residents to engage in exercise together in the form of walking together and taking an aerobics class, stretching class, or another activity offered by the facility. Increased strength, endurance, and balance are some improvements that a person may see in their condition that goes beyond the simple maintenance of ability; a stronger muscular system can help protect a person's alignment and spinal health.

Range of motion refers to the full scope of a person's joint movement; range of motion is another dimension of mobility that suffers when a person remains on bed rest for an extended period of time.

Range-of-motion (ROM) exercises involve moving the person's joints through their complete range of motion, and are usually done at least two times per day for those who need them.

The point of ROM exercises is to move a person's joints through their maximum range without causing pain.

People who are on bedrest should practice ROM exercises more frequently. ROM exercises should not be painful; rather, the point is to move the joint to the extent possible without causing pain while gradually working to extend the person's ROM in the targeted area.

The three different kinds of ROM are active range of motion (AROM), active assisted range of motion (AAROM), and passive range of motion (PROM)^[10].

- AROM exercises are when a person moves their joint through its full range of motion unassisted by the care team member.
- AAROM exercises are done with assistance from but still involve active participation from the person. This allows them to move the joint beyond the point at which they would have to stop on their own.
- PROM exercises are movements the staff member puts a joint through without help or active involvement from the person. The patient remains relaxed and lets the NA, nurse, or therapist move their joint for them. PROM exercises are usually ordered when a person is immobilized.

ROM exercises

ROM exercises can be incorporated into ADLs and other activities. For example, range of motion exercises could be incorporated in a short dance-party, folding laundry, or hygiene activities like brushing one's teeth.

Hyperextension is painful and causes complications; always respect a person's communication about their abilities and pain levels.

When NAs assist someone with their ROM exercises, it is important to avoid causing hyperextension, or the extension of a joint beyond its capabilities. NAs must always follow the care plan on ROMs regarding which joints need to be exercised, how many repetitions of a given exercise are required, how regularly they should be performed, and which specific motions are ordered.

- Abduction: moving a body part away from the body's midline, such as to swing one's leg to the side
- Adduction: moving a body part towards the body's midline, such as swinging the aforementioned leg back into place
- Extension and flexion: straightening a body part, such as straightening a bent elbow, and flexion such as bending the elbow again. Dorsiflexion is bending a body part backwards, such as flexing one's wrist so the hand points up and back toward the person.
- Pronation and supination: turning downward and upward respectively, such as turning one's hand so their palm is facing down, and then turning it to face upward.

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Wings Healthcare Training. (2015, September 30). Range of motion exercises [Video]. Youtube. https://www.youtube.com/watch?v=t6hE_ntz4Ho

ROM exercise are one excellent opportunity for NAs to provide holistic care by talking with residents, assessing their orientation, and giving residents a chance to talk about whatever they want to. NAs should be encouraging and positive when assisting a person with their ROM exercises.

Muscles and joints

In order to correctly interpret instructions for assisting residents with ROM exercises, NAs need to know some basics about the different types of muscles and joints in a person's body.

Muscles are a tissue group that allows us to move our bodies through contracting and relaxing motions. When a person moves their arm, it is because some muscles in one area are tightening and others become loose. The result is a movement coordinated by the nervous system. The muscles that do this are called voluntary muscles, or skeletal muscles.

Muscles also provide protection for organs and other internal tissues, and help a body remain supported and upright. Smooth muscles, or involuntary muscles, are muscles that line the walls of our organs; a person does not consciously control these muscles. For example, our diaphragm is an involuntary muscle that is essential for our breathing; though it *can* be activated purposely, it usually is not.

The third kind of muscles are cardiac muscles; these muscles are found only in the heart and perform the movements necessary for the contracting of the heart required for blood-flow.

A joint is any point at which two bones come together; joints are either immovable or movable. An immovable joint would be the cranium. Movable joints, by contrast, are joints that permit movement, for example the elbow and knee joints, or the point where the arm meets the scapula in the shoulder.

There are four basic types of joints NAs should know about.

- **Ball and socket** joints are joints where one joint ends in a ball that fits into the cup-like receptacle of another bone. Hips and shoulder joints are both examples of ball and socket joints. Ball and socket joints usually have a wide range of motion and can move in a variety of different ways – think of all the ways a healthy person can swing their arms. This is possible because of their ball and socket joints.
- **Gliding** joint, or a plane joint, are two smooth bone surfaces that “glide” over one another. Gliding joints are mostly found in the ankles, wrist, and in the spine.
- **Hinge** joint allows for flexion and extension, but unlike a ball and socket joint it can bend along only one plane. For example, the knee is a hinge joint because it allows for bending in a forward and back motion, but it can't move side to side.
- **Pivot** joints, also called rotary joints, allow for rotation in a specific area and are composed of a rotating bone within a ring formed by the second bone. An example of a pivot joint would be the vertebrae that allow a person to turn their head from side to side.

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Ambulation

Ambulation is moving or walking. A person who does not need any assistive devices ambulates in the way that most other people walk, while a person who uses a cane or a wheelchair ambulates with the assistance of a cane or a wheelchair. Ambulation, then, is an umbrella term for many different kinds of motion and movement, though it usually refers to walking^[1].

A person is ambulatory if they are capable of getting out of bed and moving or walking. Practicing ambulation is important, and maintaining the capability of ambulation is a necessary dimension of sustaining independence, preventing medical problems like blood clots, and managing one's own holistic health.



Ambulation has many benefits, including:

- skin health
- circulation
- appetite
- elimination
- sleep
- overall energy and zest for life

After somebody has been on bedrest, ambulation should be taken slowly and over short distances, with gradual increases as the person regains their strength. Always consult the care plan, and ask a nurse if unsure. Image is Public Domain

Helping a resident ambulate

NAs should help residents ambulate if they need it; because ambulation is so important to overall health and wellbeing, and is particularly important for preventing deconditioning in older adults, residents should ambulate as much as they can. Many of them

will need assistance and close monitoring in order to ambulate safely.

When helping a resident to ambulate, NAs will use a transfer belt or another safe and prescribed assistive device. When using a transfer/gait belt, NAs should walk slightly behind the resident while holding on to the gait belt; if the resident has a weaker side, that is the side that the NA should stand on.

To perform ambulation safely:

- Make sure that the pathway is clear of any obstructing objects and that the room or hallway is well-lit. Both the NA and the resident must be wearing proper footwear, meaning close-toed non-skid shoes.

Knowing the residents you care for will better enable you to care for those residents well; it will help you observe any changes or developments in their condition.

- Make sure to know the person you are helping ambulate, especially in terms of any medical conditions the person experiences that might make ambulation riskier. For example, if the person is prone to orthostatic hypotension, or experiences dizziness and pain, these considerations may be relevant to helping with ambulation.

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- Always ask for help if you think you may need it. It is always better to have one too many people available to assist than it is to have too few people than is necessary to complete a task safely.
- Make sure to chart the person's ambulation – when it occurred, how far they went, their capabilities during the ambulation – when finished assisting them.

Always follow the care plan when it comes to increasing a person's activity levels; going from bed rest to ambulation usually involves a couple steps in between, such as moving into a dangle, then getting out of bed and into a bedside chair, and then once they are able the person will ambulate in their room and then finally in the facility hallways. Always follow the care plan.

Falling and fall prevention

Ambulation can increase the risk of a resident falling, especially if they experience weakness or dizziness. If a resident is falling, NAs must not try to completely stop the fall, as this could result in injury to both parties. Instead, the NA should brace the falling person with their body and gently lower them to the floor. The person who fell should not be allowed to move or get up before the nurse checks them for injuries. An incident report form is *always* completed after a fall.

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Fall prevention programs are required when somebody is at risk of falling. The prevention program will be included in the person's care plan. Fall prevention programs include steps the care staff must take to minimize the risk of falls, such as keeping a tidy space and having the person equipped with proper footwear. When a fall prevention program is included in someone's care plan it must be used at all times.

Some patients who are at risk of falling will be prescribed assistive devices. NAs should always check the care plan to make sure they know whether someone needs to use an assistive device, and which kind of assistive device they need to use.

- **Crutches** are used when someone has reliable upper-body strength, but requires support on both sides for their lower body movements.
- **Canes** are used for people with weakness on one side of their body, operated on a person's strong side and used in unison with the weak side. For instance, if a person's strong side is their right, then the cane will be used by their right arm in time with their left side's gait to provide extra support.
- **Walkers** are used by people who have general weakness in the upper and lower body, but are not yet at the point of requiring a wheelchair. When a person uses a walker, they should remain close to the walker to remain as aligned as possible.
- Various **braces**, such as leg and ankle braces, can also help people walk when they otherwise may not be able to do so comfortably. Braces work to keep body parts in place and to provide extra support to a person's musculoskeletal system.

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Key Takeaways

- Inactivity comes with the risk for a variety of different complications. It can negatively impact one's overall physical and mental health, and generates problems with blood flow, eating and drinking, and muscle conditioning.
- Always practice good body mechanics for both oneself and the resident when moving or transferring. Make sure there are enough care team members to do the task safely, and never avoid asking for help. Speak to the resident throughout the whole process to create a secure and respectful environment, and to help the process go smoothly.
- Active range of motion (AROM) refers to the range of motion through which a person can move their joint on their own, which passive range of motion (PROM) refers to a joint's available range of motion when a member of the care team moves the joint through the range of motion while the resident remains relaxed. When assisting someone with range of motion exercises, never extend a joint past its capabilities, and keep talking throughout the process. Always check the care plan for details on when, how, and how many ROM exercises a given resident needs.
- Assistive devices are an essential component of practicing safe caregiving. Assistive devices are used to make moving and transferring safer for both care team members, and patients and residents. Always use assistive devices such as lifts, drawsheets, and transfer belts to make moving someone as risk-free as possible. Other assistive devices may be used to prevent pressure injuries while on bed rest, such as a foot board, and to help minimize residents' risk of falling, such as canes and walkers.

Comprehension Questions

1) How often should a resident on bed rest be repositioned? How often should a resident in a chair or wheelchair be repositioned?

- a. Every 3 hours; every ½ hour
- b. Every 1- 2 hours; every hour
- c. Twice per day; three times per day
- d. Whenever they ask for it

2) The complications of inactivity include ...

- a. Skin wounds
- b. Issues with circulation
- c. Communication challenges
- d. Musculoskeletal complications
- e. Problems with vision

3) Which of the following is true about body mechanics?

- a. Assistive devices and mechanical lifts should only be used as a last resort
- b. Protecting one's own back is an important part of assuring quality care
- c. Good body mechanics refers to lifting weights so you can move residents easily

4) Respond to the following sentences with T (true) or F (false).

- ___ Transfer belts work best when applied directly over a person's skin.
- ___ Bedrails are an entrapment risk when not used properly. They should be lowered when not actively necessary for a care task.
- ___ Lifts are used to transport people around a facility.
- ___ Mechanical lifts should be used whenever possible to make a safe transfer from a bed to a chair.
- ___ Safety is less important during transfers than it is during ambulation.

5) Which of the following is true of transfers from a bed to a wheelchair?

- a. The wheels of the wheelchair should be left unlocked.
- b. The height of the chair is not adjustable, so the bed will need to be adjusted accordingly.
- c. The person should be seated securely at the back of the chair.
- d. Residents can use a transfer belt to assist themselves with transfers.

6) What elements are necessary for a safe repositioning movement? Select all that apply.

- a. A friction-reducing device
- b. At least 2 – 3 staff members

c. A working television

d. Excellent communication

7) What are some strategies NAs can use to limit friction and shearing? Select all that apply.

a. Oil the bed so it is slippery

b. Use a friction reducing device

c. Make the bed flat during repositioning, and less than a 30-degree angle at other times

d. Have the resident assist if they are able

8) What is it called when NAs have a resident sit up in bed for a minute to allow their blood pressure to equalize before continuing with a transfer?

a. Sitting up

b. Calibrating

c. Dangling

d. Aligning

9) Respond to the following sentences with T (true) or F (false).

___ A resident is under orders of "strict bed rest" when they can only get up to use a portable commode.

___ Bed rest can allow a person the opportunity to focus all of their energy on healing after an injury or major medical intervention such as a surgery.

___ Complications from bed rest include skin breakdown, UTIs, constipation, and circulatory issues.

___ Someone on bed rest will be unable to perform range-of-motion exercises.

___ Range-of-motion exercises can be incorporated into ADLs, such as by working on wrist and hand mobility while a resident brushes their teeth.

10) Which of the following statements is true of ambulation? Select all that apply.

a. The benefits of ambulation are primarily psychological, rather than physical.

b. Ambulation is an important aspect of promoting independence.

c. Ambulation helps prevent blood clots.

d. Ambulation can be risky, especially if residents are weak, confused, or imbalanced.

e. There aren't any good assistive devices available to help someone ambulate.

11) What infection control measures are especially necessary when somebody is on bed rest? Why?

12) You are helping a resident ambulate with a gait belt. They are doing better than they usually do, so you let them walk on their own. However, they slip on an unmarked spill and begin to fall. You reach out to catch them and try to stop their fall, but in the process, you pull a muscle in your back and the resident ends up hitting the floor hard. What are the things you could have done differently to practice better safety measures and avoid injury?

References

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Module 7 – Personal Care

Learning Objectives

- Demonstrate understanding of the need for good hygiene
- Demonstrate the ability to perform hygiene tasks
- Demonstrate understanding of the safety precautions related to activities of daily living
- Demonstrate understanding of the importance of excellent skin care

Personal care refers to a person's hygiene, or the steps someone takes to keep themselves clean and healthy. Some examples of hygiene practices are showering and brushing one's teeth.

Personal care also refers to grooming, such as trimming one's fingernails and toenails or brushing one's hair. Personal care tasks are part of what make up a person's activities of daily living (ADLs), and NAs will assist people with personal care ADLs every day.

Many people enjoy their personal care routines throughout their lives; perhaps it was part of their sense of independence, or moments they had to themselves. Requiring assistance with personal care due to old age or a medical intervention can come with feelings of loss of independence, sadness, or frustration.

To make these moments easier, NAs can try and make time spent on personal care tasks fun. Some ways to do this are to cultivate a positive relationship with the person by telling a happy or funny story, or asking the resident questions about themselves with genuine curiosity. Talk with them while providing personal care.

Hygiene Matters

Hygiene is a topic that relates to the Big Three. Residents have a right to good care, and if they are not having their hygiene needs met then their quality of life will suffer. Good hygiene is also an important part of infection control and prevention because it cleanses the body and mouth of potentially harmful pathogens.



SMART CHOICE 

Good hygiene has many health benefits. It cleanses the outside of the body, dirt, and other irritants. Maintaining good hygiene also helps to prevent unpleasant odors from someone's body and breath, including sweat, eliminations.

Hygiene routines

Hygiene routines can be relaxing for a person, particularly if they enjoy the touch of another person washing their hair or enjoy the feeling of warm water.

Over time a person's illness or aging process can get in the way of performing personal care independently. NAs must recognize the necessity of attentive hygiene to a person's quality of life and, in addition to meeting their basic hygiene needs, work to make time spent addressing hygiene needs dignified, personable, and even fun.

Remember that residents have a right to dignity and privacy that is especially important during hygiene care.



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People have different relationships to hygiene, and may usually follow a personalized hygiene routine when not in a facility. Cultural background can impact how often a person washes and how they wash.

Loss of independence can be emotionally difficult. NAs can help make hygiene an activity residents can approach with a sense of agency empowerment.

Hygiene routines are also influenced by factors such as personal choice and preference. NAs should try and meet a person's personal hygiene preferences as long as the NA also closely follows the care plan and meets the person's hygiene needs as they have been determined by the nursing process.

For example, if the nurse determines that a person must have their teeth brushed twice per day with a prescription toothpaste then a person's wish to use a particular brand of store-bought toothpaste, should be explained to that person as inconducive to their health and recovery; however, the person's right to choice and to be an agent of their own care needs to be respected and encouraged whenever possible.

Hygiene needs

Hygiene needs depend on someone's condition; perhaps they require a prescription toothpaste, or you have to consider their bed sores during bathing, or perhaps they need a medicated lotion, or can only be given partial baths due to weakness.

Hygiene care can increase circulation from the application of warmth and gentle pressure on different parts of one's body.

Each person's hygiene needs will be different. The important thing for the NA is to always follow the care plan.

Nursing assistants should always observe the resident closely to assess how care is going. If you notice anything during the time spent providing hygiene care, whether it is a change in a person's skin condition, mouth sores, or orientation, chart it and let the nurse know in case something in the person's care plan needs to be adjusted.

When does personal care occur?

Personal care will be given three times per day, and whenever the resident requests it. Different kinds of care will be required at different times of the day; the schedule of care, in addition to necessary care tasks, will be detailed in the person's care plan. NAs should always check with the care plan or check with a nurse if they are unsure about something in a person's hygiene schedule.

- Morning care begins with gently waking someone and continues after breakfast. Such care may involve brushing teeth or dentures, shaving, using the toilet or commode, and bathing or showering depending on the person's preferred schedule. Morning care will also involve helping the person dress for the day.
- Afternoon care is done between lunch and the evening meal. Some residents may prefer to shower in the afternoons, while others may not need bathing or dental care but may want their fingernails trimmed. NAs must remember to offer the restroom to people often. Some people will also want to brush their teeth or care for their dentures after their midday meal.
- Evening care involves assisting residents with their bathroom needs, dental care, bathing, and with putting on pajamas. Evening is also the time to care for the resident's space by changing soiled linens and decluttering.

Assist with hygiene whenever the person requires it. Residents have a right to comfort and to safety, and a person is neither comfortable nor safe when their hygiene needs go unmet.

Addressing hygiene needs promptly is an important element of infection control. Why?

Resident Rights

It is important that NAs work to provide care tasks in a way that affords the person dignity and respect. They can do this by encouraging as much independence as possible; a person should be prompted to perform whatever care tasks they can perform on their own.

Be patient – even if somebody takes a long time to do something unassisted, if they can and they want to then you should be patient and encouraging for as long as the process takes. Briskness and frustration do not make someone feel cared for.



Always plan for privacy. When assisting somebody with personal care tasks, the NA should ensure that the person has privacy by closing the door to their room and putting the privacy screen in place.

Hygiene care is closely related to both Resident Rights and Infection Control. Write about the connection between hygiene care and the Big Three – why is hygiene important for good Infection Control? What elements of Resident Rights should NAs keep in mind when giving hygiene care? Write for 5 minutes and share your response with a friend or classmate.

Query 1

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Assisting with hygiene

Bathing

Everyone needs bathing. Bathing is important to our health, and helps people feel comfortable and refreshed. The benefits of bathing include:

- Removing microbes, dead skin, sweat, and oils
- Cleansing the mucus membranes in the genital and anal areas.
- Stimulating circulation
- Provides and opportunity for some basic range of motion exercises

Many people enjoy bathing, and will find their hygiene routines refreshing and relaxing. In addition to the medical benefits of bathing, there psychosocial benefits as well.

Bathing is a great time to talk with the resident because it is an extended period of time with individual attention. This could be a casual conversation where you continue to foster a rapport, or it could be an opportunity for a resident to discuss a problem they have been having.

Bathing presents NAs with an opportunity to closely observe the resident's behavior, orientation, mood, and the parts of their body that are usually covered with clothing. Always observe closely, and report and record anything relevant.

Types of baths

The four basic types of baths are a partial bath, a shower, a tub bath, and a complete bed bath.

When deciding what kind of bath to give a resident, always check the care plan, determine the person's needs, and take their preferences into account. The orders from the doctor or nurse are prioritized over the preferences of the patient in this case; for example, if the doctor ordered full bed rest, then the person cannot get up for a shower, even when they would prefer one to a partial bath. However, the person's preferences should be accommodated whenever it is possible and consistent with their care plan^[1].

- **Partial bath:** Partial baths can be given while the person remains in bed. A partial bath involves washing the person's face, underarms, hands, and the genital and anal area (the perineal area), and any area that appears dirty or smelly. Partial baths are useful for people who can't get up or don't want to get up for a full bath or shower, have sensitive skin, or who want to freshen up.
- **Shower:** Residents should shower if they can safely stand for the duration of the shower or are comfortable sitting in a shower chair. Residents who are fatigued or prone to dizziness should avoid showers.
- **Tub bath:** Tub baths take place in bathtubs. Tub baths are intended for residents who are capable of transferring into and

out of a bathtub, and who prefer a bath to a shower.

- **Complete bed bath:** A complete bed bath is intended for people who cannot get out of bed but who still require a full bath, rather than a partial bath.

The order of bathing

The order of bathing is important, and is part of good infection control practices. The order of a bath is intended to keep potentially harmful microorganisms from spreading to different parts of the body where they could cause infection.

When bathing a resident, the order of the bath must go as follows:

1. Eyes
2. Face
3. Ears
4. Neck
5. Arms and hands
6. Chest and abdomen
7. Legs and feet
8. Back
9. Perineal (genital and anal) area
10. Buttocks

This order is the same for a full bath, shower, bed bath, and partial bath.

Watch the video below for a demonstration on how to give a full bed bath.

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Chippewa Valley Technical College. (2022, December). Full Bed Bath. [Video]. YouTube. Video licensed under [CC-BY-4.0](#)

Safety

Bathing safety is absolutely necessary when assisting with personal care.

The first step in providing a safe bath, of any kind to prepare well. Have everything you need within arm's reach, and ask for any help that they think might be necessary during the bathing process.

Keep the floor free of water and slipping risks. The tub or shower should be cleaned before and after the person uses it.

The importance of prepping one's supplies comes from the need to remain with the person during the entire bathing process – never leave someone alone when they are in the bath or shower.

When preparing a bath or shower, NAs must be conscious of a resident's diminished sensitivity to temperature sensations and the increased fragility of the resident's skin. Burns and chilling from water are dangerous if NAs are not conscientious when preparing a bath or shower. The water in a bath or shower should not exceed 105 degrees Fahrenheit.



Perineal care

Perineal care, or the cleaning of the anal and genital region, is completed every time a person bathes or whenever waste or urine is present. Perineal care is extremely important for infection control and promotes comfort by eliminating odors and skin irritants.



Perineal care is especially important for people who have urinary catheters, have had perineal surgery, are actively menstruating, are incontinent of urine or feces, and are uncircumcised (the foreskin of the penis was not removed). All of these factors make somebody more susceptible to perineal infections and concentrations of microbes.

Patients and residents will perform their own perineal care if they are physically able to; some obstacles to a person doing their own perineal care might include lack of mobility and flexibility or an order for complete bed rest.

Receiving perineal care can evoke feelings of vulnerability. Always protect the person's dignity by being friendly and professional, and providing privacy.

When providing perineal care, always clearly communicate exactly what you are about to do before doing it. The goal is to always have the person receiving care know what is about to happen and be able to prepare themselves for it, and to have received that information in a way that they understand and helps them stay comfortable and calm.

When providing perineal care, NAs must always follow the Standard Precautions (wear gloves!), the Bloodborne Pathogen Standard, and the protocols of medical asepsis.

How to provide perineal care

Use warm water, as opposed to hot water, and soap in small amounts. The process includes items such as a washcloth or towelette and an emesis basin; NAs should always follow facility policy on the items used to perform perineal care.

Always move “front to back” when performing perineal care. For a person with a vagina, this will involve gently separating the labia majora, which are the external folds of skin that protect the vaginal and urinary openings, and wiping front to back on either side. Use a different section of the washcloth when moving to different parts of the perineal area.

After washing the genital region, clean the perineum (the area between the genitals and anus) before rinsing the perineal region with a clean washcloth. Pat the area dry from front to back, and then help the person into some clean undergarments.

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Chippewa Valley Technical College. (2022, December). Perineal Care – Female. [Video]. YouTube. Video licensed under [CC-BY-4.0](#)

When cleaning the perineal area of someone with a penis, keep using the front-to-back motion. If the person is uncircumcised, gently pull the foreskin back and clean the area under the foreskin. The penis should be cleaned in a circular motion moving front to back, with a new section of the washcloth used for each region of the perineal area.

After rinsing with a non-soapy washcloth, return the foreskin to its normal position. Once the penis has been washed and dried, the NA can move on to clean the groin. Finally, using a fresh washcloth, the NA can clean the buttocks and anal area and pat dry.

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Chippewa Valley Technical College. (2022, December). Perineal Care – male. [Video]. YouTube. Video licensed under [CC-BY-4.0](#)

Report & Record

NAs should *always report and record* whenever hygiene care of any kind is given. If care is not properly recorded, the rest of the care staff will assume that care was not given. In addition to the importance of recording that personal care took place, use personal care time to make observations about the person’s condition.

When observing during personal care, it is important to look for any signs of bleeding, skin breakdown, any discharge from the vagina or urinary tract, any foul or unusual odors, or any changes (positive or negative) in the person’s condition since the last time observations were recorded.

Recording all personal care and any observations made is necessary for providing good care. It is also necessary from a legal perspective, both because records maintenance is a requirement for facilities, and because failing to record care could lead to legal problems resulting from medical negligence. Both the person receiving care and every other member of the care team rely on NAs to report and record thoroughly.

Back rubs

One way that NAs can take some time to closely observe the condition of a person's skin while helping them feel comfortable and relaxed is to give them a backrub.

To perform a back massage or a back rub, first position the person on their side or on their stomach. Next, warm the lotion between one's hands or by running the bag or bottle under warm water, and apply lotion to one's own hands.

Begin moving hands in wide circular motions starting at the base of the spine and reaching up to the person's shoulders without lifting them off of the person's back; the massager should use firm strokes on the muscle tissue on either side of the spine, and gentle pressure on bony areas such as the spine and hip bones. The massage should last for between three and five minutes, and communication should continue throughout.

Back massages are a good opportunity for NAs to take note of changes to a person's skin condition. Prior to beginning the massage, take a moment to closely examine the person's skin for signs of breakdown.

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Shampooing

Providing personal care will also involve shampooing residents. Shampooing may be done during the person's shower or tub bath, at the sink, on a stretcher, or while the person is in bed.

In bed

- Make sure that all supplies are within easy reach.
- Water temperature must not exceed 105 degrees F.
- A shampoo tray will be placed beneath the person's head to prevent water spilling on the linens – the pillows should be removed from the bed.
- The basin of water should then be placed beneath the person's hair. Use a pitcher to get the person's hair wet before massaging their scalp with shampoo, rinsing thoroughly, and helping the person dry their hair by wrapping a towel around their head.

At the sink

- The person will place their head against the padded headrest. If there is no padded area, place a folded towel on the edge of the basing to provide some comfort.
- It is important that the person's neck is not placed at an angle – they need to maintain good neck alignment throughout the shampooing process for comfort and spinal health.
- Make sure the person is comfortable and that they are not getting soap or water in their eyes.

On a stretcher

- Set the stretcher to the same height as the sink and place it against the basin.
- Make sure the wheels are locked.
- Side rails of the stretcher should be raised during shampooing.

- Place a towel under the person's head as their hair dries.

Tub or shower

- Make sure the water is at a suitable temperature before allowing the person to enter the shower or bath; it is a good idea to let them test it.
- If using a shower chair, make sure the wheels to the chair are locked. If using a tub, transfer the person into the tub and then fill the tub roughly halfway.
- Never leave someone alone during a shower or a bath.

- Dry thoroughly to avoid skin irritation and bacterial growth.

To promote independence and dignity, the person taking the shower or bath should be encouraged to perform as much of it as they can themselves.

- Once the person is finished, help them dry off by patting them with a towel. Make sure they are completely dry.

The person's hair should be styled and dried as quickly as possible after washing. NAs should always check with the nurse before curling somebody's hair. Many people, especially residents in long-term care facilities, will have their hair done by a beautician. Some facilities will even hire a beautician to come in regularly for the residents who want their hair done.

A note on hair and respect

Always ask the person how they want their hair interacted with. This is an aspect of basic respect and of cultural competency. Different hair behaves differently, and the last thing a NA wants to do is do something unhealthy, damaging, or unwanted to someone's hair. Hair can be something with personal and cultural relevance, and having their hair done correctly while living in a facility may be one of the things that helps a person feel like themselves. Always be conscious of the potential importance of hair to a person, and use hair care as an opportunity to make someone feel agential and respected.

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Oral care and hygiene

Oral hygiene refers to the care of the mouth, gums, and teeth. NAs will provide oral care to residents at least twice per day, although possibly more. Any action taken to care for someone's mouth area or dentures all falls under the umbrella of oral hygiene^[2].

Oral hygiene is important for preventing bad breath, removing plaque, and preventing gum disease. Maintaining a healthy mouth is worthwhile for its own sake; it is uncomfortable and unpleasant to have mouth discomfort and pain.

Good oral hygiene can also help a person be more confident, can make eating a more pleasant experience and make food taste better, can improve one's overall attitude and comfort. Since plaque buildup can result in clogged arteries and heart problems, good oral hygiene also makes somebody less susceptible to heart disease, strokes, and diabetes.

Performing oral care

When providing mouth care, always communicate with the resident throughout the whole process, practice Standard Precautions, and let the resident perform as much of their own care as possible to encourage feelings of autonomy and independence.

Teeth, gums, tongue

- To brush a resident's teeth, gums, and tongue, always communicate with the resident throughout the process.
- After performing the opening procedure and prepping a work station, make sure the resident's bed is angled to a comfortable upright position and that the bed wheels are locked.
- Cover the resident with a towel, then wet a soft-bristled toothbrush and prepare it with a dab of toothpaste.
- Clean the resident's whole mouth, including teeth, tongue, and gums with short, gentle brushstrokes. Once finished have the resident rinse their mouth with water and spit into the emesis bin.
- Return mouth care supplies to their location, then empty, rinse, and dry the emesis bin and place it in "dirty" storage. Place used linen in the appropriate receptacle. Make sure the resident is comfortable before returning the bed to its lowest position.

Flossing

- Prepare the station by raising the bed to the appropriate height and gathering the materials. Always use the privacy curtain when providing personal care.
- Wrap either end of the floss around the index fingers of both hands and gently move the floss downward between the teeth in a back-and-forth motion, beginning with the teeth in the back of the person's mouth. Adjust the floss every two teeth so that there are always working with a clean section of floss.
- Once flossing is completed, offer the resident a glass of water and a basin so they can rinse their mouth and spit.
- When done, the NA can discard the used floss and water, and properly clean and store all supplied. Return the bed to its lowest height setting, and perform the closing procedure.
- Make sure the resident is comfortable and give them the opportunity to converse about whatever they want to talk about, since conversation is rather difficult when one's teeth are being flossed. Always observe the resident's mouth closely and report any changes, abnormalities, or bleeding.

Denture care

Many older adults use dentures, or fabricated teeth. Dentures in come in a half set (a full row of teeth on the top or bottom), a full set, a partial plate or a bridge, which replaces sections of missing teeth.

Dentures need to be made according to detailed specifications, and are difficult to make. They are very expensive. Handle dentures, and dental appliances in general, with the utmost care.

If dentures become damaged or chipped then it will likely prevent the person that uses them from eating. If the NA damages a person's dentures then the facility is legally responsible for their replacement.

- Always practice Standard Precautions when handling dentures by wearing gloves and any other necessary PPE. Never place dentures on a contaminated surface.
- Dentures are cleaned much like teeth are brushed, except they must be removed from their wearer's mouth before they can be brushed. First the NA should line the sink with a towel, and then fill the sink with water so the dentures will not break if dropped.
- If the resident cannot remove their own dentures, NAs should use a gauze pad to firmly but gently grasp the dentures and pull to remove them.
- Rinse the dentures in cool water (never warm or hot) over the sink before brushing them; dentures can be more easily damaged when they are dry, which is also why they must be kept moist or wet.
- Use the brush to thoroughly clean the dentures with denture cleanser (check the care plan), and then rinse them under cool water again. When finished, put the dentures into their clean container with denture fluid or cool water and place it where it is stored. Give the resident an opportunity to rinse their mouth and spit.
 - If the resident wants to wear their dentures all the time other than during cleaning, the NA can replace them in the resident's mouth by applying some denture cream and pressing them firmly back into place. Finally, clean the brush and

emesis basin and return them to their storage location.

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Oral care for the unconscious

If someone is unconscious for long periods of time, they still need mouth care. Even if a resident is unconscious, always interact with them as if they were by communicating throughout the process and keeping face-to-face contact. Always practice Standard Precautions and adjust the bed to a comfortable head to provide mouth care.

- Turn the resident on their side, with a towel under their cheek and chin and an emesis bin close by, since the unconscious resident may drool or allow fluid to leak from their mouth.
- Keep the resident's mouth open with a tongue compressor; using one's fingers is dangerous for both the NA and the resident.
- NAs won't brush an unconscious resident's teeth. Instead, use a sponge swab to apply a cleaning solution to all parts of the person's mouth. Squeeze the sponge swab in between replenishing it with the cleansing agent and applying it to the person's mouth; any drippage or excess fluid could cause aspiration. Change out the swab regularly until the mouth is clean.
- Always check the care plan when preparing to care for unconscious residents. The care plan will determine which cleansing agent to use, and include any necessary information to keep in mind. Continue to communicate with an unconscious person as if they are awake; you do not know what they can hear.

Query 3

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Assisting with grooming

Grooming is distinct from hygiene, and is also an essential dimension of a person's healthcare. Grooming includes:

- styling hair
- trimming fingernails
- dressing and changing clothes
- applying makeup and jewelry

Grooming has an impact on how a person feels about themselves – it is part of multiple layers of Maslow's hierarchy, and contributes to self-esteem and self-actualization. Assisting someone with grooming helps them meet their psycho-social needs.

Grooming is important for preventing infection and promoting comfort. Everybody has their own grooming routine and preferences. Some grooming habits are personal, while others are influenced by culture and context. The person should be encouraged to tend to their own grooming as much as possible, with basic assistance and the company of a NA.

Hair care

NAs should assist a resident with hair care whenever the resident wants. The care plan will include specific directions on how to care for a person's hair.

The nursing process and care plan should reflect the person's culture, their personal choices and preferences, the condition of their skin and scalp, their relevant health history, and their ability to perform self-care unassisted. All of these factors play an important role in determining how best to care for a resident's hair.

Brushing and combing

Brushing and combing is a regular part of early morning and afternoon care, and should be provided whenever the resident wants it, and always before they receive visitors. NAs should encourage residents to perform as much of their haircare as possible, and assist them as they need it.

The person will choose how their hair is brushed, combed, and styled. NAs should never cut a person's hair because it is matted or tangled; instead, check in with the nurse and the person about appropriate ways to manage hair care. Specific measures are required for brushing and combing curly, coarse, and dry hair. A person's haircare routine and preferences will be included in their care plan.

Skin and scalp conditions

Skin and scalp conditions can impact a person's quality of life. Carefully observe for skin conditions during hair care, and always remain composed and respectful not matter how someone's head looks.

- Alopecia is a term meaning hair loss, and alopecia to different degrees is experienced by most people throughout aging in the form of balding or thinning. Other causes of alopecia include cancer treatments, skin diseases, stress, poor nutrition, pregnancy, side effects from drugs, and changes in hormones.
- Hirsutism is a term for an excessive or abnormally high level of body hair. Hirsutism occurs in men, women, and children due to heredity and high testosterone.

Some scalp conditions may look alarming. Always remain professional, and never act in a way that might embarrass a person or make them feel self-conscious about their condition.

- Dandruff occurs when the scalp or eyebrow skin produces a lot of flakes; people with dandruff may require medicated shampoos to address the itching and flaking.
- Pediculosis is the medical term for infestation with head lice. Lice are nearly impossible to see with the naked eye. Lice are highly communicable and can travel through contact, clothing, furniture, towels and linens, or shared items like hats and combs.
 - Symptoms of lice include complaints of tickling or movement in one's hair, itching and skin irritation, sores on the head or body from scratching, or a rash.
 - If you think someone may have pediculosis, alert the nurse right away and follow the care plan for treatment.

Shaving

People shave for comfort, mental wellbeing, and self-esteem. NAs will likely need to shave a person's face, legs, and underarms at different intervals. NAs will use either an electric razor, a safety razor, or a disposable razor to shave a person.

- After performing the opening procedure, communicate with the resident while preparing the station with razors, shaving cream, a basin of warm water, and a sharps container. Before beginning to shave, the wet the person's skin with warm water and then lather the area with shaving cream.
- While shaving, hold the person's skin taut and shave in the direction of hair growth; if shaving a person's face, this will involve shaving down the cheeks and up the neck. To shave the spaces just below and above the lips, have the person pull their lips into their mouth and over their teeth to keep the skin tight.

- The razor blades in facility settings will likely become dull before the shave is over, so multiple blades will be needed; razors must be disposed of in the sharps bin when dull. NAs should always try to keep the razor blades fresh for a close, comfortable, and cut-free shave.

Some residents cannot use safety razors or disposable razors, especially if they have difficulty healing or are on drugs that inhibit blood clotting. For these residents, NAs will use an electric razor. Make sure the razor is clean before using, and never use an electric razor around water or oxygen.

People with mustaches and beards will need daily facial hair care. NAs should always ask the person how they want their facial hair groomed, and should never trim or alter a mustache or beard without asking first.

Once shaving and facial hair care is complete, clean and dry the supplies, and tidy the area so it is free of any loose hairs. Loose hairs can be irritating in a person's bed or clothing.

When shaving a person's body hair, the NA should never assume somebody wants particular hair gone. For example, many women do not shave their legs or underarms by choice. NAs must respect this and take the possibility of these preferences into consideration.

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Nail and foot care

Good nail and foot care is essential for a person's comfort, ease of mobility and the prevention of injury, infection control, and odor prevention. Finger and toenails can collect bacteria under the nails; hangnails, ingrown nails, and torn nails can cause breaks in the skin that provide pathogens a portal of entry. NAs may have to trim and clip a person's fingernails with a fingernail clipper to keep them smooth and short.

It may be helpful to soak the person's nails for 5 – 10 minutes in a basin first. This will make the nails softer and malleable before clipping.

In Illinois, NAs cannot cut or trim a person's toenails and in other states may not be permitted to trim and clip their fingernails; in situations where NAs cannot trim or clip a nail, the nail should be filed. Clipping finger and toenails can easily cause injuries, and should be undertaken with extreme care.

When providing nail care, NAs may have to clean under a person's hands with an orangewood stick or a similar device. If cleaning under the nails, NAs should soak the nails first, and then gently run the cleaning tool under each nail, rinsing the stick in between cleanings. Nails can be trimmed or filed after they are cleaned.

Foot care for a person with diabetes

People with diabetes will require attentive foot care. Because of their weakened immune system and poor circulation, people with diabetes are highly susceptible to infections of the feet. If their feet are not properly cared for, and if infections are not noticed and addressed early, then the person's foot may take months to heal and may even need to be amputated. NAs must keep the feet of people with diabetes clean and dry^[3].

People with diabetes should be in clean, dry, and soft socks at all times.

NAs must examine and clean a diabetic resident's feet every day with gentle soap. The resident's feet should be soaked for about 15 – 20 minutes per day and washed with a washcloth. Pat the person's foot dry when done, and then apply the appropriate lotion. Always check the care plan.

It is important that people with diabetes do not get any cuts or scrapes on their feet. Check the feet thoroughly, including under the toenails, for dry or cracked skin, bumps, temperature changes, and any other abnormalities^[4].

Do not trim their toenails; only use a file.

Changing clothes and hospital gowns

Helping someone to change their clothing is a daily task that NAs perform.

The weaker side should be referred to as the “weaker” or the “affected” side, never as the “bad” side.

One of the most important things to remember when helping a resident dress or undress is to favor their stronger side. Many people will have a side of their body that is weaker than the other, due to aging, stroke, or illness. When dressing a resident, NAs should begin with the weaker side, but when undressing a resident the NA should begin with the stronger side.

Resident must always be allowed to choose their own clothing. NAs can make this process fun by complementing a resident's sense of style and making them feel fashionable as an enjoyable part of preparing for the day.

Use dressing and undressing time as an opportunity to encourage independence. Dressing and undressing can promote a sense of independence and wellbeing; it is also a great time to work in some range-of-motion exercises. Assistive devices are available for residents who want to dress themselves independently, but have limited range of motion.

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[View this YouTube Video online](https://www.youtube.com/watch?v=PiHCvPHBoZs)



4yourCNA. (2016, August 26). Dress a resident with a weak arm CNA skill [Video]. Youtube. <https://www.youtube.com/watch?v=PiHCvPHBoZs>

If a resident or patient has an IV tube, this may get in the way of undressing and dressing easily. When undressing, the NA should make sure not to remove the IV tube on accident. The IV must remain inserted and cannot be removed for dressing or undressing; the NA will have to take the IV bag from its hook and slip it through the resident's clothes as they are removed or donned.

When dressing, clothing should be put on the side with the IV tube first; once the clothes on the IV side are on, the NA should hang the IV bag again before proceeding to finish dressing the person. Make sure the IV tube is dripping and is not kinked or obstructed.

Query 4

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Wound Care

Wounds are generally categorized as either open or closed. A closed wound is a wound that does not result in broken skin. Contusions, or bruises, are one form of closed wound. Internal bleeding is another.

When the skin is broken it results in an open wound. Some types of open wounds are abrasions, avulsions, incisions, laceration, and a puncture^[5].

- An abrasion is a scrape, and occurs when some of the person's skin is torn away because of contact with another surface. Abrasions tend to bleed little but still require cleaning and maintenance.
- Avulsion is more serious than an abrasion, and involves a violent tearing of tissue and substantial bleeding.
- Incisions are cuts from sharp objects. Incisions tend to bleed a lot.
- Lacerations are jagged openings caused by tissue being torn apart.
- Puncture wounds are small holes in the skin, caused by pointed objects like a pencil or a nail.

Symptoms of a wound are pain, discoloration, drainage, and observable damage such as bleeding.

Wound care instructions are included in the care plan. Always follow the care plan and maintain meticulous infection control practices when caring for wounds.

The biggest risk to consider when caring for wounds is the possibility of infection, or complications from lack of treatment.

Complications

Wounds negatively impact a person's basic needs. They cause pain and discomfort, and infected wounds can result in other medical complications including fever and affected appetite. NAs should always allow a person's pain drugs to take effect before interacting with their wound.

Healing from wounds can be a slow, frustrating, and arduous process. The person may be sad, angry, or hostile. NAs should respond to these behaviors with kindness and compassion, and continue to provide thoughtful care by consistently practicing good communication.

Always meet a frustrated person with care and empathy, especially since the person's negative feelings are ultimately a result of their pain, not directly in response to the NA.

A person's belonging and self-esteem needs can also be impacted by wound recovery. Wound recovery, and sometimes life after recovery, will require difficult adjustments, and may produce limitations in a person's actions, movements, and comfort. NAs should provide a listening ear, and be willing to hear a person's frustrations with their circumstances in a supportive and professional manner.

Reporting and recording

NAs play an important role in monitoring a wound's healing process. When observing a wound, NA should take note of its color, size, and shape. Note the type and amount of drainage, and whether the person's wound dressing needs additional changing.

It is also important to ask the person about their pain levels. After making the observations, NAs should chart them every time, including observations gathered, the, time of observation, and any care given.

Dressing

Wounds must be dressed tightly and securely as an infection control measure. Wound dressings have many important functions, including protecting the wound from further injury or infection, absorbing drainage, removing dead tissues, promoting comfort, covering unsightly wounds, creating an environment conducive to healing, and applying pressure for bleeding control.



Be careful when a person's wound is dressed with adhesive tape; abrasions can occur when the tape is removed and takes some skin with it. Many people are allergic to adhesive tape.

If tape is used to secure the dressing, it should be placed only at the top, bottom, and middle of the dressing; covering the whole dressing in adhesive tape could obstruct circulation and create discomfort in the event of swelling.

There are many different kinds of wound dressings. The doctor or nurse will determine which kind of dressings to use for a person depending on the type of wound, the wound size and location, drainage, infection, and how frequently the dressing needs to be changed. Always check the care plan.

Skin tears

Skin tears are common wounds in long-term care settings. A skin tear is a break or a rip in the outer layers of skin where the top skin layer separates from the underlying tissues – it can look like the skin is peeled back and the cavity filled with blood. Because older adults tend to have thin and fragile skin, skin tears can be caused by only slight pressure.

The best way NAs can work to prevent skin tears is by consistently providing careful and safe care. Attentively avoiding furniture and corners while ambulating and always making one's movements gently and smooth are some ways NAs can work to prevent skin tears and further injury. Note a resident's level of awareness before helping them move or ambulate

Skin tears can be caused by friction, shearing, or pulling and pressure on one's skin. They can also be caused by falls or bumps on any hard surface. NAs can accidentally cause skin tears by holding on to a person too tightly, removing adhesives, or brushing the resident's skin against a hard surface while bathing or getting dressed.

Skin tears are infection risks because they are portals of entry for microbes. NA should report skin tears to the nurse at once.

Pressure ulcers

The first thing to keep in mind when learning about how to treat pressure ulcers is that they are much easier to prevent than to cure.

Pressure ulcers occur when a person is in bed for a long period of time and their circulation is reduced; the reduction in circulation

can result in the process of skin breakdown or a dying off of skin tissue due to lack of nutrients and oxygen.

Breakdown usually begins in areas with a bony prominence, or an area where the bone sticks out or projects from the flat surface of the body. Some examples are the back of the head, shoulder blades, elbows, hips, spine, knees, ankles, heels, and toes. Bony prominences are also called pressure points.

Circulation is essential to skin health. Poor circulation can be a cause of pressure ulcers. If a pressure ulcer is going to heal, there needs to be adequate circulation to that area.

Risk factors for the formation of pressure ulcers include:

- skin breaks
- poor circulation in a localized area
- excessive moisture or dryness
- irritation caused by waste
- poor nutrition
- dehydration
- wrinkled linens

Pressure ulcers occur when a person is lying or sitting in the same position for too long. This makes people who are comatose, paralyzed, or healing from hip fractures at especially high risk. If a person is at high risk for pressure injuries, and especially if they have altered mental awareness, NAs should take extra care to make sure that person is re-positioned regularly, is free of excess moisture, has healthy skin, and moves to keep their circulation flowing.

The Stages of a Pressure Ulcer

Pressure ulcers progress in 4 stages.

In Stage 1 the ulcer appears red or otherwise discolored, and will be painful and emit a different temperature than the skin around it. It may look like a blister or rash.

In stage 2, the ulcer has shed some layers of skin and will appear red and moist. More layers of skin have corroded.

In stage 3, the ulcer will have shed further layers of skin and may appear yellow, green, brown, or red. The tissues will be sensitive, painful, and moist. Muscle tissue may be visible.

In stage 4, the tissue loss is extensive and may include muscle tissue in addition to lost skin tissue. It will look like a deep pit, and bone may be visible.

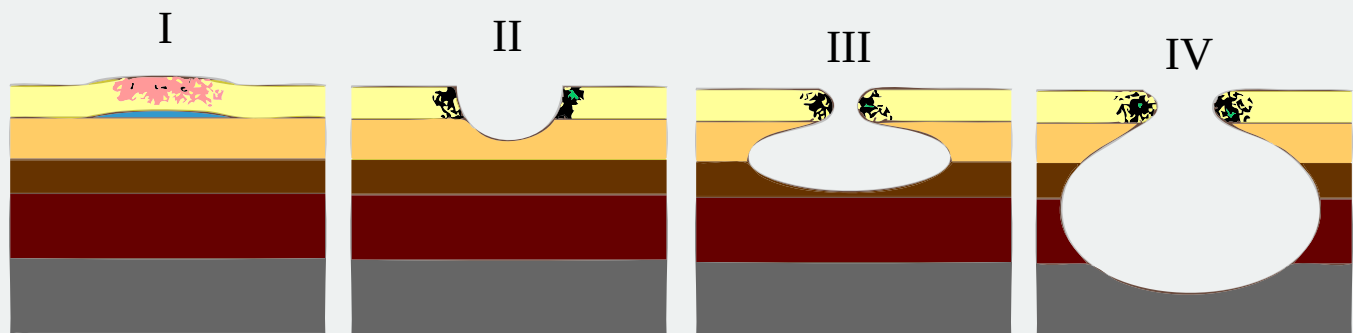


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The areas most at risk for pressure injuries are the side of one's head, the ear, shoulders, hips, buttocks, knees, ankles, collarbone, under the breasts, on the abdomen, under the scrotum, knees, toes, spinal base or sacrum, between the legs, and on one's heels.

Any place where friction occurs, or where pressure restricts circulation, is a risk factor for pressure ulcers.

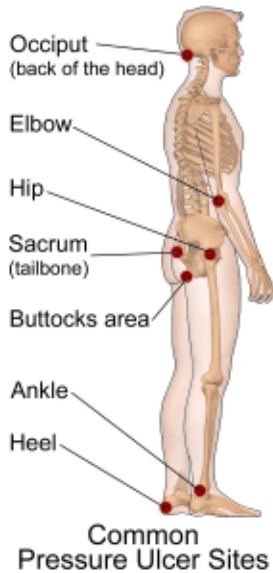


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The best way to address pressure ulcers is to prevent them before they can form. The nurse will assess a person for their pressure ulcer risk upon admission, and determine what preventative measures to include in their care plan. Managing moisture, good nutrition and fluid balance, and relieving excess pressure are all key measures to preventing pressure ulcers. Always follow the care plan.

Report and record any signs of skin breakdown immediately. NAs should take every opportunity to observe the person's skin closely, and tell the nurse if any abnormalities are noticed, even if they seem slight or insignificant.

Query 5

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Key Takeaways

- Good hygiene is part of the Big Three, especially Infection Control and Resident Rights. Good hygiene prevents infection and can help residents feel refreshed and ready for the day. Good hygiene is an important part of meeting someone's basic physical and psychosocial needs.
- Hygiene tasks such as bathing, providing perineal care, and providing oral care will be done daily. Grooming tasks such as nail and hair care will also be done regularly. Always be patient, respectful, compassionate, and observant when providing care.
- Observe residents' skin closely, and report any signs of irritation or breakdown. Skin breakdown in the form of pressure injuries and ulcers is a serious problem, and is easier to prevent than to cure. Providing excellent skin care helps residents feel good, stay clean, and prevents infections.

Comprehension Questions

1) Write a paragraph describing how you would like to be woken up in the morning if you were a resident. What would you like the

NA to say to you, and how do you think you'd like to be interacted with? What care tasks would the NA perform as part of morning care?

2) Respond to the following sentences with T (true) or F (false).

- ___ Partial baths are best for residents who are energetic and mobile.
- ___ A complete bed bath is for someone who needs a full bath but cannot get out of bed.
- ___ Residents who are prone to tiredness and become dizzy easily are encouraged to shower.
- ___ Tub baths are good for people who can transfer into and out of the tub, and who prefer it to using a shower chair.
- ___ Partial baths include washing the face, underarms, hands, and perineal area.

3) What are some concerns to keep in mind when providing hygiene care? Select any that apply.

1. Make sure the water does not exceed 105 degrees.
2. Allow residents privacy while bathing by leaving the room. This helps maintain their dignity.
3. Promote the person's independence during personal care by prompting them to do as much of it as they can. Be patient during the process.
4. Always follow transmission-based precautions

4) When bathing someone, make sure to dry them thoroughly to ...

1. Help them stay cool and regulate their temperature
2. Prevent bacterial growth in moist areas of the body
3. Show them that you are caring for them
4. Prevent their linens from becoming damp and causing skin irritation

5) Why is oral care important? Select all that apply.

1. Oral care is important for health across the body, and helps prevent gum and heart disease
2. It's a fun experience having one's teeth brushed
3. It helps make a person more confident
4. It can make eating a more pleasant experience

6) A resident has developed a thick tangled matte of hair. What should you do?

1. Comb it out at all costs – if you pull the tangle out, the discomfort for the resident will be quick.
2. Cut it yourself while the resident is sleeping so they don't have to look at it.
3. Discuss it with the resident, and then shave their head.
4. Discuss the tangle with the resident and then tell the nurse about it for further planning.

7) Why do the feet of people with diabetes require special attention?

1. Their blood sugar builds up in their feet
2. They are highly resistant to infection
3. Poor circulation and a weakened immune system make them susceptible to infection
4. They need soft and thick socks with non-skid soles

8) If a resident has a stroke, then their impacted side will be called the ...

1. Worse side
2. Incapable side
3. Weak side
4. Impaired side

9) When observing and recording an existing wound, NAs must take note of...

1. The wound's color
2. The wound's size
3. The wound's sound
4. The wound's shape
5. The wound's origin

10) Respond to the following sentences with T (true) or F (false).

___ If a wound's dressing is damp or loose, it must be changed quickly.

___ Adhesive tape should be removed quickly and forcefully so make it as fast as possible and minimize resident discomfort.

___ NAs should make an informed decision about what dressing to bandage a wound with.

___ Skin tears are caused by lying in the same position for too long and cutting off circulation to a particular area.

___ Frequent repositioning and immediately addressing damp or wrinkled sheets are two ways NAs can help prevent pressure ulcers from forming.

11) Personal care relates closely to the Big Three. Why is providing good personal care such an important part of Resident Rights? Why is it a necessary consideration of Infection Control? What are some Safety considerations NAs must keep in mind while providing personal care, such as while bathing, shaving, and dressing residents?

12) Write a paragraph listing the four stages of pressure ulcers, and describe the characteristics of pressure ulcers at each stage.

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Module 8 – Nutrition and Fluid Balance

Learning Objectives

- Demonstrate understanding of good nutrition
- Demonstrate understanding of therapeutic diets
- Identify signs of dehydration
- Develop working knowledge of intake and output measurement
- Demonstrate understanding of alternative feeding methods

Nutrition and Diet

Resident Rights

A person's diet is important to their overall wellbeing and physical health. It is also important for mental wellbeing and cognitive function. Because nutrient consumption is so important to a person's health, NAs should try to make eating as enjoyable and fulfilling an experience for residents as possible. This means that personal, cultural, and social considerations are all at play.

NAs should do what they can to honor a person's dietary preferences. Not only does this lead to better health outcomes, because people are more likely to want to eat if eating is enjoyable, but it is also an important dimension of person-centered, holistic care. Being able to make choices about what one eats is a moment of agency in circumstances that otherwise may feel disempowering.



Cultural and psychosocial needs

A person must have access to culturally relevant food. If a resident does not have culturally affirming food options available at the facility, discuss with nurses so the facility can acquire some. Culturally affirming food choices for many patients and residents are often not available, despite the fact that having such food as option leads to better health outcomes and is legally required^[1].

Assist the resident in getting the facility to provide culturally appropriate meal options by requesting them from the nurse. Family members can also supply the resident with snacks and drinks that they enjoy.

Religion can also be a barrier to nutrient access in healthcare facilities. Practitioners of religions such as Judaism and Islam may uphold certain dietary restrictions, in this case Kosher and Halal respectively. Many religions involve fasting, or require vegetarianism.

If a hospital or facility does not have food that aligns with a person's cultural and religious values, they may choose not to eat

it. It is the facility and facility staff's responsibility to create conditions in which anyone can become and remain holistically well, regardless of their cultural background.

In long-term care facilities, mealtimes can be an opportunity for residents to wear clothes they like, sit with their friends (and make new ones), socialize, and share a communal experience. It helps a resident with nutrient consumption, and positively contributes to their overall quality of life, when they enjoy and look forward to meals. NAs should make conversation with the residents during meals, facilitate introductions, and include everybody at the table in conversation.

A resident's dietary needs will be communicated when they enter the facility, and will be included in their care plan. If you don't see any information about cultural, religious, or personal food preferences in a resident's plan, follow up with the nurse.

Nutrition

Nutrition is the process involved in the ingestion, digestion, absorption, and use of foods and fluids by the body. "Good nutrition" is when a person gets a sufficient amount of the right kinds of sustenance from their diet; in other words, they eat a well-balanced diet, their body can absorb what it needs to from the diet, and they consume the correct number of calories. Malnutrition occurs when a person does not absorb enough nutrients, whether because of their diet or a medical condition, and their body is weakened by insufficient sustenance.

Good nutrition is necessary for the body to function. It is also needed for new tissue growth and healing. A well-balanced diet supports immune health, mood and cognitive function, healthy elimination, a healthy circulatory system, and more. Nutrition is a consideration when providing holistic care because it is holistically important.

Insufficient nutrition, overconsumption of processed sugar and cholesterol, and lack of physical activity is linked to cardiovascular disease, diabetes, obesity, and osteoporosis.

Insufficient nutrition can contribute to many different health problems. While good nutrition can bolster the immune system, insufficient nutrition can increase a person's risk for infection and illness, and make any diseases they are already experiencing worse.

Whereas good nutrition allows a body to heal, insufficient nutrition can drag out a healing process or even inhibit it entirely. While good nutrition is important for cognition and awareness, malnutrition can negatively impact mental functions such as alertness, memory, orientation, decision-making, and mood regulation.

Nutrition in the geriatric population

The geriatric population will have a specific set of dietary needs and considerations.

As a person ages they lose some of their senses of taste and smell, and may find that they have difficulty swallowing due to slowed saliva production. They may also experience a lack of appetite from lowered physical activity levels.

Medications and illness may affect appetite, or the sensory experience of foods. Considering these factors emphasizes the importance of the NA's role in making eating a positive and enjoyable experience so that residents can continue to meet their nutrient needs.

Nutrients

Nutrients are different substances within foods and beverages that a human body needs to absorb in order to function. There are six basic nutrients: water, fats, carbohydrates, proteins, vitamins, and minerals^[2].

Water

Water is the most important nutrient and is essential for all bodily functions; it is an important part of our blood, keeps our cells healthy, helps our body filter out toxins, and assists in digesting food and absorbing nutrients. A person cannot live without

consuming water, and would die after only a few days without it. Water is key to all bodily systems and functions.

Fats

Fats are an important part of a balanced diet, and come in four varieties. There are saturated and trans fats, of which the body requires only a very small amount, and which can increase cholesterol levels and the risk of cardiovascular disease if over-consumed. Monounsaturated fats and polyunsaturated fats, by contrast, are necessary in the diet and decrease the risk of heart disease and diabetes. Some sources of essential healthy fats are avocado, nuts and seeds, olives, and fish.

Carbohydrates

Carbs are the body's primary source of energy, and are necessary for the body to metabolize other forms of nutrients. Carbohydrates such as whole grains and certain fruits and vegetables like corn and mango also contain fiber, which is important to healthy digestion and solid waste elimination.

Protein

Proteins are important for the body's tissue growth and repair, and are a substantial source of energy. Proteins are also important for blood health. Good sources of protein can be found in nuts, beans, seeds, peas, some grains such as quinoa, eggs, fish, and fowl.

Vitamins

Vitamins are essential substances that perform a variety of different functions, including the health of our immune system, supporting cognitive function, bone strength, the health of our mouths and teeth, and much more.

The body cannot produce most vitamins, and many vitamins can only be properly absorbed when eaten in the right amounts and in conjunction with other vitamins and nutrients. Some vitamins are fat-soluble, which means they can be stored in the body's fat tissue and used at a later time. Water-soluble vitamins are broken down by water and then any excess water-soluble vitamins are passed when the body eliminates.

Minerals

Minerals, like vitamins, cannot be produced by the body and must be acquired from outside sources in one's diet. Examples of minerals are zinc, sodium, and other electrolytes necessary to balance our blood. Minerals perform a variety of different functions in the human body from fluid balance and regulating blood levels to bone strength to energy levels.

USDA MyPlate

The US Department of Agriculture (USDA) developed the "MyPlate" system to help people determine what goes into a balanced diet for their age demographic. The USDA MyPlate icon is a visual representation of what a "healthy" plate looks like, in terms of the breakdown between fruits, grains, vegetables, proteins, and dairy^[3].

Some nutrition tips from myplate.gov geared towards older adult from plate are to eat a protein-rich diet to help maintain muscle mass and density, include fruits and vegetables as snacks between meals, and to eat plenty of protein and B12 fortified foods since the body's ability to absorb this necessary vitamin lessens with age.

The USDA MyPlate system divides a "healthy" plate into five basic food groups and visually represents them so that one half of a plate is made up of fruits and vegetables, the other half is made up of grains and proteins, and dairy is represented on a small plate to the side. It is a set of recommended dietary guidelines published by the US Department of Agriculture so the public can stay up to date on changes in our scientific understanding of nutrition and health.



USDA myplate. (n.d.). Retrieved May 24, 2023, from <https://www.myplate.gov/>

- **Fruits and vegetables** are an essential food group. An abundance of leafy greens, dark green, red, and orange vegetables and fruit is especially important because of their high vitamin and mineral content. The fruit and vegetable category includes all fresh, frozen, or dehydrated fruits and vegetables, including 100 percent juice. NAs should encourage residents to eat a wide variety of fruits and vegetables every day for their beneficial nutrients and fiber.
- **Grains** make up a little over a quarter of the MyPlate and are foods like rice, oats, and wheat. Many foods are made using grains including pastas, cereal, bread, tortillas, and various doughs. Grains are either considered “whole” or “refined.” When a grain is refined, its outer layers are removed and only the inside of the flowering plant remains. A whole grain is one where literally the whole grain is present; its outer layers remain, which makes whole grains more nutrient dense and rich in fiber.
- **Protein** is slightly less than one quarter of the MyPlate. Proteins come from plant-based sources, such as legumes, soy products like tofu and tempeh, and peas. Protein is also concentrated in animal products like seafood, eggs, poultry, lean meat and red meat. If consuming animal proteins, older adults should make sure to include sea food regularly in their diet because it has fewer health detriments than red meat, and is an important source of healthy fats.
- **Dairy** makes up the smallest portion on the MyPlate visualization. Dairy includes any foods made from animal milk, such as yogurt and cheese. Dairy can provide important nutrients for the body, such as vitamin D and protein. Products made from soy, nuts, and oats are healthier alternatives to dairy, especially when fortified with vitamins.

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Therapeutic Diets

It is the whole care team’s responsibility to make sure that the person being cared for has their nutritional needs met. This will especially involve the nursing team, doctor, dietitian, speech-language pathologist, occupational therapist, and potentially the person’s family. Sometimes a special therapeutic diet will be necessary to meet the person’s nutritional needs, or to work with a resident’s dysphagia.

Special diets are ordered for people who require a certain nutrient profile to achieve their care goals. Only a doctor can prescribe a therapeutic diet, and the special diet is then taken into account by the facility’s dietitians.

NAs must always ID residents before serving them their food, and check the resident’s ID to make sure it corresponds with the card on the meal tray. Serving somebody the incorrect food when they are on a special diet could produce serious health consequences.

Types of therapeutic diets

Doctors prescribe a wide variety of therapeutic diets. Some of these diets are intended to meet a person's needs around food consistency and swallowing, while other diets are designed to increase or decrease the amount of particular nutrients^[4]. Here are some common therapeutic diets it is useful for NAs to know about:

- Liquid diet: Only served liquid food. On a clear liquid diet the liquids are restricted to broths and juices, while on a standard liquid diet a person can have cream-based soups and ice cream.
- Soft diet: Only served foods that are soft and easily swallowed and digested.
- Pureed diet: Only served food that has been pureed into a grainy paste.
- Bland diet: No spicy or acidic foods or other foods that can irritate the digestive system.
- Lactose-free diet: Not served anything containing lactose. Lactose is a protein found in dairy products, and people who lack the ability to process this protein are considered lactose-intolerant. Some kinds of milk will still be allowed, such as lactose-free animal milk, or milk alternatives from soy, rice, oat, and nuts.
- High-fiber diet: An abundance of foods with high fiber, such as whole grains and raw fruits and vegetables. High-fiber diets can help with some digestive disorders and constipation.
- Low-fiber diet: Fiber intake is purposefully decreased by diminishing high-fiber food sources and eliminating foods with laxative properties like coffee and milk.
- Modified calorie diet: Caloric intake is raised or lowered depending on whether they need to gain weight or lose it.
- Low-sodium: Salt intake is restricted. This is an important diet for people suffering from heart or kidney disease. Sodium causes the body to retain water and places a higher workload on the human heart.
- High-protein diet: Prescribed for people who are recovering from wounds or another physical trauma. A person's protein intake is drastically increased.
- Fluid-restricted diet: Fluid intake is restricted. Be careful not to give a person on a fluid-restricted diet fluid-based foods such as ice cream and soup.
- High-iron diet: Iron intake is increased through foods like dark leafy vegetables, legumes, and iron-enriched whole grains.
- Diabetic diet: Insulin is an enzyme that helps the body convert sugar into energy. If a person's body does not produce enough insulin, as is the case with people with diabetes, then sugar can clog the blood and cause problems.
 - A person who has diabetes must closely monitor all of their nutritional intake, and carbohydrates, fats, and proteins must all be consumed in the proper relative amounts at the right times.
 - People with diabetes must avoid high-sugar foods, especially those made with processed and refined sugars.
 - NAs must always serve meals exactly on time for someone on a diabetes meal plan. NAs should carefully observe the intake of a person with diabetes to see what was eaten and what was left on the tray and report this information. NAs should also report observed changes in the person's eating habits.



Created by Loren Klein
from Noun Project

- Gluten-free diet: Some people cannot process gluten (protein found in wheat and some other grains) due to celiac disease or a gluten intolerance. Gluten is common in wheat products like bread, pasta, and crackers; it can also be found in most beers, and may be used as a filler ingredient in processed foods and beauty items.

- If gluten needs to be eliminated from a person's diet, they can turn to non-gluten alternative flours made from rice, almonds, oats, and others. The increasing recognition of celiac disease and gluten intolerance means that alternatives to gluten products have been becoming more available.

Gluten Free by Loren Klein from [Noun Project \(CCBY3.0\)](#)

- Vegetarian or vegan diet: A person may choose to uphold a vegetarian diet, or it may be prescribed for medical reasons. Vegetarian diets always exclude meat, though a pescatarian diet excludes all meat except seafood. A lacto-ovo vegetarian diet excludes all meat but includes milk and eggs. A lacto-vegetarian allows milk but excludes eggs, while an ovo-vegetarian excludes milk but allows eggs. A vegan diet excludes all animal products. People on vegetarian or vegan diets may need to take iron and B12 supplements.

Dysphagia

People who don't experience difficulties swallowing may take their ability to swallow easily for granted, but those with difficulties swallowing require special care from the care team. Difficulty swallowing is called dysphagia, and people with dysphagia must be evaluated by a speech-language pathologist to determine the proper course of care^[5].

Thickened liquids

People with dysphagia may be prescribed thickened liquids. This is because regular liquids, such as water and tea, can be difficult to swallow and harder to control by the mouth and throat muscles. Once a person is prescribed thickened liquids, the doctors, nurses, dietitians, and speech-language pathologist work together to determine the proper thickness to make the person's liquids. Thickened liquids travel slowly down a person's throat and decrease the risk of choking for people with dysphagia.

Liquids are either pre-thickened or have a thickening agent added to them. Thickened liquids will either come in a nectar consistency (a thick juice), a honey consistency (viscous like honey, pours slowly), or a pudding consistency (does not pour like a liquid – consistency of pudding). NAs must always be patient with people on thickened liquids, since getting through a thickened drink can take much more time than drinking regular water or soda.

NAs should never offer unthickened liquids, such as coffee and tea, to people prescribed thickened liquids. NAs should also remember not to leave a water pitcher in this person's room.

YouTube Video

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Foodservice express. (2011, April 1). Dysphagia – about thickened liquids [Video]. Youtube. <https://www.youtube.com/watch?v=UYBb4PrCTJk>

Signs, symptoms, & strategies

Observe residents when they eat, and report any signs of difficulty swallowing to the nurse immediately. Dysphagia can be extremely dangerous if left unaddressed. If NAs notice any of the following problems while a person eats, they should report it immediately:

- Avoiding eating or eating slowly and with observable difficulty or anxiety
- Spitting food out, or small bites of food and/or pills remaining uneaten
- Saliva dribble
- Vomiting, or food/fluid exiting or entering the nostrils during consumption

- Coughing, choking, and difficulty breathing
- Eyes watering during food or fluid consumption

Difficulties swallowing puts somebody at risk for choking; they must be monitored closely during the eating process. Aspiration refers to the inhalation of food or fluids (including bodily fluids) into a person's lungs; aspiration can cause serious problems, including choking and pneumonia, and can lead to death. To prevent choking and aspiration, NAs can deploy some of the following strategies:

- Make sure that person is in a 90 degree position sitting upright. A person is more likely to aspirate if they are reclined.
- NAs should be slow and methodical when feeding somebody, alternating between food and drink in small amounts.
- Both the NA and the person eating should focus on eating; distractions increase the likelihood of choking.
- Make sure that the person completely swallows their food before offering more. Check non-invasively – never stick fingers in the person's mouth.
- Closely observe a person the whole time they are eating. Report signs of difficulty and discomfort immediately in case intervention is necessary.

NAs must always exercise patience, composure, and kindness when helping a person eat. If the person requires assistance and the NA is rushed the person's emotional wellbeing be compromised and a negative association formed around mealtimes. A rushed NA is a safety hazard, because it increases the likelihood of residents choking and aspiration, and makes the NA less likely to closely observe the person as they eat.

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Appetite & Comfort

A person's appetite is distinct from their need for food. Appetite refers to a person's desire for food and their drive to consume it, not just the need for nutrients. Many different factors can impact a person's appetite. These are some factors that can negatively impact a person's desire to eat:

- Weakness, illness, and confusion or disorientation
- Unpleasant odors, sights, or sounds. Making sure the person's space is as comfortable as possible helps make eating a pleasant experience.
- Uncomfortable positioning. Make sure the person is physically comfortable and safely positioned when they eat.
- The need for oral hygiene can impact a person's appetite. If a person finds eating difficult or unpleasant due to sensations in their mouth, NAs can report this to the nurse and alternative mouthcare strategies can be implemented.
- The need to eliminate. Always offer the bathroom before mealtime.
- Pain negatively impacts appetite.

Promoting appetite

NAs can do lots of things to promote general comfort and help make mealtimes an enjoyable experience for residents.

- Always help a resident use the bathroom before and after meals.
- Provide some oral care prior to meals by making sure that the resident's dentures are fixed in place and free of debris.
- If a person experiences incontinence, make sure they are clean and dry before their mealtime.
- Make sure the person is positioned safely and comfortably for their meal at an upright 90-degree angle at table height. Sometimes tables or wheelchairs will need to be adjusted for a resident to eat comfortably.
- Make sure the resident has any assistive devices they need, such as hand-grips for silverware.
- Give residents as much say in their meal experience as possible. This includes their choices on what and how much to eat,

and where and with whom to sit.

- Try to make eating a positive experience for residents, and always conscientiously practice patience. Remain positive and conversational throughout the meal, encourage positive socializing at the table, and assist the person as discretely as they can to ensure the resident's dignity and sense of independence.
- Assist the resident with handwashing before and after their meal.

When assisting someone with visual impairments, describe the person's plate of food including the type of food and its location. Always describe what is on the food tray. If the NA is feeding the person, they should describe what is on each bite. If the person is able to feed themselves, describe the food on the whole tray and describe its location using the numbers on the clock. For example, "peas at 9 o'clock, and mashed potatoes at 6 o'clock."

Dehydration

Fluid balance

Water is essential to survival. Every single part of the human body needs water to function. Human bodies use water, and then get rid of it through sweat and elimination. An adult needs at least 1500 mL (milliliters) of water per day to survive (50 oz, or about 6 glasses of water), but should ideally have between 2000 and 2500 mL of water (about 66 – 83 oz) per day, or about 8 – 10 cups.

As a person ages their awareness of their own thirst can diminish, so NAs may need to prompt residents to drink so they do not become dehydrated.

A person's daily water requirement can change depending on variables like hot weather, activity levels, illness and fever, fluid loss, medications, and age.

A person's fluids must be balanced in their body. Dehydration is when a person's body does not have enough fluid in it. Water retention edema, by contrast, occurs when somebody has too much fluid in their body, a condition in which a person's body retains too much water.

Water retention edema

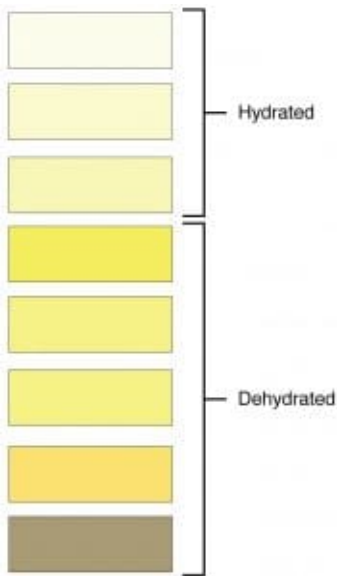
Water retention edema can be uncomfortable; symptoms include bloating and increase of size in the abdominal area, swelling and puffiness of the arms and legs, shiny skin, heavy legs, and skin that holds a dimple after being pressed^[6].

If the resident experiences shortness of breath, an irregular heartbeat, or chest pain, it could indicate fluid buildup in the lungs. Edemas can be caused by a number of factors, including being sedentary, consuming too much salt, and taking certain medications. If the NA notices any signs of edema water retention, especially stretched and shiny skin and if the skin holds a dimple after being pressed, then they should report it to the nurse immediately.

Symptoms of dehydration

If fluid output exceeds fluid intake, then dehydration occurs. Remaining properly hydrated is necessary for a person's health, especially as they age. Peoples' hydration needs can vary a lot depending on age and activity level, though a general guideline for daily water consumption is about 64 oz^[7].

As people age they become less thirsty, but that doesn't mean they need less water. Sometimes a doctor will prescribe "force fluids" for a resident, which just means that they should be regularly encouraged to drink. If NAs notices the resident exhibiting signs of dehydration, they should report it immediately.



A resident may be dehydrated if:

- The resident drinks little throughout the day, and doesn't drink at meals
- The resident has difficulty drinking from cups unassisted, experiences dysphagia, or is disoriented
- The resident frequently expresses being thirsty
- Diminished urine production
- Dry mouth and cracked lips
- Constipation
- Dark and strong-smelling urine
- Feeling weak, dizzy, disoriented, and irritable

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NAs are responsible for making sure residents maintain proper fluid balance. NAs should encourage residents to drink by regularly offering them fluids they like and knowing how residents like to consume fluids (ie, with or without ice, in a specific cup, etc).

Always check the care plan to see whether a person needs their liquids thickened, and always follow the posted schedule for routine fluid consumption. Ice chips and ice sticks can be offered to residents who need fluids but have a difficult time consuming them in large enough quantities in liquid form.

Fluid-restriction

Many people will require encouragement to stay adequately hydrated. However, some medical conditions will require a fluid-restricted diet, or NPO, an acronym for the Latin words for “nothing by mouth.” NPO is the most restrictive kind of fluid-restricted diets.

On a fluid restricted diet, the person will consume few if any liquids by mouth. They can drink, but only up to the point permitted by the doctor's order.

If the person is prescribed NPO, they cannot consume any liquids and will instead receive their hydration and nutrients through their IV line. A person is put on NPO for a variety of reasons, such as preparing for or recovering from surgery, or another medical test or procedure. A person on NPO is not even permitted chewing gum.

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Intake and Output (I&O) Measurement

A doctor or nurse may order that Intake and Output (I&O) measurements be kept on a patient. I&O means that the facility keeps track of all of the fluids that go into a person's body and all of the fluids that come out. I&O records are kept to help the facility evaluate fluid balance and kidney function, to help plan medical treatment, and when the person has a special fluid order^[8].

When taking intake, NAs should measure all of the fluids the person takes by mouth, as well as any fluids they take in through IV fluids and tube feedings. "Fluids" refers to all liquids, some solids like gelatin, and any food that melts at room temperature.

Output of course refers to urine, as well as vomit, diarrhea (not solid feces), and drainage from wounds. "Fluid balance" is achieved when a person's intake and output are roughly equivalent.

Recording I&O

An I&O record is a series of tables that a facility uses to track all of a person's fluid intake and output over 24-hour periods. All I&O measurements are taken in milliliters (mL), which is 1/1000th of a liter. One ounce is equal to thirty milliliters, or 1oz = 30 mL.

NAs must be able to perform conversions between ounces and milliliters (abbreviated as mL or cc), because some fluids may be measured in ounces. For example, if the NA serves a patient 8 ounces of water, and the patient consumed about 6 ounces, then the intake would be recorded as 180 mL ($6 \times 30 = 180$). A helpful tip for making quick mental conversions using the multiplier 30 is to multiply the number by 3 and then add a zero to the end. In the above equation, this would look like $6 \times 3 = 18$, and then adding the zero so the final answer is 180.

NAs will a tool called a graduate to measure fluids. A graduate looks like a large cup with a handle and a pitcher tip, and will be marked using lines labeled with measurements in milliliters and ounces.

Calculating intake

Intake measurements are taken right after the person is served a meal, snack, or drink. Once the person is finished with their food and/or drink, take note of how much food or drink there was originally – for example, if the resident was served 4 ounces of ice cream and an 8 oz cup of tea, then 12 ounces of fluid was served.

Once the person is finished, gather whatever fluid went unconsumed, measure it, and then subtract that number from the total amount of fluid served. The total fluid minus the remaining fluid will yield the amount of fluid the person has consumed. Or, T (total) – L (leftover) = C (consumed).

1/8th cup = 1 oz = 30 mL

1/4th cup = 2 oz = 60 mL

1/2 cup = 4 oz = 120 mL

3/4 cup = 6 oz = 180 mL

1 cup = 8 oz = 240 mL

1 ¼ cup = 10 oz = 300 mL

1 ½ cup = 12 oz = 360 mL

2 cup = 16 oz = 480 mL

3 cup = 24 oz = 720 mL

4 cup = 32 oz = 960 mL

So, let's say that after 4 oz of ice cream and 8 oz of tea were served, the person has 1 oz of ice cream and 2 oz of tea leftover. First, we should put the numbers in milliliters: 1 oz x 30 = 30 mL, and 2 oz x 30 = 60 mL, and 30 + 60 = 90 mL. So 90 mL is the leftover. 12 oz x 30 = 360 mL is the total. So if T - L = the total fluids consumed, then 360 - 90 = 270 mL of fluid consumed.

To properly tally I&O at mealtimes, NAs will need to know the volumetric servings of facility dishware such as cups, bowls, dishes, pitchers, and glasses. For example, usually a cup of water is 8 oz, or 240 mL, while a bowl for cereal and milk will be about 5 oz, or 150 mL. Dish, bowl, and cup volume may vary depending on the facility.

The serving amounts for the facility dishware will likely be listed on the I&O sheets; if they are not, always follow up with the nurse to make sure I&O records are performed correctly.

Measuring output

To measure output, use a graduate and whatever device the person uses for urinary elimination, such as a handheld urinal, bedpan, or commode. Plastic urinals and basins for collection will likely have mL amounts marked.



Image by Laboratoires Servier, [CC BY-SA 3.0](#),

After performing the opening procedure, empty the contents of the person's voiding device into the graduate, being careful to make sure that no fluid is lost to spillage or splashing.

After carefully remembering the accurate measurement, pour the urine down the toilet, rinse the graduate and the urinal/bedpan and store them to be cleaned, and perform the closing procedure. Finally, record the output amount and the time it was taken.

I&O measurement for each patient is totaled at the end of each shift.

YouTube Video

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RegisteredNurseRN. (2018, February 26). Intake and Output Nursing Calculation Practice Problems NCLEX Review (CNA, LPN, RN) I and O [Video]. Youtube.

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Assisting with feeding^[9]

Persons with weakness, paralysis, casts, confusion, and other conditions may require assistance when feeding; this information will be included in their care plan and on the diet card that accompanies their meal tray.

Passing out food

When passing out food, the NA should make sure that residents who can feed themselves safely are helped first, while those who need high levels of assistance should only be given food once the NA can devote full attention to them. If a resident who requires assistance eating attempts to eat on their own, it may put them in an undignified situation or create a choking and aspiration risk.

If a resident requires food to be pureed, NAs should still refer to that food by its actual name, i.e. “steak” or “carrots,” even if the food may look like an indiscriminate mush.

Residents have rights around meals, such as a right to choose what they eat and drink, and a right to choose whether or not to wear a clothing protector.

Food should be served as quickly as possible so that it is appetizing for the resident. Food also must be served and eaten promptly because food that is allowed to sit at room temperature becomes a safety hazard and may induce foodborne illness. Serving food promptly helps minimize the risk of pathogens entering a person’s body through their meal.

Food safety

To keep food safe, people who handle food should wash their hands often, and keep countertops and food preparation sites as clean as possible. Different foods should stay separated to avoid cross-contamination.

Food must always be cooked thoroughly and to a safe internal temperature; if re-heating a dish, it should be re-heated to at least 165 degrees Fahrenheit. Once prepared, food should be refrigerated or frozen with two hours, or within one hour if the room is

warm.

Helping someone to eat

When helping a person eat, the NA should give that person their total and full attention. Not paying full attention to a person can result in missing an important sign of difficulties eating.

It is also important from a holistic health perspective; if the NA is constantly distracted or devoting their attention elsewhere, the person needing assistance may feel like a burden, or will be less likely to ask for help when they need it.

Always be patient when assisting somebody with meals. It is a resident's right to take as much time as they want to with their meal, and not to be rushed.

Even if a person requires substantial assistance with eating, the NA should do everything they can to encourage the person to perform actions independently if possible, such as holding and using a napkin.

Always directly face a resident while the resident is eating. This is so the NA can pay close attention to the resident in case they have any issues chewing or swallowing, and so the resident knows they are attended to and taken care of. Face-to-face contact can put a person at ease, and make them know they are cared for; somebody who is being fed but who needs to communicate something will use their eyes and face, so it is important that the NA is paying close attention and looks directly at the resident.

YouTube Video

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Chippewa Valley Technical College. (2022, December). Preparing Clients for Meals and Assistance with Feeding. [Video]. YouTube. Video licensed under [CC-BY-4.0](#).

Nutritional support

If a person can't eat, or can't eat enough, then they will require nutritional support and may need IV therapy. Enteral nutrition is the term for supplying a patient with nutrients using a tube that has been inserted into their gastro-intestinal (GI) tract. Gavage is the process that occurs when a person receives a feeding through their tube.

People using feeding tubes will be given formula; the type, amount, and scheduling will be prescribed by the doctor and included in the care plan. Enteral nutrition formula is only given at room temperature; don't heat or chill it. The nurse will provide scheduled feedings with a syringe, or a feeding bag. If continuous feeding is ordered, the person will receive a steady supply of formula over 24 hours through the use of a feeding pump.

There are different kinds of tubing available depending on how the person needs to be fed.

- **Naso-gastric** (NG) tube: feeding tube is inserted through the nose, down the esophagus, and into the stomach.
- **Naso-enteral** tube: feeding tube is inserted through the nose and extends down into the small intestine.
- **Gastrostomy** tube: the doctor surgically creates an opening into the person's stomach and inserts the feeding tube directly into the person's stomach. A gastrostomy is a surgical opening that leads into a person's stomach.
- **Jejunostomy** tube: the feeding tube is inserted into a jejunostomy, or a surgical opening at the upper portion of the small intestine.

In Illinois, NAs will never insert feeding tubes, clean feeding tubes, or provide feedings through feeding tubes. They will likely

assist the nurse with performing some of these actions though. Always closely follow instructions when assisting the nurse.

NAs will need to be conscious of the tubing when they provide care. Make sure that the area around the tubing is cleaned frequently, and apply lubricant to keep the area free from chapping and dryness. NAs should make sure the tubing is smooth, free of kinks and wrinkles, and securely in place. Always check in to make sure that the person is comfortable and calm.

Complications

Report to the nurse if anything seems wrong with the person or the person's tubing, such as the tubing having come undone, respiratory difficulty, aspiration, signs of infection at the tube site, or any sources of irritation or discomfort for the person.

Report any irregularities and signs of unwanted side effects immediately. Symptoms of enteral nutrition complications include:

Avoid placing a person using feeding tubes in the left side-lying position. This positioning can lead to an increased risk of regurgitation.

- nausea
- discomfort
- vomiting
- abdominal swelling
- coughing
- complaints of indigestion or heartburn
- fever
- respiratory distress
- increased pulse
- complaints of flatulence
- diarrhea

Nasal feeding tubes can irritate and create pressure on the nose, alter the shape of a person's nostrils, and create pressure ulcers. NAs should report any irregularities to the nurse as soon as possible.

Aspiration is a major risk when a person is being fed through a tube. Aspiration can occur during the tube insertion, if the tube is moved out of place, or if formula is regurgitated.

NAs can help prevent aspiration by placing the person in Fowler's or semi-Fowler's position before they are fed, and maintaining Fowler's or semi-Fowler's for a while post-feeding. Always follow the care plan and nurse's directions when assisting a person who uses feeding tubes.

Parenteral nutrition

Parenteral nutrition is similar to enteral nutrition, except rather than a feeding tube that leads to the person's GI tract, nutrients will be provided for the person through a catheter inserted directly into a vein. In this case, nutrients never pass through the person's GI tract at all and instead the nutrient solution is given directly into the person's bloodstream. This is also called "total parenteral nutrition" or "TPN." TPN is used when the person cannot receive oral or enteral feedings.

NAs are never responsible for TPN care or performing any of the functions of TPN. The NA's role with persons who need TPN is to assist with basic needs and ADLs, and to carefully observe the person for any adverse responses to their TPN.

Report any adverse responses to TPN promptly, including:

- fever and chills
- signs of infection
- chest pain
- difficulty breathing
- nausea and vomiting
- diarrhea

- thirst
- irregular heartbeat
- weakness
- sweating
- paleness
- trembling
- disorientation or behavior changes

Patients using an arterial catheter or an IV line are at increased risk for infection, so any signs and symptoms of infection must be responded to quickly.

IV Therapy

IV therapy is the administration of fluids directly into a person's bloodstream. IV therapy may be ordered for a person when they are unable to drink regularly, for people who need to rapidly replenish vitamins and minerals, to provide sugars, or to give a person blood or drugs.

NAs are not responsible for IV therapy, and should always closely follow the nurse's instructions when caring for somebody receiving IV therapy.

Intra-venous lines are either peripheral or central. A peripheral IV is located away from the center of the body, such as in a person's hand or calf. A central IV is located close to the person's heart.

A central venous line is a kind of catheter than is inserted into a persons chest or upper respiratory area to make IV lines more convenient. They are used when somebody needs IV therapy for a long period of time or frequent blood drawings. Central venous sites are used for parenteral nutrition, providing large amounts of fluid, long-term and repeated IV therapy, and to administer some drugs.



NAs must maintain rigorous safety standards when caring for people receiving IV therapy. NAs should never change the position of the IV clamps or adjust any controls on the IV pumps. If they accidentally bump the machine or nudge the IV out of place, they should record the incident and tell the nurse immediately.

- Tell the RN immediately if no fluid is dripping from a person's IV line, or if the rate of fluid is too fast or too slow. There will be a "time tape" on the IV bag to display how much fluid should be given over a period of time. If the fluid does not match the time tape, tell the nurse at once.
- NAs will *never* be responsible for starting or maintaining IV therapy, regulating the IV flow rate, changing the IV bag, or giving blood or drugs through an IV line. Your responsibility will be to clean the area around the IV site and to make the person as comfortable as possible.
- Always ask for help or clarification if you are unsure about how to perform a delegated task, or whether the task falls within your scope of practice.

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Key Takeaways

- Good nutrition is key to holistic health. Malnutrition negatively impacts every system in the body, including mental and psycho-social wellbeing. Good nutrition involves absorbing adequate amounts of essential nutrients like water, proteins, fats, vitamins, and minerals.
- Therapeutic diets may be necessary for residents with specific dietary needs or preferences, dysphagia, diabetes, or other conditions. Always check the care plan to see whether a special diet is ordered; when a resident needs a special diet, be especially careful that they only receive food that accords with their diet.
- Our bodies need water to function; dehydration can be an extremely dangerous condition. As a person ages their sense of thirst diminishes, but their need for water does not, which leaves them prone to dehydration. If residents display signs of dehydration, report it to the nurse immediately.
- NAs will need to keep track of fluid intake and output (I&O) for some residents. I&O measurement involves tracking all of the fluids that somebody consumes orally or by IV and tube feeding, and all of the fluids that they release through urinating, vomiting, and diarrhea.
- Residents may require the use of alternative feeding methods when they cannot consume any or enough nutrients using conventional means. Some often used alternative feeding methods include enteral and parenteral nutrition. Enteral nutrition is supplying someone with nutrients through tubing that leads into their gastrointestinal tract. Parenteral nutrition involves supplying someone with nutrients through a direct line into their bloodstream, bypassing the GI tract entirely.

Comprehension Questions

1) If a facility does not have food that meets someone's culturally relevant preferences or religious diet, the facility should ...

- Ask the resident's family to supply their meals
- Suggest that the resident alters their diet so they can remain nourished in their new circumstances
- Adhere to the resident's right by procuring culturally or religiously appropriate food
- Do nothing

2) Malnutrition refers to ... (Select the best answer)

- Consistently eating fewer calories than recommended
- Absorbing less nutrients is than necessary to remain healthy
- Drinking too little water and eating too few vitamins and minerals
- Eating too many unhealthy foods

3) Respond to the following sentences with T (true) or F (false).

___ The six basic nutrients are water, fats, carbohydrates, protein, vitamins, and minerals.

___ A healthy, balanced diet contains more protein than carbohydrates.

___ Fruits, vegetables, and whole grains are good sources of fiber.

___ A human body's ability to absorb nutrients increases with age.

___ Fortified dairy alternatives from soy, oats, and nuts are healthy alternatives to dairy.

4) What are some signs and symptoms of dysphagia? Select all that apply.

- a. Excessive hunger and eagerness to eat
- b. Coughing or choking during food or fluid consumption
- c. Saliva dribble
- d. Pausing in between bits of food
- e. Anxiety around or during meal times

5) When providing nutrition assistance to someone with visual impairments, NAs should ... ?

- a. Vividly describe the color of the food
- b. Say "here comes some good food" when feeding the resident an especially delicious bite
- c. Describe the location of the food on the plate using the face of a clock, and describe the food in an appetizing way
- d. Check the resident's ID at least three times

6) If a resident receives 12 oz of fluid from an IV bag, drinks a 10 oz milkshake, and drinks 2 cups of green tea, what is their total fluid intake in mL?

- a. 1,130
- b. 1,170
- c. 1,140
- d. 1,200

7) If a resident drinks one cup of water, eats a grilled cheese sandwich with one cup of liquidy tomato soup, and finishes it off with ½ cup of ice cream, what is their meal's total fluid intake in cc's?

- a. 1,000
- b. 930
- c. 960
- d. 900

8) If a resident receives 900 mL of fluid from an IV bag, leaves two ounces of juice in a regular sized cup after drinking the rest, and then drinks a 10 oz mug of hot cocoa, what was their total fluid intake in mL for the afternoon?

- a. 1,400
- b. 1,380
- c. 1,320
- d. 1,290

9) If a resident eats a 4 oz cup of jello and one cup of ice chips, leaves 3 oz in a cup of coffee, receives 10 oz of fluid from an IV, and voids 200 mL of urine, what is their fluid intake in mL?

- a. 610
- b. 600
- c. 810
- d. 840

10) Respond to the following sentences with T (true) or F (false).

___ NAs may be responsible for inserting cleaning feeding tubes if the task is properly delegated.

___ Residents only have a limited time window where the NA will be able to assist them with their meal, so they should eat quickly to accommodate the staff's schedule.

___ Residents receiving naso-gastric enteral nutrition will require especially attentive skin care around their nose.

___ "TPN" stands for Total Parenteral Nosh.

___ NAs will never be responsible for beginning or adjusting IV therapy.

11) Nutrition and fluid balance deals closely with the Big Three, especially concerning matters of Resident Rights and Safety. What is at least one example of an important Resident Rights consideration when facilitating a resident's nutrition? What is at least one example of a safety consideration when facilitating a resident's nutrition and fluid balance? As a nursing assistant, how would you handle each consideration listed?

12) You are assisting a resident with their meal in a common area. The resident likes to eat in their geri-chair; today they are experiencing a lot of back pain, and ask if they could please recline to a 60-degree angle to eat their meal. How would you respond to the resident and why?

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Module 9 – Elimination

Learning Objectives

- Demonstrate understanding of normal urination and urinary incontinence
- Demonstrate understanding of catheter care
- Demonstrate understanding of normal bowel elimination and bowel problems
- Demonstrate proper specimen collection

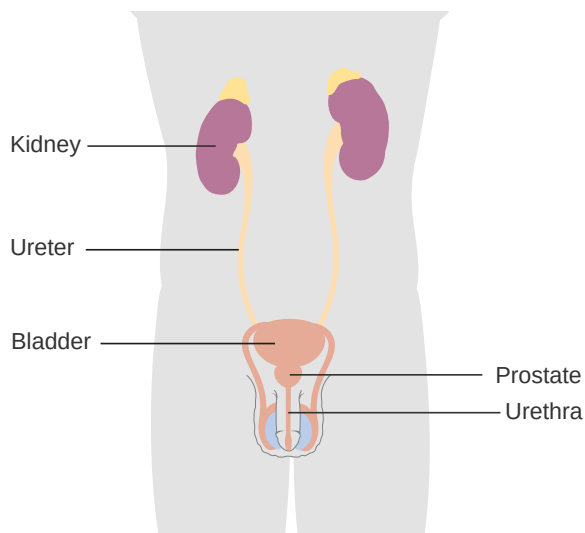
Urination

The urinary system

The urinary system is extremely important to a person's overall health. It filters the blood, helps humans absorb nutrients, balances fluids, and facilitates the disposal of liquid waste. The urinary system consists of two kidneys, two ureters, the bladder, and the urethra.

Our kidneys are our body's filters. They filter the blood so it's free from toxins and waste, and are important for regulating the body's mineral and electrolyte balance and fluid amount.

Our kidneys are bean-shaped, lay towards the back of our abdomens and are roughly the size of one's palm.



Kidneys filter out usable material (nutrients, minerals, etc) from liquid waste, which it then turns into urine. Kidneys then send the urine to the bladder through ureters; each kidney has its own ureter, or the tubes that carry urine from the kidneys to the bladder.

Once the urine is in the bladder it remains there until the bladder reaches a certain fullness, when the bladder will tell the brain “I’m full, please pee” and the person develops the urge to urinate.

When the person decides to release their urine then their urinary muscles relaxes and allow urine to pass through to the urethra. The urethra is the tube that runs from the bladder to the meatus, or the external urinary opening. Image by Cancer Research UK, [CC BY-SA 4.0](https://creativecommons.org/licenses/by-sa/4.0/).

Healthy urination

Normal, healthy urine will mostly consist of water. It will be a pale-yellow, although its color can change depending on a person's hydration, medications, or diet^[1]. For instance, someone who eats beets may have a reddish hue to their urine; someone who has recently eaten asparagus may have urine with a pungent smell.

Urine should not be cloudy; healthy urine is clear, with a faint but discernible smell. If the NA notices that a person's urine is cloudy right upon voiding (another word for urinating) then they should tell the nurse at once. Cloudy urine or urine with particulates indicates the possible presence of infection.

Healthy adults produce about 1500 mL (50 oz) of urine per day, though this amount can vary with age, activity levels, and health.

Urination should be painless, and should contain only urine. If the person's urine appears to contain blood, mucus, pus, or particulate, the NA should report it to the nurse right away. Also report any strong or foul-smelling urine, painful urination, incontinence, and abnormally frequent urination.

Factors influencing urination

A person usually voids at bedtime, upon waking, and before meals. Others may urinate as frequently as every 2 – 3 hours. Some people can use the bathroom on their own, while others require assistance. NAs must always respond to bathroom requests as quickly as possible. Lots of different factors impact urinary health.

Age: As a person ages, their bladders become less flexible and their capacity diminishes. This means that older adults will need to urinate more often than they did when younger. As a person ages, they also become less likely to completely empty their bladder when voiding, which results in more frequent trips to the bathroom and heightens the person's risk of infection. NAs should prompt residents to consume fluids and make sure that the person's bedside water pitcher is always replenished.

If a person's call light is on, respond as quickly as possible, since it may be a bathroom request. NAs should not expect people to "hold it," since this is uncomfortable, undignified, and can lead to bladder infections and "accidents."

Emotions: Stress, anxiety, and depression can all have an impact on a person's urination. For example, a lack of privacy can lead to altered urination habits. The stress of moving into an assisted living facility and feeling uncomfortable around so many new people may cause someone to urinate more frequently in smaller amounts. Always provide privacy, exercise patience, and make sure that residents know that NAs are there to assist them in a friendly and non-judgmental way.

Thirst: Thirst diminishes as a person ages. If someone is not thirsty then they are less likely to drink, which means that their urinary system may suffer. Maintaining good hydration is necessary for the body's ability to filter its blood. NAs should encourage people to consume water and other fluids often.

Muscles: As a person ages their muscles weaken and their muscle tone diminishes; good muscle tone is helpful for controlling the flow of urine. NAs can promote the muscular dimension of healthy urination by encouraging ambulation and other forms of exercise. Activity is important both because it helps maintain muscle tone and helps a person become thirsty.

NAs should always respond to requests to use the bathroom as quickly as possible. This is essential for preventing urinary infections. It is also important for keeping a person generally comfortable, and psychologically and emotionally well. Person-centered, holistic care requires attending to a person's basic needs promptly.

Promptly assisting residents with their bathroom needs closely relates to all three dimensions of the Big Three. How does assisting residents with urination relate to Resident Rights, Infection Control, and Safety? Write for 5 minutes, and discuss your response with a friend or classmate.

Reporting & Recording

Reporting and recording when somebody urinates, the quality of the urine, and any other relevant details will be an important task for NAs. These are some useful vocabulary words for talking and writing about urination^[2]:

- Dysuria: painful or difficult urination
- Hematuria: blood in the urine
- Nocturia: frequent urination at night
- Polyuria: voiding abnormally large amounts of urine
- Oliguria: scant amounts of urine, less than 500 mL in 24-hour period
- Urinary incontinence: losing control of one's bladder
- Urgency: needing to void immediately
- Frequency: urinating often with little time between one voiding and the next

NAs should report and record meticulously. Healthy urination, or lack thereof, can give the care team clues as to what may be wrong with someone. It is also important to address complications with urination quickly, and to include strategies for promoting healthy urination in someone's care plan.



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Signs of unhealthy urination include:

- swelling in the hands and feet
- painful urination
- changes in the qualities of urine
- changes in frequency or amount of urine
- abdominal swelling
- pain in the bladder area
- urinary incontinence including dribbling
- back pain, which may be related to a kidney disorder
- inadequate fluid intake

If anybody in your care exhibits these symptoms, alert the nurse promptly.

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Urinary Disorders

Urinary disorders are common among older adults, and vary in severity. Some especially common disorders of the urinary system include an enlarged prostate, urinary tract infections, kidney infections, kidney stones, and urinary incontinence^[3].

Enlarged prostate

Benign prostatic hypertrophy commonly occurs in older persons with a penis and a prostate. It involves the enlargement of the prostate gland, located in the groin between the rectum and the base of the penis. When the prostate enlarges it squeezes the urethra and blocks the urine.

Symptoms of an enlarged prostate include:

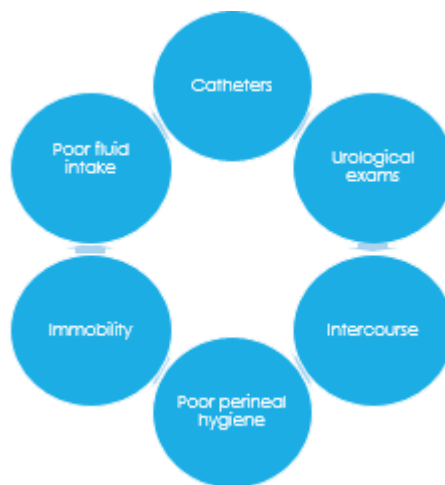
- a weak stream when urinating
- frequent urination in small amounts
- urgency
- leaking or dribbling
- nocturia
- urinary retention or inability to void

UTIs

Urinary tract infections (UTI) occur when pathogens reproduce along the urinary system. UTIs usually begin when a pathogen enters the body through the urinary opening. UTIs are a common healthcare acquired infection (HAI), and if left untreated can lead to kidney infections and death. If a person experiences symptoms like frequent painful urination, seems confused or disoriented, or has blood in their urine, the NA should alert the nurse immediately.

When they are HAIs, UTIs are usually acquired by the use of catheters, or by bacteria acquired during urological exams. Other causes of healthcare acquired UTIs could be from poor perineal hygiene, immobility, and poor fluid intake.

Meticulous perineal care and proper catheter care are essential to preventing UTIs. A person can also develop a UTI from sexual intercourse. NAs should encourage sexually active residents to urinate shortly after intercourse to help prevent UTIs.



[4]

Treatment for UTIs always involves drinking lots of fluids, and may also involve medication.

Kidney disorders

Kidney infection

Pyelonephritis is the medical term for an infection in the kidneys. Kidney infections are serious and can be life-threatening. They are also extremely uncomfortable.

Symptoms of pyelonephritis include:

- chills
- fever
- back pain
- nausea
- vomiting

Since kidney infections can follow UTIs, looking for the symptoms of UTIs can help provide warning signs of a kidney infection. Treatments for kidney infection include powerful antibiotics and increased fluid intake.

Kidney stones

Kidney stones occur when crystals form in the kidneys, creating deposits as small as sand and as large as a golf ball. Some kidney stones will pass through the urinary system on their own, which is a notoriously agonizing process. Others require medical interventions like surgery.



“Kidney Stone” by [peterjr1961](#) is licensed under [CC BY-NC 2.0](#).

Common risk factors for calculi, the medical term for kidney stones, are bedrest, immobility, and poor fluid intake. Kidney stones most commonly occur in people over the age of 40. Symptoms of kidney stones include an intense ongoing pain that becomes worst during urination. Other symptoms include fever, chills, dysuria, and hematuria.

Treatment for kidney stones involves pain medication and increased fluid intake. It may also include straining the person’s urine to see whether the stone passes on its own. If a kidney stone is too large to pass, it may require surgery.

Urinary incontinence

Urinary incontinence occurs in people when they lose control over their bladder. Urinary incontinence can occur due to paralysis, surgery, illness, and other factors. Whatever the reason, NAs must always be respectful and professional when caring for somebody

experiencing incontinence.

Many people find experiencing incontinence uncomfortable and embarrassing. A person experiencing incontinence will need empathy, understanding, and reassurance. Maintain a positive attitude and respond promptly to bathroom requests or cleaning needs from residents experiencing incontinence.

Safety is an essential consideration. If somebody is incontinent, they may have an urgent need to relieve themselves; this can make a person who usually needs assistance attempt to get to the bathroom without assistance. NAs should respond to call lights from people experiencing incontinence immediately to avoid a situation where somebody tries to get to the bathroom unassisted, is forced to retain their urine for longer than is comfortable, or risks voiding while in bed.

There are six general kinds of incontinence^[5]:

- **Stress incontinence:** incontinence due to pressure in the abdomen, caused by something like laughing, hiccupping, sneezing, or any action that causes the abdominal muscles to clench.
- **Urge incontinence:** accidental voiding due to a sudden urge and need to urinate.
- **Mixed:** incontinence as a combination of stress and urge incontinence
- **Functional incontinence:** urinating because of a reason other than the urinary tract, such as environmental or cognitive feature. Urinating out of fear would be an example.
- **Overflow incontinence:** incontinence caused by an overflowing or swollen bladder.
- **Reflex incontinence:** urine is lost at predictable times when the bladder is full, but the person doesn't experience the need or urge to void.

The goal of caring for somebody experiencing incontinence is to prevent UTIs, practice infection control and resident rights by addressing wet linens, and to restore the urinary system to proper functioning. Never make somebody feel embarrassed or like a burden because of incontinence – all residents have a right to dignity and respect.

Incontinence can be emotionally taxing. It may impact a person's dignity and self-esteem, which can lead to social isolation, a diminished sense of independence, and depression. The quality of life of somebody who cannot reliably control when they go to the bathroom will suffer. These feelings will understandably be met with sadness and frustration. Always be kind, courteous, and understanding with people experiencing incontinence.

Caring for somebody experiencing incontinence means NAs are paying close attention to that person's skin care, particularly in regions that are affected by incontinence episodes. NAs should never let a person sit in wet linens, since this causes skin irritation and can lead to infection.

Always change wet or soiled clothing and linens immediately.

Some people will use incontinence pads or briefs. Incontinence briefs should never be referred to as “diapers;” it is infantilizing, and they are different products. NAs should check incontinence briefs regularly to make sure that a resident always has dry and comfortable garments.

YouTube Video

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Chippewa Valley Technical College. (2022, December). Changing an Incontinence Brief. [Video]. YouTube. Video licensed under

How does each part of the Big Three (Resident Rights, Safety, Infection Control) relate to caring for somebody experiencing urinary incontinence? Write for 5 minutes, then discuss your response with a friend or classmate.

Query 2

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Eliminative care

Assisting with urination

NAs will assist people with toileting every day, multiple times per day. Yet, for something that we know everybody does (eliminating waste), people have different levels of comfort around their body's waste disposal^[6].

Privacy: When helping somebody with toileting, always provide for the person's privacy and dignity by shutting the door and closing the person's privacy screen.

Professionalism: NAs should always be professional and aware of language. Use terms like "elimination," "voiding," and "using the bathroom." Refrain from slang, casual language, and any terminology that could be labeled as crude. Such language can embarrass somebody and make them feel undignified.

Skincare: NAs must provide extra diligent skin care to persons with incontinence, both in general and immediately following an episode of incontinence. Linens should be changed immediately; allowing somebody to sit in their own waste is undignified, promotes skin irritation and infection, and violates their rights.

Patience: NAs should always exercise patience when helping somebody with toileting. People are able to use the bathroom at different paces, and some people will take much longer than the NA may initially expect. However much time it takes for somebody to empty their bladder, the NA should remain calm, positive, and encouraging. It is never acceptable to display signs of annoyance or to rush a resident when they are voiding.

Comfort: When assisting the person with urination, NAs should help the person with warmth, privacy, and comfort. The first thing NAs can do to encourage comfortable elimination is to know the person's patterns and routines when it comes to voiding. NAs can offer the bathroom at regular and predictable intervals, as well as promptly responding to bathroom requests when they occur. If the person is susceptible to chill, the NA can provide warmth by supplying them with a bath blanket to drape over their bare legs while using the toilet.

After helping the person to the toilet, NAs should make sure that the bathroom call light is easily within reach before leaving the bathroom to allow the person some privacy. Once the person has finished in the bathroom, the NA can enter and provide perineal care as needed; if the person is capable of performing their own perineal care after voiding, they should be encouraged to do so. The NA can then assist the person with handwashing, wash their own hands, and then help the person back to their bed or chair.

Portable commodes

NAs will often use portable commodes to assist residents with urination. A portable commode is a kind of chair with a toilet seat, a container under the toilet seat to catch waste, and support for the person's back and arms. The commode allows for a normal position during elimination, rather than using a bedpan or handheld urinal. Portable commodes will be used for patients who are unable to comfortably make it to the bathroom and back. The container on a commode can be removed and the frame positioned over a standard toilet for added support.

To help somebody use a commode, perform the steps necessary for a wheelchair transfer. If the commode has wheels, they must be locked before initiating the transfer. The NA can then help the person to the commode, and assist them with removing their clothes.

Before leaving the room to allow the person privacy, make sure that the call light is within easy reach. Once the person has finished, the NA can ask them to clean their hands with a sanitary wipe, and then provide perineal care as needed. The NA can then help the person back to their bed or chair.

The container attached to the commode requires cleaning after every elimination. Follow facility policy on the cleaning and storing of commode bins.

NAs must always practice Standard Precautions when helping somebody with elimination. This will always include gloves, and may include gowns and facial PPE depending on the person's care needs.

Catheter Care

A catheter is a tube inserted into a person's body to give or take fluids. Urinary catheters remove urine from the bladder and drain it into a drainage bag. Urinary catheters are necessary when a person can't urinate in the usual way (perhaps they are under anesthesia or on bed rest), or if the person is too weak or disabled to use the urinal, commode, toilet, or bedpan. They are also used to prevent wounds and pressure ulcers from coming into contact with urine, and as a last resort for incontinence.

Urinary catheters are major contributors to healthcare-acquired UTIs. UTIs are extremely painful and dangerous. Urinary catheters are a risk factor for developing UTIs, so they should be avoided to treat incontinence if possible. NAs and caregivers should never use urinary catheters for convenience or because they would prefer not to manage incontinence in other ways.

Types of urinary catheter

There are four common types of urinary catheters; indwelling catheters, condom catheters, straight catheters, and suprapubic catheters^[7].

An **indwelling catheter** is a tube that is inserted along the whole length of the urethra and into the bladder. A small balloon at the end of the tube in the bladder keeps the tube from coming out. Indwelling catheters remain inserted and are used when people require a catheter for a period of time.

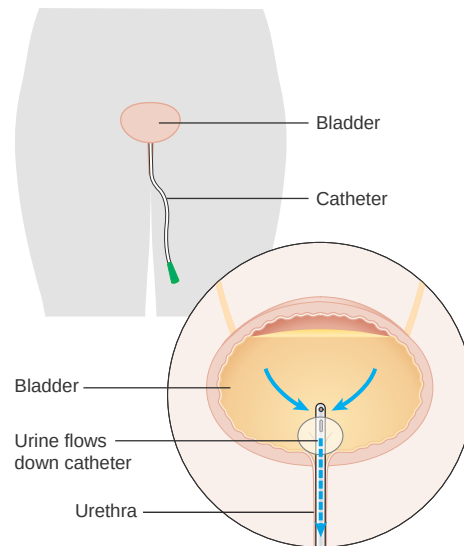


Image by Cancer Research UK, CC BY-SA 4.0

Indwelling catheters use a closed drainage system, which means that nothing can enter the system at any part, from the catheter to the drainage bag. A drainage system consists of a drainage bag to collect the urine and tubing to transport urine from the catheter to the drainage bag.

A drainage bag always hangs from the bedframe, chair, or a wheelchair on the side farthest from the door. Drainage bags must be hung lower than the person's bladder; if a drainage bag hangs higher than the bladder then urine can flow in the wrong direction back towards the bladder. This creates a heightened risk for UTIs. NAs should never hang a drainage bag on a bed's guardrails, only ever on the bedframe itself.

Never let the spigot on a drainage bag touch another object when emptying the bag. Allowing the bag's opening to come into contact with another object could introduce a pathogen, which might then multiply in the drainage bag and make its way into the person's urethra and bladder by way of the catheter. Practice conscientious infection control measures when handling urinary drainage systems; drainage bags should never touch the floor or another contaminated surface.

A **straight catheter** is inserted into the bladder through the urethra at regular intervals throughout the day. A straight catheter is removed after each use.

A **condom catheter** is fitted over the penis with tubing that drains into a drainage bag. Condom catheters are external and are not inserted through the urethra.

A **suprapubic catheter** is inserted into the bladder through a surgical opening in the lower abdomen, above the pubic area. Suprapubic catheters carry less risk of infection, and may be simpler to manage for people who require catheterization long term.

Hygiene

Cleaning catheters is an essential part of practicing infection control. Urinary catheters present a high risk of UTIs; in order to keep residents safe and healthy, the area around their catheter will need to be cleaned regularly, and whenever providing perineal care.



To clean someone's catheter, perform the opening procedure and practice Standard Precautions. The next step is to gather a basin of warm water and a washcloth. The NA can then have the resident bend their knees and raise their pelvis a few inches from the bed to expose the area for cleaning.

It is important to respect the resident's dignity and privacy, and only expose the area that is necessary for cleaning. A towel should be placed under the catheter tubing, a bed protector placed between the bed and the person's buttocks.

Once everything is in place, wet the washcloth and apply soap to it. Gently holding the catheter tubing near the person's meatus (urinary opening), the clean the four inches of tubing beginning at the meatus and wiping away from it without tugging at the catheter. Wiping away from the meatus, rather than towards it, helps to prevent infection.

Once the area has been cleaned, use a clean washcloth dipped in water to rinse the area, and a third clean washcloth to dry it. Once the area is dry, the NA can dispose of the bed protector and used washcloths, then empty and store the basin.

YouTube Video

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Chippewa Valley Technical College. (2022, December). Catheter Care. [Video]. YouTube. Video licensed under [CC-BY-4.0](#)

Drainage bag

To empty the drainage bag, the perform the opening procedure and practice Standard Precautions. Use a graduate and position it under the drainage bag on the floor atop a paper towel. The drainage bag will empty into the graduate once its clamp is opened.



Empty the Drainage Bag

Image by BruceBlaus, [CC BY-SA 4.0](#),

After the urine has drained into the graduate, close the drainage bag's spout and clean it with alcohol wipes. Next the NA should take the graduate full of urine into the bathroom and place it on a flat surface, letting the urine settle before observing the measurement.

Once the measurement is observed, flush the urine, properly clean and store the container, doff PPE, wash hands, and record the amount of urine according to facility protocol.

Drainage bags are emptied and measured either when they are at capacity or at the end of each nursing shift.

Assistive devices for urination

Bedpans look like a toilet seat with a container attached to them, and are used by people who cannot get out of bed. Anybody who cannot get out of bed will use a bedpan for bowel movements, while those who cannot urinate into a handheld urinal will also use a bedpan for voiding.

The person will have to lift their hips long enough for the NA to slide the bedpan under them. NAs must always practice Standard Precautions when assisting someone with elimination.



“Blue Steel Enamelware Bedpan” by VCU Libraries is licensed under [CC BY-NC-SA 2.0](#).

For some people, a bedpan may be too tall to lift their pelvis over. A **fracture pan** is similar to a bedpan except it is only about ½ inch deep on the side that will slide under a person’s buttocks, so it is easier to use for a person with limited mobility. Fracture pans are used for persons in casts, persons with limited back mobility, after a spinal cord injury or back surgery, after a hip fracture, and following a hip replacement surgery.

Urinals are handheld plastic repositories with an angled opening that a person with a penis can urinate into. NAs should be careful when handling urinals, because they are easy to tip over and if the lid is not securely closed may spill urine. Urinals should never be placed on tables or directly on the bed; they can be placed on the bed rail or on the floor next to the bed. NAs should encourage the person to use the handheld urinal themselves.

Urination equipment should be stored in the bathroom when not in use. If the bathroom is shared, the equipment must be labeled. Bedpans and urinals can also be kept in the bottom section of the person’s bedside stand.

When assisting someone with urination in bed, always use a protective pad. Protective pads help keep bed linens dry and prevent the need to change linens whenever a person uses equipment to urinate from bed. Similarly, a towel or protective pad should be used to transport equipment so no urine dribbles or leaks from the container.

Wash hands (both your own and the residents) multiple times throughout the urination process – before, after, and sometimes during. Make sure to complete the closing procedure.

Query 3

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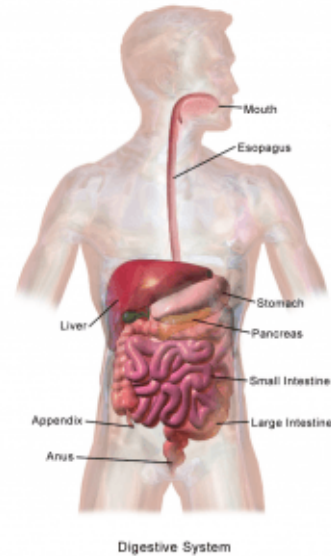
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Bowel Elimination

Digestion

The function of the digestive system to receive food, break it down into the elements it is made of, absorb the usable nutrients, and dispose of what isn't used. Digestion begins in the mouth with the chewing of food and the application of saliva to chemically



break down the food. Once the food is swallowed, peristalsis begins^[8].

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Peristalsis is the contracting motion that the body uses to move food along down the esophagus, into the stomach, and through our intestines. Peristalsis is the reason most humans can swallow while upside down; the contracting motion means that we don't just have to rely on gravity to keep our sustenance moving along the digestive tract.

The stomach and stomach acid process the chewed and broken-down food into a substance called chyme, which moves along into the intestines where it is either absorbed or becomes waste.

Defecation is the excretion of solid waste once it is processed by the intestines. It is the final stage of the digestive process, and is referred to as bowel elimination. When a person eliminates, they empty their colon of feces, or stool.

Factors influencing bowel movement

Factors like aging, mental and emotional wellbeing, diet, fluid intake, physical activity, and personal routines can all affect a person's ability to have healthy bowel movements.

Age: As a person ages their body moves food through their GI tract more slowly. The mechanics of chewing become more difficult, less saliva is produced, and the body absorbs fewer nutrients. NAs can promote normal elimination in aging persons by prompting hydration and encouraging nutrient-dense food choices.

Mental and emotional wellbeing: Privacy and disruptions to routine can have a negative impact on bowel elimination.

Always promote privacy and exercise patience when someone is attempting a bowel movement.

When someone is not at home, if they have a roommate for the first time in a while, or factors like anxiety and stress can have a negative impact on bowel movements. The distressing circumstance may make elimination more difficult, produce loose and watery stool, or make somebody need to eliminate urgently.

Diet: Fiber is an important part of a diet conducive to healthy bowel movements, because it helps to hold the stool together. A low-fiber diet can make somebody constipated, and animal fats from dairy, meat, and eggs can also produce constipation. NAs should promote nutritionally dense meals with high quantities of whole grains, fibrous fruits, and vegetables. If the digestive trouble continues, the healthcare team may decide to introduce a probiotic, which is a sample of live bacteria meant to help regulate the body's digestive system.

Hydration: As a person ages their thirst diminishes, which can result in dehydration and difficult elimination. NAs should prompt residents to drink fluids, and should make sure that their bedside pitcher is always replenished and within reach.

Routines: Personal routines are helpful in maintaining healthy bowel movements. It can be helpful for NAs to prompt residents use attempt a bowel movement at the same time every day; NAs should give residents about 15 – 20 minutes per attempt. Encouraging the resident to consume warm fluids can also stimulate elimination.

People who are on medications that cause constipation may be prescribed laxatives or probiotics to help their bodies manage the digestive side effects of their medication.

Healthy elimination

Stool is usually brown in color, soft, moist, and holds its shape. Stools vary in color depending on the diet of the person, their medications and supplements, or whether they are ill. Stool that is small and hard is difficult to pass and indicates a need for more hydration. Stool that is mostly liquid is called diarrhea, and indicates a need for more fiber or another intervention depending on the cause of the diarrhea^[9].

NAs should observe patients' stool for any signs of unwellness. Report to the nurse immediately if the resident experience:

- stool that is bloody or discolored
- stool that is hard and dry
- liquid stool
- stool containing discharge such as pus
- the person reports pain when eliminating

Such symptoms indicate a need for further assessment and follow up. When a resident defecates, ask them not to flush until you've had a chance to look at their stool.

Common bowel problems

Some common bowel problems include constipation, fecal impaction, flatulence, diarrhea, incontinence, and gastrointestinal bleeding.

Constipation occurs when somebody has difficulty eliminating stool. When somebody is constipated, their body waste moves very slowly through their digestive system, resulting in feces that are hard and dry and difficult to pass.

Constipation may be caused by aging, poor diet, lack of activity, low fluid intake, and other factors. If somebody is constipated it can cause gassiness, abdominal discomfort, and irritability.



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Treatments for constipation start with lifestyle changes in the areas of diet (more fiber), fluid intake (more water), and activity (more exercise). If these less invasive interventions are impossible or ineffective, the doctor may order stool softeners, laxatives, or medication in the form of rectal suppositories.

Fecal impaction is a total inability to pass waste. Feces build up in the rectum. These feces are hard and cause liquid stool to ooze from the anus.

Some symptoms of fecal impaction are abdominal distention (swelling), pain and cramping, and no stool for multiple days.

Fecal impactions cannot be removed by the person on their own, and require a digital exam to diagnose. NAs should report signs of possible fecal impactions immediately. If left untreated, fecal impactions can become extremely severe, resulting in fever, disorientation, and even death. Impactions can be prevented with hydration, exercise, high-fiber foods, and a regular elimination schedule.

Flatulence refers to passing gas, and occurs when gas builds up in the digestive tract and is released. Some flatulence is normal, but excessive flatulence may indicate an intolerance to certain foods, excess dietary fiber, nutrient malabsorption, or irritable bowel syndrome (IBS).

Increased activity levels can help with constipation and flatulence because it promotes digestion, increases thirst, and helps a person stay physically relaxed.

Diarrhea is the frequent passage of liquid stool. Diarrhea is caused by any number of things from dietary disturbances, medications, and illness. Diet changes and drugs are prescribed to harden stool and reduce peristalsis.

NAs will surely care for somebody experiencing diarrhea, likely with some regularity. When caring for somebody with diarrhea, always respond to call lights immediately, since a person may not have much time between realizing they need to go and going. If the person is using assistive equipment to eliminate while in bed, NAs should dispose of stools as quickly as possible.

Diarrhea is highly irritating to skin, and can lead to skin breakdown, pressure ulcers, and infection. Remember to give excellent skin care when a person experiences diarrhea, with special attention to the impacted areas.

Diarrhea contains higher water content than regular feces, which means that a person experiencing diarrhea will lose more water through defecation than they would otherwise. NAs should encourage people experiencing diarrhea to hydrate so they can replace the fluids lost through diarrhea.

Gastrointestinal bleeding is any bleeding along the GI tract. The symptoms of GI bleeding will show up in a person's stool. Bleeding in the stomach and small intestine causes black or tarry stool. Bleeding in the lower colon and rectum causes red-colored stools. If NAs notice any discoloration in residents' stool they should report it immediately and record it in the resident's chart.

Fecal Incontinence

Fecal incontinence is the inability to control the passage of feces through the anus^[10]. The involuntary elimination of feces has a negative emotional impact on a person; it can rob a person of independence and personal empowerment. Frustration, sadness, anger, humiliation, and embarrassment are common and understandable responses. NAs must always respond to people experiencing fecal incontinence with kindness, compassion, empathy, and patience.

The causes of incontinence include intestinal disease, nerve damage and injuries, fecal impaction, diarrhea, drugs, illness, dementia or other mental health problems. Other causes of fecal incontinence include not being able to get oneself to the bathroom in a timely manner, not receiving timely assistance with elimination if one requires it, and not being able to locate the bathroom when confused or in a new setting.

The goal treatment for fecal incontinence is to return a person's bowel control to normal functioning, or as close as possible to normal functioning. Treatment for incontinence may include bowel training, changes in diet, or even surgery.

A person experiencing incontinence may use incontinence briefs and other products to keep their garments and linen clean when they have an uncontrolled bowel movement. NAs should respond to peoples' call lights right away when they are experiencing incontinence; changing incontinence briefs quickly is essential to maintaining a person's skin health and overall wellbeing.



All three aspects of the Big Three must be kept in mind while caring for people experiencing incontinence. Residents have a Right to timely care and to dignity, which precludes them being permitted to sit in their own feces. Infection control is paramount, since people with incontinence are more likely to develop skin breakdown and pressure ulcers. Safety matters too, since somebody with incontinence may attempt to get themselves to the bathroom quickly when they really ought to be assisted.

Treatments for fecal incontinence

Bowel training

Bowel training is one tool that a care team can use to help a person experiencing fecal incontinence. The goals of bowel training are to help a person gain control over their bowel movements and to get someone on a regular elimination schedule. Bowel training involves taking the patient to the bathroom at specific times every day. NAs must always follow the care plan carefully and consistently. Recording observations of when a person needs to use the bathroom and the quality of their stool will be an essential part of bowel training.

NAs must always be respectful, kind, and positive, especially when a person experiences an episode of incontinence. Becoming frustrated or angry with somebody when they have an episode of incontinence, or when they take a long time to use the bathroom, is abusive and cannot be tolerated. Additionally, if caregiver reactivity becomes a source of anxiety or worry for somebody experiencing incontinence it can hurt their treatment outcomes. If a NA notices somebody engaging in this type of behavior, they should alert the nurse.

Other factors in someone's treatment for fecal incontinence may include a high-fiber diet, increased fluids, drinking warm fluids, increased activity levels, and ensuring privacy. Different residents will respond to different things; NA should pay attention to people as individuals to best determine what they need and how they can be helped most effectively.

Suppository

A suppository is a cone-shaped drug that is inserted into a body opening. When a suppository is inserted into the body through the rectum it is called a **rectal suppository**.

When somebody needs a rectal suppository in order to defecate, a bowel movement will usually occur about 30 minutes after insertion. Doctors may order a rectal suppository to stimulate a bowel movement for persons experiencing constipation, fecal impaction, or to promote a bowel training schedule.

Enema

An **enema** is a cleansing of the colon with water or another liquid solution to stimulate a bowel movement. NAs are allowed to give enemas in some facilities after they have been trained on the procedure – NAs should always ask further questions if they are unsure about a delegated task. Enemas are given to relieve constipation, impaction, or flatulence. They are also given in preparation for surgery or for the performance of a diagnostic test.

Enemas are either given with tap water, soapsuds, saline, or a prepared commercial solution. For tapwater, saline, and soapsuds enemas, 500 – 1000 mL of water is used, with either no additives, two tea spoons of salt, or 5 mL of castile soap added depending on the type of enema. A commercial enema will be 120 mL of a prescribed solution^[1].

When a tap-water enema is given the enema should not be repeated. However, if a saline or soapsuds enema is ordered the doctor may order that enemas be repeated until the liquid solution is clear and free of stools when it exits the rectum. An enema usually takes about 10 – 20 minutes to perform. The person receiving the enema will be in the left side-lying position throughout.

To give an enema, NAs should make sure they perform the opening procedure, practice Standard Precautions, and communicate with the person throughout the whole process. Once the enema solution is prepared in the IV bag and the person is in position, the NA should lubricate the tip of the tubing before inserting it 2 – 4 inches into the person's rectum. Do not continue if the person feels pain or if the tubing encounters resistance in the rectum – if this occurs, the NA should tell the nurse immediately.

The solution should be administered slowly and will take 10 – 15 minutes for 750 – 1000 mL of fluid. The temperature of the enema should be roughly body temperature, and must not exceed 105-degrees Fahrenheit. NAs can help the person stay comfortable by encouraging deep and regular breaths, and making light conversation to pass the time. The tube should be clamped and the flow stopped before the bag is empty, so no excess air gets into the bowels.

The person should hold the solution in as long as they can. The NA should make sure the bedpan is immediately available or that the pathway to the person's bathroom is clear and safe. NAs should make sure to provide proper perineal and skin care following an enema.

YouTube Video

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[View this YouTube Video online](https://www.youtube.com/watch?v=iJvKxxn40zE)



RegisteredNurseRN. (2014, August 8). How to Give a Soap Suds Enema Administration [Video]. Youtube. <https://www.youtube.com/watch?v=iJvKxxn40zE>

Ostomies

Ostomies are surgically created openings in the body that allow for things inside the body to exit through a surgically created path; the tissue surrounding the opening itself is called a stoma. Sometimes a person with an illness that impacts the bowels will require an ostomy to expel waste.

- A colostomy is an ostomy between the colon and the abdominal wall. It allows for the expelling of stool into an ostomy bag. Stool from colostomies will usually be semi-solid. Colostomies can be temporary or permanent; if somebody has their colon removed, they will require a permanent ostomy.
- An ileostomy is an opening made in the small intestines that leads outside the abdominal wall. Stool from an ileostomy will look more liquid and have a somewhat foul smell.

Ostomies use a two-piece system: there is the ostomy pouch, which carries the waste once it is eliminated, and there is the skin barrier that seals the stoma (ostomy opening) from the outside and prevents leaking.

Good skin care is paramount for persons with an ostomy. The stool that ostomies help a body expel is highly irritating to the surrounding skin. NAs should closely observe the area around an ostomy for signs of skin breakdown. The ostomy equipment will be changed every 5 – 7 days.

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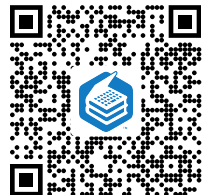


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Collecting Specimens

A specimen is a sample of something like blood, tissue, urine, or feces. Doctors may order a specimen be collected; if the order is for a urine or stool specimen, the task will likely be delegated to the NA. All specimens are labeled with at least 2 forms of ID (name and identification number), as well as the date and time of collection.

Once waste specimens are sealed in their appropriate container, they must also be bagged in a bio-hazard bag. Waste samples are considered highly contaminated, and NAs should wear gloves and practice Standard Precautions while collecting and transporting the sample. If specimens need to be stored before being taken for testing, they will be placed in a specific refrigerator; never place stool or urine specimens in the same refrigerator as food.

Stool specimens

Stool specimens are collected using a device called a hat. Hats, in this context, are cups with wings that sit beneath a toilet seat

and catch the stool before it reaches the toilet basin. They look like an upside-down top-hat.

Make sure to let the person know not to mix any urine or toilet paper with the stool sample.

When someone has an order for a stool specimen, the NA should make sure the person lets them know when they are about to have a bowel movement. The NA can then set up the hat on either the toilet or the bedpan, and allow the person privacy to do their business (always practice Standard Precautions throughout).

Once the person has completed their bowel movement, the NA can assist them with cleaning up. After washing hands and with a new pair of gloves, the NA can then take a wooden tongue blade or disposable spoon and transfer about two tablespoons of stool from the hat to the specimen container and screw the cap closed before placing the specimen container in the biohazard bag for transport.

The wooden tongue blade should be wrapped in a paper towel before being disposed of in the proper bin. The rest of the equipment should then be cleaned and stored in the proper place. The specimen can then be taken to the lab for analysis^[12].

Urine specimens

NAs will collect urine specimens; there are a few different kinds of urine specimens that can give the care team different sorts of information on what is happening in a person's body^[13].

A **routine urine specimen** is a specimen that can be collected any time the person urinates. A routine urine specimen is collected using a hat or a bedpan. After performing the opening procedure and getting the supplies ready, the NA should let the person have some privacy. Once they are finished, assist them with perineal care and transfer urine from the hat or bedpan into the specimen collection container before discarding the remaining urine into the toilet.

A **fractional urine specimen** is collected much the same way that routine urine specimens are collected, except they must be collected within a specified time frame. A routine urine specimen can be collected at any time, but a fractional urine specimen must be collected within the time window specified in the doctor's order.

A **clean catch specimen** or a **mid-stream specimen** is a urine sample that does not include the first or the last urine during voiding. Perineal care is provided before the sample collection.

Set up the specimen collection kit in a similar way to a routine specimen, except the person should void a little bit before the specimen collection begins. Once the person initially voids in the toilet or bedpan, they should pause and let the NA place the specimen collection container beneath their stream. The person can then begin urinating again, and should continue until the specimen container is at least ½ full.

Once an adequate amount of urine has been collected, remove the container and let the person finish voiding. After wiping the urine container with a paper towel and placing it in the biohazard bag, assist with perineal care as needed before making sure they are comfortable and leaving with the sample.

A **24-hour urine specimen** is a collection of all the urine voided by a person in a 24-hour period. The collection will usually begin at 7 a.m. and last until 7 a.m. the next day. A person should begin the collection process with an empty bladder, which means the NA should ask them to void right when the collection starts and then discard the first urine. Take care to store and label the urine sample properly as it is being collected; if any of the sample is mishandled, spilled, or improperly stored, the 24-hour collection window will start over.

When collecting a 24-hour urine sample, perform the opening procedure and check in with the resident. There should be a sign placed on the person's bedside stand; signs may read something like "24-hour urine specimen collection in process, save all urine." Once everything is in place, the resident will void once. The NA should mark the amount and exact time of the first voiding, and discard it so it is not included in the sample.

Standard Precautions must be used every time the NA collects urine samples and adds them to the container. The urine from the bedpan, urinal, or hat will be added to the container upon voiding. Store 24-hour specimens according to facility guidelines, usually refrigerated or over ice. Follow instructions closely and always ask follow up questions if unsure about something. Once

the 24-hour period is up, add the final void to the container and remove the sign.

Resident Rights and comfort



Having urine and stool specimens collected can make someone feel embarrassed. NAs should always be professional and friendly when collecting specimens, and can make casual conversation to help put the person at ease.

Always explain the procedures clearly and comprehensively to the person, and continue to narrate care as you give it; keeping someone informed about their care in the moment can help calm anxious feelings, and is a good way to practice person-centered care. NAs must always provide privacy, dignity, respect, and autonomy in all aspects of their care, including (perhaps especially) those dealing with a person's stool and urine.

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Key Takeaways

- Healthy urination involves the purposeful voiding of about 1500 mL per day of clear pale-yellow urine. Adequate hydration and activity levels are important for maintaining urinary health. When someone experiences urinary incontinence, it means that they cannot always control when they void and may urinate at times when they do not expect to. Always respond to call lights from incontinent residents as soon as possible.
- When caring for a person with a catheter, begin with a lightly soapy washcloth and clean 4 – 5 inches of catheter tubing beginning at the urinary opening and wiping away from the urinary opening every time. Always wiping away from the urinary opening is an important part of infection control; wiping towards the urinary opening may push pathogens toward the urinary tract, rather than away from it.
- When someone has healthy bowel movements, their stool will be brown and soft, but will still hold its shape. Excessively watery stool is called diarrhea, and stool that is hard and dry can cause constipation. Constipation occurs when someone cannot, or has difficulty attempting to, pass stool. Some common causes of constipation include dehydration, lack of dietary fiber, and age. Fecal incontinence is when someone may eliminate stool uncontrollably; someone experiencing fecal incontinence may use incontinence briefs to manage their symptoms.
- Always practice excellent skin care with incontinent residents. Answer their call lights immediately, and assist with skin and perineal care frequently.
- Follow instructions carefully when collecting a stool or urine sample. Make sure that you follow the correct process for the sample ordered.

Comprehension Questions

1) The function of the kidneys is too ...

- a. Carry the urine until the person is ready to void
- b. Connect to the ureter
- c. Filter nutrients and minerals from fluids, and turn the waste into urine
- d. Keep the bladder clean

2) What are some qualities of healthy urination?

- a. Urine is faintly cloudy
- b. Urine is clear and pale yellow in color
- c. Producing roughly 500 mL of urine per day
- d. Voiding is painless
- e. Urination occurs every 30 minutes

3) Respond to the following sentences with T (true) or F (false).

___ Urinary health is impacted by emotional wellbeing.

___ As someone ages they usually develop stronger urinary muscles and better control.

___ Swelling in the hands and feet is a sign that the urinary system is working as it should, especially when the person is being treated for incontinence.

___ One way NAs can help prevent UTIs is by responding to bathroom requests immediately.

___ Oliguria refers to producing abnormally large amounts of urine.

4) How should nursing assistants respond to a resident who has an episode of incontinence?

- a. Change any wet linens, clothing, or incontinence briefs immediately
- b. Politely suggest that the resident just holds it until a staff member can get there next time
- c. Insist to the nurse that the resident use an indwelling catheter
- d. Provide perineal and skin care to the impacted area to prevent rashes and skin breakdown

5) What are some practices NAs should use when providing care to someone with a catheter?

- a. Place the drainage bag higher than the person so it fills up at the right speed
- b. Always use Standard Precaution and excellent infection control measures
- c. When providing perineal and catheter care, place a towel beneath the person's buttocks
- d. If the person complains of discomfort, NAs can temporarily remove the catheter to give the person some reprieve

6) What is a bedpan?

- a. A pan that residents can use to cook some or all of their meal from bed if they want to. This promotes independence and

self-esteem

- b. A handheld plastic container residents can urinate into, used for people who cannot get out of bed
- c. A device that looks like a container with a toilet seat attached to it, used for people who cannot get out of bed
- d. An area under a resident's bed for storing devices related to elimination

7) Please list at least three signs or symptoms of unhealthy stool that should be reported.

8) If a resident experiences fecal incontinence, which of these elements of their diet may be increased?

- a. Milk and yogurt
- b. Fowl, such as chicken
- c. Fruits and whole grains
- d. Coffee

9) Respond to the following sentences with T (true) or F (false).

___ A constipated person usually has diarrhea and uncomfortable defecation.

___ Fecal impactions can be diagnosed by gently feeling for lumps around the person's anal region; only doctors or nurses can diagnose fecal impaction.

___ Persons experiencing diarrhea should be prompted to hydrate.

___ Enemas cleanse the colon with water or a water solution; NAs may be responsible for administering enemas.

___ Ostomies tend to promote skin health.

10) When collecting a 24-hour urine specimen, NAs should ...

- a. Collect the first void, record the amount, and include it in the 24-hour total
- b. Place a sign by the person's bed alerting staff that a 24-hour collection is in process
- c. Use Standard Precautions
- d. Store the urine specimen in a warm and sunny corner of the resident's room

11) Why is it important that nursing assistants express patience and kindness when residents experience incontinence? Think of your answer in terms of the Big Three. How might a negative caregiver reaction to an episode of incontinence produce negative health outcomes for the resident in the future?

12) A resident's call light went off once an hour ago, but you were helping another resident finish their meal. By the time you were done, the call light was off and you assumed that another staff member had responded to it. When you go into the first resident's room, you see that she has soiled herself and has been sitting in urine-soaked sheets for about an hour. When you asked why the call light hadn't been on, the resident said "Oh, I just didn't want to bother you and I knew you would get here eventually." How were the Big Three violated in this situation? How would you respond to the resident in this moment? What could you have done to prevent this situation from occurring?

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Module 10 – Vital Signs

Learning Objectives

- Understand the importance of vital signs
- Demonstrate proper technique in obtaining vital signs
- Demonstrate understanding of interpreting vital signs
- Develop understanding of cardiovascular and respiratory disease processes
- Demonstrate working knowledge of oxygen delivery

Vital Signs

Vital signs are measurements the healthcare team can take on a person that gives them key information on the functioning of a person's key bodily processes like their blood and their breathing. The four basic vital signs are temperature, pulse, respiration, and blood pressure.

Always take vitals accurately; if vital signs cannot be taken for some reason, then vital sign measurements should not be guessed or estimated.

Vitals can help the team determine their illness, or the direction of their recovery. Vital signs can also be a general indication of health, or a sign that a patient is having a medical emergency.

Vitals measurements must be accurate, because they are important information for care planning, and give diagnosticians necessary information to make their diagnoses^[1].

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Temperature

The human body only functions properly within a specific temperature range. Temperature refers to the amount of heat in the body. While the body has its own means of regulating temperature, but sometimes the balance between heat produced and heat lost tips into an unhealthy range.

A human's body temperature will be slightly lower in the morning and will rise as the day progresses due to activity and wakefulness.

Standard average body temperature for a human is about 98.6 degrees Fahrenheit, though it fluctuates depending on how the measurement is taken. Normal temperature range is considered to be 97 – 99 degrees Fahrenheit.

Body temperature is affected by multiple factors such as age, exercise, stress, illness, and medications

- **Age** impacts body temperature due to associated loss of fatty tissues and diminished blood circulation.
- **Exercise** increases body temperature as muscles produce heat during activity.
- **Stress** can increase a person's body temperature because of hormones like adrenaline, cortisol, and epinephrine. The human body's temperature responds to its hormonal state.
- **Illness** can increase a person's body temperature either due to a symptom of the illness or as a result of fever.
- **Drugs** such as Tylenol, aspirin, and ibuprofen are considered fever-reducing drugs because they lower body temperature. Somebody is only considered "fever-free" if their body temperature stays within a normal range without the use of fever-reducing medication.



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Taking someone's temperature

A normal human temperature range is 97 – 99 degrees Fahrenheit. Subnormal body temperature could be caused by exposure to cold, alcohol use, illness and infection, and other factors.

A person has hypothermia when their body temperature is too low to permit normal functioning. Symptoms of hypothermia include cyanotic skin (pale and blueish in color), numbness, shivering, impaired breathing, slowed movement, and confusion and disorientation. If any of the symptoms are observed, alert the nurse.

A person's temperature can be taken in different ways, and each method will have slightly different normal ranges. Always practice Standard Precautions while taking someone's temperature by wearing gloves and other PPE as required. The most common methods of taking someone's temperature are the oral, rectal, tympanic, and axillary^[2].

Oral temperature

Oral temperature is taken from the mouth, and is usually taken with a digital thermometer. A normal temperature range for most oral thermometers is 97.6 – 99.6 degrees Fahrenheit. Eating or drinking, smoking, or exercising within 30 minutes prior to taking oral temperature can produce an inaccurate reading.

Do not take oral temperature from people who are:

- confused
- unconscious
- paralyzed
- in mouth pain
- using nasogastric tubes
- using oxygen

After performing the opening procedure, the NA should remove the thermometer and put on the plastic sheath. Put it in the person's mouth to one side after instructing the person to hold the thermometer in their closed mouth.

When the thermometer indicates that it has read the temperature the NA should commit the number to memory before taking the thermometer from the person, discarding the sheath, and cleaning the thermometer in accordance with facility protocol.

Wait with the person and not leave the room while an oral temperature reading is being taken. The process is finished after recording the temperature and performing the closing procedure.



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Rectal temperature

Rectal temperature is taken by inserting a thermometer $\frac{1}{2}$ to 1 inch into a person's rectum; a normal temperature range for a rectal reading is 98.6 – 100.6 degrees Fahrenheit. A person may need their rectal temperature taken if they cannot use an oral thermometer.

A person may be uncomfortable having their temperature taken in this way, so NAs should be respectful and explain the process thoroughly. The person must hold still during the temperature reading, so their being calm and cooperative is essential for taking accurate vital measurements.

To take someone's rectal temperature NAs should always begin with clear and calming instructions on how the person needs to cooperate by sitting still during the process in order to get an accurate reading. Provide privacy when someone is exposed by closing their door and privacy screen.

NAs should prep the thermometer by lubricating the tip or applying a cover for the probe. Rectal thermometers look similar to oral thermometers. Once the thermometer is prepped and the person is positioned in left-lying Sims' with only their buttocks exposed, the thermometer tip can be inserted $\frac{1}{2}$ to 1 inch in the person's rectum.

Never force an object into someone's rectum; if the thermometer encounters resistance, the NA should stop. The person's buttocks should be covered again while the thermometer gets the reading; the NA must hold onto the thermometer at all times.

After recording the temperature, clean the thermometer according to facility policy.

Tympanic temperature

Tympanic temperature is a temperature reading taken from the person's ear canal. A normal reading for tympanic temperature is between 96.6 and 99.7 degrees.



After preparing the thermometer, gently position the person's head right in front of them and straighten the ear canal by tenderly gripping the outer edge of the ear at about 11 o'clock, and pulling it up and back. Tympanic thermometers should only be inserted about $\frac{1}{4}$ to $\frac{1}{2}$ an inch into the ear canal.

Keep holding the ear and the thermometer until the thermometer is finished with the reading. The reading should be memorized immediately.

After committing the reading to memory, Image by [wuestenigel](#), CC BY 2.0 the NA can clean the thermometer or discard the disposable sleeve, discard gloves and wash hands, and record the person's temperature on their chart.

Temporal temperature

A temporal thermometer is a non-invasive thermometer that takes a person's temperature by being swiped across their forehead. It is especially useful for children, and people who require a noninvasive approach. A normal reading for a temporal thermometer falls between 97.6 and 99.6 degrees Fahrenheit.

Axillary temperature

Axillary temperature is taken at the person's armpit. While this method is less accurate than oral, rectal, and tympanic temperature, it is also safer and less invasive than methods that require inserting a thermometer into an orifice. A normal range for axillary temperature is between 96.6 and 98.6 degrees Fahrenheit.

When taking a person's temperature always perform the opening procedure and allow for privacy. Once the thermometer has been prepared, help the person remove their arm from their sleeve and tuck the thermometer into the person's armpit. The person should hold their arm close to their chest to keep the thermometer in place. The reading will take between 8 and 10 minutes.

Once the reading is complete the NA should commit the number to memory before discarding gloves and washing hands, and helping the person get re-situated in their clothing. The temperature reading should be recorded immediately along with the method used to take it.

Pulse

The heart

The three vital signs other than temperature (pulse, respiration, and blood pressure) all closely involve the circulatory system. In other words, a person's vital signs closely relate to the workings of their heart. A person's heart is located on the right side of their chest and is about the size of a fist. The heart is made of muscle tissue and, through its contractions, is responsible for the movement of blood throughout the body. The heart pumps about 7,000 liters of blood through the body every day.

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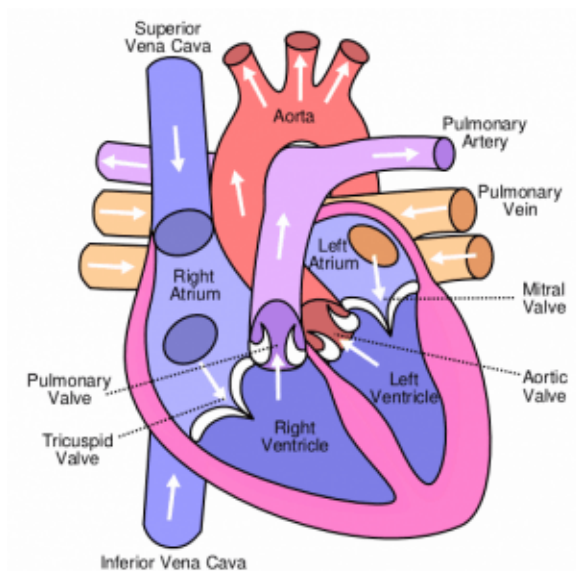
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FuseSchool – Global Education. (2017, April 6). Heartbeat and Pulse | Physiology | Biology | FuseSchool [Video]. Youtube. <https://www.youtube.com/watch?v=DLmmN0jy-s0>

The heart consists of four hollow chambers; there are two atria, which fill with blood before being pumped to other areas of the body, and two ventricles, which pump blood to the lungs, head, and all the way to the feet. When the heart beats it makes a lubb-dubb sound.

The “lubb” part of that sound is the systole, or the part of the heartbeat when the heart contract and makes the motion that pumps blood. The diastole is the “dubb,” or the part of the heartbeat when the heart relaxes, refills with blood, and prepares to make another contraction. During diastole, blood from the atria flow into the ventricles before being pumped to other parts of the body.



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Measuring pulse

Pulse is an important vital sign that will need to be measured regularly. Pulse refers to the rhythm of blood moving against an arterial wall, and is measured as “beats per minute” (BPM). Pulse can be measured in many different areas on the body, technically anywhere an artery is close enough to the surface of the skin for a person to feel the rhythm of blood.

The normal range for pulse in adults is 60 – 100 BPM, with most adults averaging about 70 – 80 BPM. When counting a person’s pulse, in addition to counting BPM, NAs should pay close attention to the rhythm and force of the beats^[3]. A pulse’s rhythm should be regular as in the time between beats is roughly equal; a pulse should feel strong but not thumping.

Use to visually mark the passage of 30 seconds; trying to count both seconds and beats at the same time makes errors likely.

When taking a **radial pulse**, the NA should gently and firmly place two fingertips on the thumb side of the person's inner wrist. The person may also appreciate some extra support to support their arm and hand. Count each pulse beat for exactly 30 seconds. However many beats the person's pulse has in 30 seconds should be doubled to find the beats per minute. If the pulse is irregular then the NA should count the pulse for the full 60 seconds.

The **apical pulse** is taken for a full 60 seconds and is located on the left side of a person's chest, just below their nipple. Apical pulse is used for persons with irregular heart rhythms, heart disease, and heart medications^[4]. The apical pulse is taken using a stethoscope; NAs should make sure that the earpiece and diaphragm (flat piece placed in contact with the person whose pulse is being taken) of the stethoscope have been wiped off properly before use. The stethoscope should also be cleaned after use.

The apical-radial pulse is a way of measuring pulse that takes both the apical and radial pulse into account. Counting an apical-radial pulse will require two people, one to take the apical pulse and one to take the radial pulse. The apical pulse is usually either the same or higher than pulse taken at other areas of the body; if the apical pulse is lower than pulses elsewhere, it is an indication of very poor circulation. When the apical pulse is higher than the radial pulse the difference is called the pulse deficit.

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Skills Lab. (2017, August 20). B 804 Assessing apical-radial pulse [Video]. Youtube. <https://www.youtube.com/watch?v=yhoi2nVE9o8>

Blood pressure

While pulse is the rate at which blood is pumped through veins and arteries, blood pressure refers to the amount of force exerted upon the walls of an artery by the blood. A person's blood pressure is determined the amount of force with which the heart contracts, the amount of blood pumped with each heartbeat, and how easily and smoothly the blood is able to flow through the blood vessels.

Blood pressure readings are recorded as the systolic blood pressure over the diastolic blood pressure; they look like a fraction, such as 110/70. The top number, systolic pressure, measures the force of blood as the heart contracts, while the lower diastolic number measure the force of blood as the heart is at rest in between lub-dubs. The normal range for systolic blood pressure is 90 – 119, while the normal range for diastolic blood pressure is 60 – 90.

Hypo- and hypertension

Hypotension is the word for low blood pressure. A person is considered hypotensive is their systolic blood pressure falls below 90 or their diastolic blood pressure falls below 60. Postural hypotension is a common form of hypotension where a person experiences a sudden drop in blood pressure when they stand or sit up quickly. A person with postural hypotension may become lightheaded, dizzy, or event faint if they stand or sit up quickly.

Hypertension is high blood pressure. Hypertension can be dangerous in its own right, and is a symptom of many different heart conditions and circulatory problems. There are a few different classifications of high blood pressure^[5].

- Elevated: Systolic pressure 120 – 129 and diastolic less than 80
- Stage 1 of hypertension: Systolic 130 – 139, or diastolic 80 – 89 (only one needs to be present for classification)
- Stage 2 of hypertension: Systolic pressure 140 or higher, or diastolic 90 or higher
- Hypertensive crisis: Systolic pressure 180 or higher, and/or diastolic pressure 120 or higher. A person in hypertensive crisis will require immediate emergency medical services.

Hypertension is widely known as the “silent killer.” Hypertension can develop in people of any age, and is diagnosed when

a person's blood pressure is regularly above 130 (systolic) and/or above 80 (diastolic). Symptoms of hypertension include headaches, dizziness, and blurred vision.

Long-term hypertension usually occurs when a person's blood vessels harden and narrow; it can also be caused by high levels of stress and pain, arterial plaque buildup, as a side effect of medications, and other factors.

Hypertension can lead to heart attacks, especially when it is related to a blockage of a blood vessel, also called an occlusion. Occlusions can cause ischemia, which is when an area does not get sufficient blood supply, which can also lead to a stroke.

NAs will need to take frequent blood pressure readings on people with hypertension to closely observe and record any abnormally high readings or sudden changes from the person's usual readings.

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TED Ed. (2015, July 3). How blood pressure works – Wilfred Manzano [Video]. Youtube.com. <https://www.youtube.com/watch?v=Ab9OZsDECZw>

Measuring blood pressure

Blood pressure is measured using a tool called a sphygmomanometer. Sphygmomanometers are either manual or digital. To take someone's blood pressure, the NA will need the sphygmomanometer, a stethoscope (only if using a manual sphygmomanometer), a blood pressure cuff, and alcohol wipes.

Sphygmomanometers are made of an armband that tightens either through the manual use of an attached handheld squeeze-ball air pump or the arm band will tighten automatically, as well as an interface where the blood pressure is displayed, and tubing that connects the arm band with the display.



“sphygmomanometer” by [kndynt2099](#) is licensed under [CC BY-NC 2.0](#).

A person's blood pressure should not be taken if they have recently engaged in activities that raise or lower their blood pressure. Examples include exercise within the last 30 minutes, and the presence of caffeine, tobacco, and other drugs.

Be careful of placement when taking blood pressure. The sphygmomanometer's arm band should not be placed on an arm that has an IV line, a cast, burns or injuries, recent physical trauma, a mastectomy or another surgical incision on that side, or dialysis treatment. Arms that are paralyzed or have been amputated should not be used to measure blood pressure.

Taking a person's blood pressure manually requires substantial concentration and focused listening. After performing the opening procedure and cleaning the equipment, discuss the procedure with the person and ask them to cooperate by remaining calm, quiet, and still.

After making sure the cuff is completely deflated, the NA should wrap the blood pressure cuff around the person's bare arm positioned palm-up at about heart level, with the cuff's center placed about 2 inches over the inside of the elbow.

Place the stethoscope over the artery on the inner elbow and tighten the valve on the arm cuff until it is closed but not too tight. Use the handpump to inflate the cuff to 170 – 200. The valve should slowly be opened until a pulse beat is heard; if a pulse is heard immediately at the original number, deflate and begin the process at a higher pressure.

Listen carefully while deflating the cuff. The number on the gauge when the first pulse becomes clearly audible is the systolic blood pressure and the first number in the reading. The gauge reading when the pulse beat sound changes or disappears is the diastolic blood pressure. Once the diastolic pressure is observed the NA can fully release the cuff valve before removing it. The systolic and diastolic numbers should be recorded immediately after handwashing. If the reading is abnormal or a significant change from other readings, inform the nurse.

Obtaining a blood pressure reading on someone is much simpler with an automatic sphygmomanometer than with the manual variety. After performing the opening procedure, the NA should make sure the cuff is totally deflated before positioning it so the center is right above the brachial artery. The cuff should be snug. Next, turn on the blood pressure machine and select the proper settings. After the machine performs the reading the NA should chart the blood pressure immediately and details like the arm used and the time the measurement was obtained.

YouTube Video

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RegisteredNurseRN. (2019, June 4). Blood Pressure Measurement: How to Check Blood Pressure Manually [Video]. Youtube. https://www.youtube.com/watch?v=UGOoeqSo_ws

Respiration

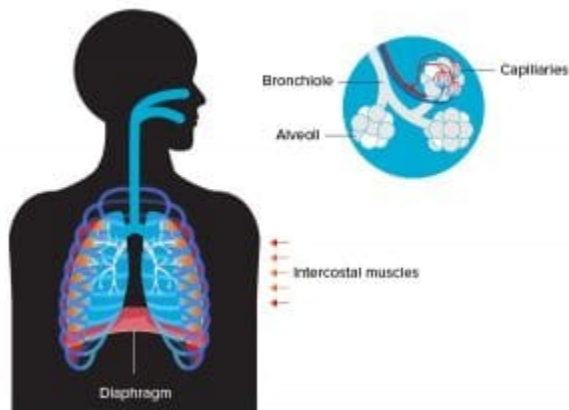
Respiration is the process of breathing, or moving air into and out of the lungs. Our lungs extract the oxygen from the air and use it to replenish the oxygen in our blood. Respiration occurs in two parts; we inhale during inspiration, and exhale during expiration; a full respiration is both an inspiration and expiration, or one breath in and one breath out. The normal rate of respiration for adults is between 12 and 20 breaths per minute^[6].

Nobody breathes in exactly the same way, however in general a person's breathing should be effortless and quiet. Occasional sighing is normal, though if sighing is consistent and regularly it could be a sign that they are breathing too shallowly.

When a person breathes it activates their diaphragm, a small and powerful muscle beneath the lungs, and the intercostal muscles, which are the three layers of muscle tissue between the lungs and the ribcage. As inspiration occurs the muscle system expand and makes space for the inflating lungs, and upon exhalation the muscles contract and help to squeeze the leftover carbon out of the molecules. The bronchiole carry air to the alveoli, which help oxygen enter the blood stream.

Measuring respiration

Breathe in, breathe out



SOURCE: REPORTING BY G. MILLER

KNOWABLE MAGAZINE

NAs can obtain a count on a person's respirations during the same process as getting their radial pulse. After the first 30 seconds spent taking a person's radial pulse, the NA should keep their fingers on the person's radial pulse while switching to counting their breaths for the next 30 seconds.

A person's respirations often change when they know that their breathing is being observed. Instead of explicitly telling them, transition right from taking a person's radial pulse to counting their respirations by observing or feeling the rise and fall of their chest. Respirations can be counted for 30 seconds and then multiplied by two to obtain respirations per minute; if breathing is irregular, respirations should be counted for the full 30 seconds. Image by [knowablemag](#) is licensed under [CC BY-NC-ND 2.0](#)

Observing respiration

Closely observe a person's breathing for signs of irregularity and difficulty. If a person experiences apnea, the temporary absence of breathing, or dyspnea, labored or difficult breathing, they should alert the nurse immediately.

Other symptoms of breathing problems include:

- irregular breathing or changes in breathing rhythm
- weak or shallow breathing
- breathing noises such as gurgling, wheezing, snoring sounds, grunting, etc
- use of shoulders and chest during respiration
- breathing abnormally fast or slow
- skin and lip discoloration

Problems with a person's breath often result from or precede an adverse medical event, and must be reported immediately.

Vital sign review

YouTube Video

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RegisteredNurseRN. (2019, May 13). Vital Signs Nursing: Respiratory Rate, Pulse, Blood Pressure, Temperature, Pain, Oxygen [Video]. Youtube. <https://www.youtube.com/watch?v=gUWJ-6nL5-8&t=23s>

Query 2

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Oxygen Delivery

What is respiration?

Respiration is the process of gas exchange between a person and their environment; the human body takes in oxygen from the environment, removes the oxygen to fuel its blood and cells, and then expels carbon dioxide back into the environment. The average adult takes about 20 breaths per minute.

The lungs are where blood exchanges carbon dioxide waste from the body's cells with fresh oxygen to re-supply the cells with energy. The blood then transports oxygen throughout the body, while removing carbon dioxide from our cells and taking it back to the lungs to be disposed of. The body naturally strives for balance in oxygen and carbon levels, and when the balance is tipped someone may start to breathe irregularly in response.

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[View this YouTube Video online](#)



Medical Animation Videos. (2014, February 4). Gas exchange in lungs physiology video animation – made easy [Video]. Youtube. <https://www.youtube.com/watch?v=AJpur6XUiq4>

Factors impacting oxygen delivery

Different factors impact a person's oxygen needs and ease of respiration. A person's oxygen needs are impacted by their overall respiratory health; how wide and clear the airways are, levels of inflammation, and the health of the person's lungs and air sacs all contribute to oxygen needs^[7].

Circulatory health: The circulatory system delivers the oxygen to the rest of the body. Blood vessels must be open and flexible enough to deliver large amounts of blood to every area of the body. Capillaries are tiny blood vessels that widely distribute blood throughout the body including the areas that don't have large blood vessels, such as our fingers, ears, and scalp. Capillaries are everywhere, are about the thickness of a small hair, and have extremely thin walls to promote the exchange of fluid, gas, and nutrients between blood vessels and other tissues.

Anemia is a condition where people do not have enough red blood cells. Anemia can result in some areas of the body being deprived of oxygen.

As a person ages their blood has a lower red blood cell (hemoglobin) count. Red blood cells carry the oxygen to different parts of the body. The fewer red blood cells a person has, the less effective will their oxygen delivery system will be.

As a person ages their blood vessels become stiffer and inelastic, which also inhibits oxygen delivery.

Exercise: When a person exercises their body uses much more oxygen than when it is at rest. Exercise can have a positive impact on a person's oxygen delivery system by expanding lung capacity and widening blood vessels, or a negative one by worsening symptoms of respiratory conditions such as asthma.

Nervous system is also involved in respiration; the nerves throughout our body send signals to our brain when our oxygen needs change and when something is wrong. Impairments to the nervous system can impact a person's breathing. For example, if somebody is paralyzed from the neck down they may require an assistive device to continue delivering oxygen.

Aging: Lung and respiratory muscle strength diminish with age, and lung and airway tissue loses elasticity.

Environment: The particulate content and air quality of the air a person breathes can cause negative side effects. Persons who smoke cigarettes, especially if they've been smoking for a long time, will have harmed their respiratory system. Environmental pollutants can have a harmful impact on a person's ability to breathe well. Seasonal or environmental allergies have a negative impact on a person's respiratory system when the allergen is present, sometimes causing airways to swell and close, or causing breathing to be interrupted by severe congestion.

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[View this YouTube Video online](https://www.youtube.com/watch?v=y3LUlag7W1s)



MotivationalDoc. (2015, December 6). Proper Breathing Exercise to Strengthen Lungs to Keep Healthy – Dr Mandell [Video]. Youtube. <https://www.youtube.com/watch?v=y3LUlag7W1s>

Abnormal Respiration and Oxygen

Abnormal respiration patterns are described in healthcare contexts using some technical terminology. When communicating with other members of the care team it will be helpful for NAs to know some key terms about breathing^[8].

- Apnea: not breathing, usually for a short period of time. Many people have sleep apnea, which means they temporarily stop breathing at times when they are asleep.
- Tachypnea: breathing abnormally fast
- Bradypnea: breathing abnormally slowly
- Hypoventilation: not taking in enough oxygen or removing enough carbon dioxide
- Hyperventilation: breathing very quickly and taking in too much oxygen
- Dyspnea: difficulty breathing
- Orthopnea: shortness of breath that only occurs when the person is laying down

YouTube Video

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EMTPrep. (2019, November 18). Hypoventilation and Hyperventilation – EMTprep.com [Video]. Youtube. <https://www.youtube.com/watch?v=aVyAWjaGT8Q>

Hypoxia

Hypoxia is the term for low oxygen levels. The symptoms of hypoxia occur across physical and behavioral systems because the entire human organism relies on oxygen. Symptoms of hypoxia include:

- restlessness
- disorientation
- confusion
- anxiety
- agitation
- fatigue
- changes in personality
- dyspnea
- orthopnea
- skin discoloration
- poor focus and concentration
- increased pulse

If any of these symptoms are observed, particularly when accompanied by other symptoms on the list, should alert the nurse.

Respiratory illness

Diseases that affect the respiratory system come in many different forms. These diseases can be acute or chronic; an acute disease is one that comes on somewhat quickly and has a relatively short duration, while a chronic disease lasts a long time and may be a lifelong condition.

While the goal of treatment is almost always to return a person to their normal functioning, approaches to treatment and the extent to which a respiratory illness impacts a person's lifestyle may depend in part on whether the illness is acute or chronic. Sometimes managing symptoms is the only realistic care goal.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) is a disease that gets worse over time that results in dyspnea due to obstructed airways. There is no cure for COPD, and if patients were smoking at the point of diagnosis then they must stop immediately^[9]. Treatment can be helpful in hindering the disease's progression, even though a return to full respiratory functioning is highly improbable. Chronic bronchitis and emphysema are the two illnesses grouped under COPD.

Chronic bronchitis occurs when the bronchial tubes become inflamed repeatedly and for long periods of time, and is caused by general air pollution, pollution in one's environment (such as secondhand smoke), and cigarette smoking.

There is also an acute variety of bronchitis caused by infection that sometimes develops out of a bad cold and involves the coughing up of yellow-green mucus from the lungs.

The bronchial tubes branch from the throat into the lungs and help to facilitate the gas transfer between the lungs and the environment; bronchial inflammation can result in difficulty breathing and chest pain. The scarring and long-term inflammation of the bronchial tubes leads to a persistent cough. Eventually the lung tissue also scars and becomes prone to irritation and infection.

Chronic bronchitis and cigarette smoking lead to **emphysema**, a disease where the air-sacs in the lungs, called alveoli, become damaged and break. Symptoms of emphysema are a persistent cough and dyspnea. Medications, oxygen, and respiratory therapy may be prescribed to slow the disease and make the person more comfortable.

When treating a person with COPD, always practice meticulous infection control practices, and follow the care plan closely concerning medications and oxygen delivery. It is also important to extend patience and understanding to residents' feelings of anger, fatigue, anxiety, and frustration over their difficulty breathing and respiratory problems.

Pneumonia

Pneumonia is a respiratory illness caused by lung inflammation, and has many different causes. Depending on the cause, pneumonia may be communicable. The alveoli fill with fluid and lung tissue becomes inflamed, leading to difficulty breathing and an aggressive wet cough.

Pneumonia can be bacterial, viral, fungal, or in response to a pollutant; anything that causes the lungs to inflame and fill with fluid could be a potential cause of pneumonia. People at high-risk for developing pneumonia are the very young and elderly, habitual smokers, people who have had a stroke, people who are immobile or on bed rest, people with another respiratory illness, people who receive tube-feedings, and people who must use a ventilator.

Tuberculosis

Tuberculosis (TB) is a bacterial infection usually of the lungs, but can impact other areas of the body as well. Symptoms of TB include extensive coughing, dyspnea and chest pain, coughing up blood, fever, chills, and sweats, and exhaustion.

TB is airborne, which means it is spread through droplets of moisture and mucus expelled into the air through an infected person's speaking, coughing, laughing, singing, etc.

NAs should use isolation-level precautions whenever caring for somebody with TB, including the use of a respirator mask.

A person is less likely to spread (or contract) TB in spaces with excellent ventilation and air circulation, and in a spaces where people wear PPE like masks and respirators.



Any tissues that comes into contact with mucus should be flushed or placed in a biohazard bag and re moved.

Caring for persons with respiratory illness

NAs can assist residents with respiratory illnesses by positioning them upright and making sure their body stays aligned. NAs may also position a person so they are bent over a table with a pillow on it; this position can take some of the weight off their chest and may partially alleviate dyspnea.

Some resident will need exercises including deep breathing and forceful coughing to help open their airways and slow the weakening of their chest muscles. Deep breathing and coughing exercises may be included in a person's care plan to mitigate respiratory illnesses; always closely follow the person's care plan.

Deep breathing

A deep breathing exercise involves taking a deep breath, holding it in for 3 – 5 seconds, and then exhaling as long as possible. A coughing exercise may follow a deep breathing exercise, and involves the resident holding a pillow or blanket tightly against their abdomen, taking a deep breath, and coughing as hard as they can. Have tissues and a basin ready to catch anything that is coughed up. Always check the care plan for details on the type of exercises and number of repetitions to use.

An incentive spirometer is a device used to dictate deep and slow breathing exercises, usually following surgery. NAs should prompt people to use the incentive spectrometer as prescribed in their care plan; however if the person is resistant or refuses the NA should not push the matter and should instead report it to the nurse instead.



How to Use an Incentive Spirometer

Image by [BruceBlaus](#) is licensed under [CC BY-SA 4.0](#).

NAs should clean the mouthpiece of the spirometer device prior to use. The person should close their mouth around the mouthpiece and inhale slowly and deeply while trying to keep the indicator at the proper level. They can then exhale slowly. The number of repetitions and frequency of incentive spirometer exercises will be detailed in the care plan.

Oxygen delivery

Oxygen is totally essential to every part of the human body. Some people may require oxygen therapy, where oxygen is delivered directly to their lungs using mechanical assistance. A person may need additional oxygen delivery after a surgery, due to a respiratory illness, or any illness that impacts the person's oxygen levels^[10].

NAs should *never* hook somebody up to oxygen, take them off of oxygen, or change the settings on their oxygen delivery system.

Some require additional oxygen temporarily or at different points throughout the day and night, while others may need to be connected to an oxygen device at all times.

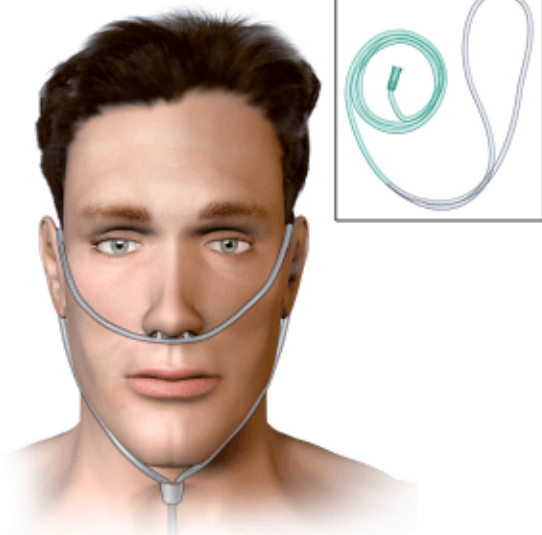
Oxygen is usually delivered either through a nasal cannula or by a face mask. A nasal cannula is a two-pronged device attached to a tube, where the prongs are inserted into the wearer's nostrils. The cannula's tubing is attached to the source of additional oxygen. Nasal cannulas are common in long-term care contexts.

Face masks fit over the nose, mouth, and chin of the wearer, are held there by a band that stretches around the wearer's head above the ears, and are connected to an oxygen source by tubing similar to that used with a nasal cannula. Face mask oxygen delivery is less convenient and less comfortable than using a nasal cannula because it irritates the skin and prevents any talking, eating, and drinking.

Delivery systems

Additional oxygen may come from a wall outlet in the facility, from a tank of compressed oxygen, from an oxygen concentrator, or from a tank of liquid oxygen.

Nasal Cannula



When the oxygen comes from the wall outlet, the cannula or mask's tubing will simply hook into the designated spot on the wall in their room. If they are using a tank of compressed gaseous or liquid oxygen then the tank will likely be on a cart.

Oxygen concentrators are devices that gather oxygen from the surrounding air and deliver it to the recipient in a concentrated form; they come in various shapes, sizes, and levels of portability. Oxygen concentrators usually plug into electrical outlets.

BruceBlaus, [CC BY-SA 4.0](#)



National Heart Lung and Blood Institute (NIH), [CC 1.0](#)

Oxygen Safety and Comfort

Oxygen safety is paramount. Compressed and concentrated oxygen is highly flammable. Anything that could possibly cause a spark becomes an extreme fire hazard around an oxygen delivery system; no unnecessary electrical devices or wool linens around an oxygen system, nor anything that could cause a spark.

- It should go without saying, but nobody should ever smoke anywhere near an oxygen delivery system. Open flames must be kept far away from compressed oxygen. NAs should post “oxygen in use” signs on the doors and over the bed of residents using oxygen therapy. NAs should make a point of knowing where all facility fire extinguishers and alarms are located.



Created by Nesdon Booth
from Noun Project

- Oxygen tanks must be well secured in their holders to prevent damage, oxygen leaks, and explosions. They must always be

kept upright and in the proper holder. Oxygen concentrators should be used in a well-ventilated space with adequate air circulation.

- Never use petroleum-based products for a person's skin care when they are on oxygen. NAs should use water-based lubricants and skin care products that do not pose a fire safety risk.
- NAs should observe the oxygen delivery tubing to make sure it is clean and free of kinks, and changed in accordance with facility policy. Image by Nesdon Booth (CCBY3.0)
- NAs should keep a close eye on the oxygen delivery system's measurements: is the oxygen flow rate remaining at the level prescribed in the person's care plan? Are the oxygen levels adequate, or does the person's oxygen tank need to be replaced.

YouTube Video

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VITAS Healthcare. (2017, November 20). Demonstrations: The Dangers of Oxygen [Video]. Youtube. <https://www.youtube.com/watch?v=LrfHnKtKwvs>

NAs should make a point of providing emotional support to persons on oxygen. Requiring an oxygen delivery system can be a jarring experience; they are uncomfortable, may be difficult to use and disruptive to a person's routines, and can come with feelings of claustrophobia and loss of control. NAs should provide a listening ear, and encourage the person to continue with the activities they can healthily maintain so their psycho-social needs to do not go unmet.

Reporting and Recording

Report any adverse side-effects or indications of problems with patients using oxygen, including:

- sore, crusty, or reddened areas on the person's skin
- discoloration in the person's skin or eyes
- changes in vital signs
- complaints of pain and tightness
- dyspnea

Artificial airways

A person may need an artificial airway to ensure that their airways are kept open so the lungs can continue to take in new oxygen and expel carbon dioxide. Without an open airway the lungs cannot function, and the person will not have enough oxygen to live.

Artificial airways are necessary when the person's airways would otherwise be obstructed due to illness, injury, or surgery. An artificial airway is created when a doctor or nurse inserts a tube, through a process known as intubation, into the person's windpipe (trachea). The tube may be inserted through the person's mouth or nose, or through a surgically created opening in the neck. There are a few different kinds of artificial airways^[11].

An oropharyngeal airway is a relatively short, curved plastic tube inserted through the person's mouth that prevents their tongue from blocking their airway.

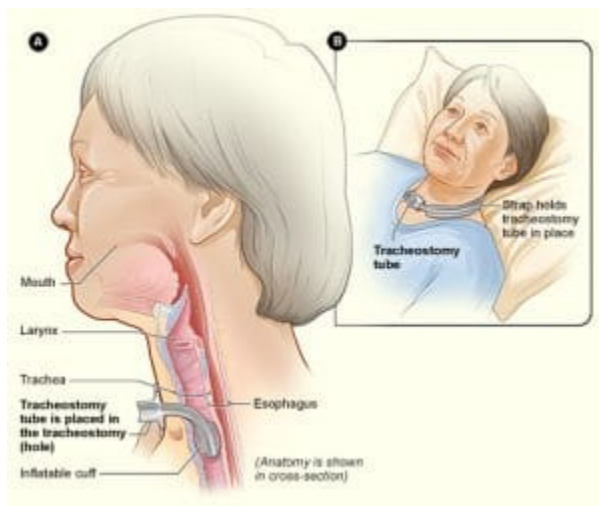
An endotracheal airway is inserted through the person's mouth or nose, and extends into their trachea and sits between their vocal cords.

A tracheostomy is a surgically created stoma in the neck that leads into the trachea. A tracheostomy tube delivers oxygen directly into the trachea. People with tracheostomies will need attentive, sanitary care.

- Caring for a tracheostomy includes maintaining meticulous infection control measures by cleaning the area around the stoma (opening), helping the nurse with changing dressings, and assisting with cleaning the tracheostomy tubing. If the NA notices any gurgling or otherwise abnormal noises coming from the device when the person breathes, they should tell the nurse since the tubing may need to be cleaned.
- Perform oral care every two hours as directed in the care plan. Patients with tracheostomies are at high risk for aspiration, so oral care may need to be performed with specific tools meant for people using artificial airways.
- NAs should not change anything about a tracheostomy device. Do not move or jostle any tubing while performing oral and skin care.
- Tracheostomies are cleaned using a process called suctioning. Suctioning involves the use of a pump to remove all secretions from the person's airway, and may need to be done regularly. NAs cannot perform the suctioning procedure, it must be done by a nurse or a respiratory therapist. If a person with a tracheostomy shows signs of respiratory distress such as noises, shortness of breath, or pain then they may need suctioning.
- NAs should be as supportive as possible when a person needs an artificial airway, particularly during moments of acute discomfort. When a person is having extreme difficulty breathing, maintaining conversation and light touch can be comforting.

Let a nurse know if you see

- respiratory difficulty
- discoloration in the skin or eyes
- sores or breaks in the mouth or the skin
- changes in vitals
- loose dressings or tape
- disconnected tubing



National Heart Lung and Blood Institute (NIH), [CC 1.0](#)

Caring for artificial airways

When caring for somebody with an artificial airway, NAs should regularly closely inspect the tubing and any adhesives that keep tubing in place. If the tubing falls out or comes undone, remain with the person and alert the nurse using the person's call light.

Positioning matters more than usual for someone using an artificial airway. Always follow the care plan regarding positioning and repositioning.

Artificial airways are uncomfortable. Always practice empathetic communication. Some people using artificial airways cannot speak, so the NA will have to devise alternative means of communication through writing, typing, or gestures.

If the NA observes any signs of abnormal respiration, discoloration in the skin or eyes, secretions in tubing, drainage from surgical sites, or emotional distress, they should alert the nurse.

Mechanical ventilators & chest tubes

A person who cannot breathe on their own may require the assistance of a mechanical ventilator to breathe for them by automatically moving air into and out of the lungs. Ventilators supply a person's body with oxygen through an artificial airway; because the air bypasses the larynx and vocal cords, a person using a mechanical ventilator will be unable to speak. NAs should be a frequent and calming presence to a person on a ventilator by checking in with them, spending extra time with them if possible, and devising modes of communication to use when the person cannot speak.

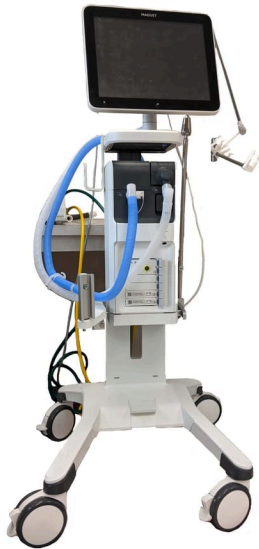


Image by BreathDriver, [CC BY-SA 4.0](#)

NAs should pay close attention to a person on a ventilator, and always make sure that their call light is easily within reach.

If there are any alarms or irregular beeping coming from the mechanical ventilator, notify the nurse immediately. Notify the nurse if a person on a ventilator is exhibiting any signs of respiratory distress, or pain and discomfort.

Practice careful infection control with people who are using ventilators; HAIs are common results of ventilator use in facilities.

NAs will not hook or unhook anybody to or from a mechanical ventilator. The NA's primary role will be to closely observe the ventilator's tubing and connections to make sure everything is smooth and free of blocks or kinks, and to provide oral care often and as directed. NAs should work with the person to find effective ways of communicating when they are unable to speak.

A person may require chest tubes in between layers of lung tissue to help drain air, blood, or other fluids. The tube is attached to a drainage system which allows for the removal of gas or fluids.

NAs must be careful and aware of all tubing and tubing connections, and try to prevent kinks from forming. The system must be completely airtight.

The drainage collection system must be kept below the person's chest at all times.

The NA should notify the nurse immediately with any changes in the condition of the ventilation system or the patient. Indications of respiratory distress, disconnected or malfunctioning tubing, and coughing up blood must be urgently addressed.

The Nursing Assistant's Role

NAs have a specific and important set of responsibilities when caring for respiratory patients using oxygen, artificial airways,

and chest tubes. While NAs do not insert or connect oxygen, artificial airways, or chest tubes, they perform vital tasks in their observation, and in the care of the people who need them.



SMART CHOICE

- NAs should regularly check to make sure that the oxygen flow is set to the correct amount. Always ask or check the care plan if unsure about a person's prescribed oxygen treatment. If the oxygen flow is incorrect, tell the nurse immediately.
- A person's mouth, nose, and skin can develop sores and irritation when using respiratory equipment. Maintaining good oral and skin care can help make a person's experience less uncomfortable, and will help prevent infections. Maintain communication throughout care tasks even when the person is unconscious and unresponsive.
- Follow the care plan instructions for deep breathing and coughing exercises, and incentive spirometer use. Remain positive and encouraging during these exercises, and exercise patience and empathy when the person expresses frustration.
- Reposition people frequently in accordance with the care plan and instructions from the nurse.
- Alert the nurse immediately if observing any disconnections in the oxygen equipment, any changes in the amount or quality of the drainage, changes in the condition of the device or the person, and any signs and symptoms of hypoxia or respiratory distress.
- Observe and chart carefully and thoroughly.

Query 3

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Key Takeaways

- Vital signs are measurements of some mechanisms part of a body's basic functional processes. Vital signs include temperature, pulse, respiration, and blood pressure. It is essential that NAs take vital measurements accurately, and alert the nurse if a resident's vital signs are abnormal.
- Always obtain vital signs properly and respectfully. Chart vitals right after taking them so they are remembered correctly. If temperature, pulse, blood pressure, or respirations are abnormal, they may clue the care team into an ongoing problem or an active medical emergency.
- Hypertension and hypotension are common cardiovascular disorders. While both are dangerous, hypertension can be deadly, cause heart attacks, and points to severe cardiac diseases. Chronic obstructive pulmonary disease (COPD), pneumonia, and tuberculosis are some common respiratory diseases. COPD is an incurable respiratory disease that progresses as alveoli and lung tissue scar and engage in excessive mucus production.
- Some patients may require additional oxygen using an oxygen supply or a mechanical ventilator. When using an oxygen supply, the oxygen will either be delivered using a nasal cannula or a face mask. NAs should not hook up oxygen, unhook oxygen, or change any of the levels on an oxygen supply device. When caring for someone using additional oxygen, make sure

that they are comfortable, the tubing is free of kinks that could block flow, and the oxygen is flowing at the rate prescribed in the care plan. Always practice oxygen-specific fire safety, and do not use items that may produce a spark.

Comprehension Questions

1) The normal temperature range for a human is considered to be ____ degrees Fahrenheit, though it varies depending on factors like age, activity level, and illness.

- a. 97.6 – 99.6
- b. 98 – 99.5
- c. 97 – 99
- d. 96.6 – 98.6

2) Please list the four vital signs, and describe what each of them mean.

3) The systole is _____, while the diastole is _____.

- a. the top number on a blood pressure reading; the bottom number on a blood pressure reading
- b. the atria; the ventricles
- c. the motion of the heart as it contracts; the motion of the heart as it refills with blood
- d. “dub”; “lub”

4) Respiration is _____; the body takes in _____ to distribute throughout the body, and removes _____.

- a. the exchange of gas between a person and their environment; oxygen; carbon
- b. the inhalation of fluids during eating and drinking; food or fluid; air
- c. the exchange of gas between a person and their environment; air; oxygen
- d. the exchange of gas between a ventilator and a person; carbon; oxygen

5) Respond to the following sentences with T (true) or F (false).

- ___ Aging impacts the circulatory system as hemoglobin decreases and blood vessels harden.
- ___ Symptoms of hypoxia include oxygen saturation, restlessness, and high energy levels.
- ___ Some respiratory illnesses cannot be cured. When an illness cannot be cured and lasts a long time it is acute.
- ___ Hyperventilation includes an excess of oxygen.
- ___ Someone experiencing hypoxia may act differently, and not seem like themselves.

6) How does someone use an incentive spirometer?

- a. By exhaling forcefully into the mouthpiece to get the piston as high as possible
- b. By shaking it up and down while inhaling and exhaling slowly
- c. By inhaling slowly and trying to keep the piston at the appropriate level
- d. By inhaling deeply and blowing back into it again

7) Which of the following should nursing assistants do for someone receiving oxygen therapy? Select any that apply.

- a. Adjust the oxygen levels to the prescribed levels in the care plan
- b. Remove nasal cannula tubing for cleaning
- c. Provide careful skincare around the cannula or mask area
- d. Carefully observe the resident for signs of difficulty breathing, and observe but do not change oxygen settings.

8) What is a tracheostomy?

- a. An opening through which mucus and secretions can be removed from the lungs
- b. A stoma in the neck that allows somebody with mouth sores to speak
- c. An opening in the neck that allows oxygen to be pushed directly into the trachea
- d. An opening in the neck that removes drainage from the vocal cords

9) Please list at least three adverse side-effects of oxygen use nursing assistants should report to the nurse and record in the resident's chart.

10) Respond to the following sentences with T (true) or F (false).

___ Oxygen may come from a wall outlet, a portable oxygen tank, or a device called an oxygen compressor.

___ Smoking near oxygen is acceptable as long as you blow the smoke away from the tank.

___ Residents receive oxygen through a nasal cannula, a face mask, or in liquid form.

___ Post an "oxygen in use" sign outside of resident's doors when they use oxygen so that the rest of the healthcare team is aware of the fire hazard.

___ When tracheostomy tubing becomes disconnected, NAs should hook it up again as quickly as possible as long as they have been trained.

11) Think back to the nursing process (assess, diagnose, plan, implement, evaluate/assess). What goes into each step of the nursing process, and what role do vitals measurement play in each step?

12) How might oxygen use impact someone's psychosocial needs and wellbeing? How should nursing assistants respond to a person for whom oxygen use is negatively impacting their emotional and social wellbeing?

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Module 11 – Supportive Care

Learning Objectives

- Demonstrate understanding of the importance of supportive care
- Demonstrate ability to perform supportive care tasks
- Apply knowledge of safety and infection control to supportive care

Supportive Care

Supportive care involves caring for people around the time they have surgery. NAs play important roles before and after a person has had surgery.

Surgery

People have surgeries for many different reasons. Surgeries are classified as either elective, urgent, or emergency.

- An elective surgery is a surgery that is medically recommended or desired by the patient. Some elective surgeries are medically necessary but not in an immanently time-sensitive way.
- An urgent surgery is a medically necessary surgery that needs to be performed soon. Urgent surgeries can be scheduled in advance.
- An emergency surgery is a medically necessary surgery that needs to be performed immediately. Emergency surgeries may not be schedulable with much, or any, advanced notice.

Surgeries may cause somebody anxiety or distress. This is not unwarranted; surgeries come with risks, especially those that require anesthesia. The doctor or nurse will provide the patient with information about what will happen before, during, and after their surgery.

The NA's role includes listening to the concerns of the person without belittling or minimizing those concerns. Be calm, compassionate, and attentive to the person's worries, and answer any questions that fall within the NA scope of practice. If the person's anxiety escalates or they ask questions that NAs cannot answer, notify the nurse so they can converse with the patient further.

Where and when?

Surgeries are either classified as in-patient or same-day.

In-patient surgeries involve a person staying in the hospital for at least one fully day after their surgery, though in-patient surgery stays may be longer depending on the kind of surgery and post-surgical complications. A person undergoing an in-patient surgery may need to be admitted to the hospital one or two days prior to their surgery for pre-operative care.

Same-day surgery is also referred to as outpatient or ambulatory surgeries. For same-day surgeries the person can go home the same day, or may need to stay until the next day, depending on how they respond to the surgery. Surgeries are usually done in hospitals or another specifically equipped location.

If a person goes to the emergency room and it is determined they need surgery then they may go right to surgery from the hospital's emergency department.

What happens?

When a person is prescribed surgery, the doctor will be the member of the care team that explains the diagnosis and prescribed surgical procedure to the person and their family^[1].

Residents always have a Right to be fully informed about their care.

The doctor will inform the person and their family about the surgery, the risks associated with the surgery, and possible post-operative complications. They will also be informed about the risks posed by not having the surgery and following other courses of treatment, or no treatment. Entering into a medical decision fully informed and aware is part of giving informed consent.

Questions about surgeries should be left for the doctor or nurse; NAs can provide a listening ear, but should not answer any questions outside of their scope of practice.

After the surgery the doctor will let the person and family know about the results of the surgery. Even if the rest of the care team learns the results before the family does, they should not answer any questions about the surgery's results and should instead let the doctor have that conversation with the person and family. It is outside the NA scope of practice to discuss or answer technical questions about surgeries.

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Preoperative care

A person about to have surgery will need to be taught a couple of protocols before they receive their operation. The person should learn how to perform deep breathing, coughing, and incentive spirometer exercises. These exercises should be performed every 1 to 2 hours post-surgery when the person is awake. They will also learn how to do their leg exercises, which must be done every 1 – 2 hours post-surgery when the person is awake.

If the person will require anesthesia for their surgery then they should be informed about the post-anesthesia care unit (PACU) where a person recovers from anesthesia immediately post-surgery. Once the person's condition is deemed stable, they will be transferred out of the PACU for the remainder of their recovery.

Preparing for surgery

The person may have food and fluid restrictions during the hours or day leading up to the surgery. NA must follow fluid and food orders meticulously. The person may have an NPO (nothing by mouth) order for 8 hours or more leading up to the surgery. Going into a surgery with an empty digestive system can help to prevent vomiting and aspiration while under anesthesia.

Creating reasonable expectations around recovery helps patients feel in-control and is an important dimension of person-centered care.

The person will be taught the type and amount of pain to expect while recovering from the surgery. Every surgery, and every person, has a different recovery process with different kinds and levels of pain and discomfort.

A person should be briefed on all of their post-operative treatments and recovery equipment before they go into the surgery. Having this knowledge beforehand is an important part of holistic, person-centered care, and will allow the person to be more cooperative with the healthcare team during recovery.

Learning all of these facts about surgery is included in obtaining the patient's informed consent for the procedure.

Preparing the person for surgery

Elimination

NAs should assist with voiding and bowel elimination as needed. If a person is about to receive bowel surgery, they may require bowel prep. Bowel prep involves cleansing the bowels of feces by drinking special fluids. Bowel cleansing is an important preoperative practice for bowel surgery patients because an open intestine that has not been cleansed may spill waste into the abdominal cavity, which would be bad.

When a person receives pre-operative care NAs will measure and record their urinary output. The person will void before their preoperative drugs are administered by the nurse; if they are already using a urinary catheter, their drainage bag should be emptied. A urinary catheter may be inserted in the operating room for accurate output measurement during and after surgery. A person should go into surgery with an empty bladder because a full bladder is more vulnerable to injury.

Thorough and cleansing personal care prior to surgery is an important infection control practice because it removes microbes from the body. Being as clean as possible going into a surgery will also help someone be more comfortable during their recovery^[2].

Preoperative personal care

- NAs should help the person with a complete bed bath, shower, or tub bath depending on their mobility. A special soap or cleanser may be ordered for the preoperative bath to reduce the risk of surgical wound infection.
- The person should not go into surgery with makeup, nail polish, or artificial nails.
- Remove all jewelry and hair adornment; the NA can place valuables in a secure place. Make sure to write down exactly what valuables the person has in facility safekeeping.
- The NA should administer oral hygiene care before surgery. Make sure the person does not swallow any water while receiving oral hygiene.
- NAs should remove and store a person's dentures before they are taken in for surgery. Always store a person's belongings, including their dentures, according to facility policy.
- People who have imperfect circulation may need to wear elastic stockings, also called compression or anti-embolism stockings, to promote healthy circulation during and after surgery. Elastic stockings are used to create even compression across the legs for smooth blood flow.
 - The risk associated with elastic stockings is that they will block circulation, rather than make it easier. NAs should regularly check the feet and toes of persons using elastic stockings for discoloration and cyanosis.
 - There should be no wrinkles or uneven areas in the sock.



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Communication is key

One of the most important roles NAs play in preoperative care is an emotional and communicative role. People preparing for surgery may be worried, anxious, apprehensive, or experiencing another negative emotion. NAs can help alleviate these feelings by providing reassurance and a listening ear. Refer any of the person's questions NAs cannot answer to the nurse, and report signs of fear and anxiety.

YouTube Video

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Roberts, B. (2008, October 11). Pre- and Postoperative Care [Video]. Youtube. <https://www.youtube.com/watch?v=XZq1gExGh8k>

Anesthesia and Sedation

A person will likely receive either sedation or anesthesia for their surgery. Sedation and anesthesia allow procedures to be performed that would otherwise be intolerable in a person's fully conscious state. Sedation is used to put somebody into a state of calm and relaxation or sleep, while anesthesia is a drug that causes a loss of feeling and sensation.

Sedation may either be minimal, moderate, or deep. Minimal sedation is given to relieve anxiety and agitation, and does not usually impact a person's awareness. Moderate sedation involves calmness and a depression of conscious awareness, but still allows the person enough awareness to respond to verbal and tactile stimuli. Deep sedation puts somebody in a state of unconsciousness; they will be unresponsive and/or asleep.

Anesthesia is drug-induced loss of feeling or sensation. Drugs that produce anesthesia are anesthetics. The three common forms of anesthesia are general anesthesia, regional anesthesia, and local anesthesia.

- General anesthetics are usually administered through IV lines. General anesthesia induces a lack of consciousness and a total loss of feelings and sensation.
- Regional anesthesia induces a loss of feeling in a region of the body, such as below the waist, for a hand or foot surgery, or during joint replacement surgeries. The person stays awake when under regional anesthesia. Regional anesthesia is administered by injection into a regional body part.
- Local anesthesia induces a loss of feelings and sensation in a small area of the body. For example, local anesthesia would be used when removing a mole, pulling a tooth, or when stitching a wound.

A person recovering from a surgery where anesthesia was used will begin their recovery in the post-anesthesia care unit (PACU). They will be transferred out of the PACU when their condition has stabilized, which usually means at minimum that they are awake and alert with regular and consistent vitals.

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Postoperative care

Postoperative care is the care that somebody requires while recovering from a surgery. Once the person's condition has stabilized the PACU staff will notify the nursing team.

The PACU team will usually be responsible for transporting the person to their next room on a stretcher. NAs can assist with transferring the person from the stretcher to their bed, and with positioning the person comfortably.

The nurse will check the person's incision site for damage or bleeding. The nurse will also double check the person's catheter, IV, and tubing placement and function. Once the person has been carefully observed and checked, then their family can come be with the person as they continue recovering.

Preparing the room

NAs may be asked to prepare the person's room for recovery from surgery. This will include making a surgical bed for easy transfer from a stretcher and moving any furniture that might get in the way of a stretcher transfer. NAs can also assist by making sure all necessary equipment is in the room. The necessary equipment includes all equipment that is always in a person's room, such as a bedpan, and any special equipment that the person requires following surgery like an incentive spirometer or ventilator.

Repositioning

A person should be repositioned and/or turned every 1 – 2 hours to prevent pressure areas and to stimulate circulation. NAs should be aware of any positions the person cannot be put in due to their surgery.

The person is usually positioned so they can easily breathe (Fowler's or semi-Fowler's), and to prevent stress or pressure on the incision site. Positioning is also important for preventing aspiration by arranging the bed so that the head is slightly raised.

Fowler's:



Semi-Fowler's:



[4]

Nurses will communicate when and how often to reposition, and in which positions to place them. If questions remain, always follow up and check the care plan.

Turning or repositioning can be painful for the person. NAs should provide as much support as they can, and use smooth and gentle motions so as not to jostle the person or any of their equipment. If unsure about completing a motion smoothly NAs should always ask for help from other members of the nursing team.

Breathing

NAs should work with post-operative surgery patients on their ordered breathing exercises, usually every 1 – 2 hours. Keeping up a breathing and coughing exercise routine will help prevent the development of respiratory complications.

Closely observe any tubing and breathing devices to make sure they remain clean and free of kinks; if a person's tubing looks like it needs to be cleaned, or a person using additional oxygen is making a gurgling sound when they breathe, the NA should alert the nurse right away.

Assisted ambulation after surgery can help a patient regain respiratory strength.

Breathing exercises will usually include “turn, cough, deep breath” (TCDB) exercises, as well as the ordered use of an incentive spirometer to help with lung capacity and breath control. .

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[View this YouTube Video online](https://www.youtube.com/watch?v=flIV8c38zDE)



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Circulation

Circulation must be stimulated in the person's legs. Circulation can slow after surgery, leaving someone at risk of developing blood clots. Thrombus is the term for a blood clot that is currently stationary in the blood stream. The risk with thrombi is that they will become an embolus, or a blood clot that travels through the vascular system until it lodges somewhere in a blood vessel, the lungs, the heart, or the brain^[5].

Signs and symptoms of thrombus include:

- a warm swollen area of the leg
- pain and tenderness in the leg
- skin discoloration
- chest pain
- shortness of breath

If the NA notices these symptoms they should alert the nurse at once.

Techniques for promoting healthy circulation

NAs should assist a person with their postoperative leg exercises every 1 – 2 hours. Doing so prevents muscle degeneration and stimulates healthy circulation^[6]. Doing range-of-motion exercises with the person can also help stimulate circulation in other parts of the body.

Stimulating circulation after surgery is necessary to prevent thrombi, or blood clots, from forming. Remaining stationary in bed or sitting for a long period of time puts someone at risk for developing blood clots, which are dangerous if they aren't caught. The best thing to do is prevent them from forming in the first place.

Leg exercises and early ambulation are some ways thrombi are prevented in advance. A person may have difficulty the first times they try to walk. NAs should assist the person with early ambulation according to the care plan, even if only a little bit.

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UNH Patient Education. (2013, May 13). My Surgery Guide: Improving Leg Circulation Exercises [Video]. Youtube. https://www.youtube.com/watch?v=SA_f0bj7oIE

Elastic stockings are used following a surgery to equalize pressure across the leg, promoting even and smooth circulation. Elastic stockings, or anti-embolism stockings, have a small hole in the seams near the toes so that NAs can check a person's toes and feet for discoloration or swelling, which may indicate a lack of proper circulation. Check a person's toes regularly and report any abnormalities to the nurse.

A person receiving postoperative care should not sit or stand for prolonged periods of time, since this can slow the flow of blood and make circulation more difficult.

Infection control



A postoperative patient's surgical wound will need protection and attention. Meticulous infection control practices should be upheld at all times. The incision may be covered with a sterile dress; NAs may be asked to assist the nurse or doctor with a sterile dressing change, though they should not do one themselves. Loose or wet bandages and tape are cause to alert the nurse.

Nutrients and elimination

A person returns from surgery with an IV in place for nutrients and fluids, and begins on an NPO diet. If all goes well, the person's diet will progress from NPO to a clear liquid diet, then to a full liquid diet, and then to a regular diet. How long the IV needs to be continued depends on the type of surgery performed and the person's condition during recovery.

Frequent oral hygiene care is especially important when someone is NPO; provide regular oral care on a schedule and when requested.

Anesthesia, surgery, and being NPO affect normal bowel and urinary elimination. NAs should do what the nurse and doctor order, and what is in the care plan, to promote elimination following surgery. Enemas may be given to ease post-surgical constipation, and catheters may be necessary if the person does not void soon after surgery.

Constipation is a common experience following surgery.

A person's intake and output are measured following surgery. NAs should note the time and amount of the first voiding, and continue to keep track after that.

Rest and care

A person requires substantial rest and comfort to fully recover from a surgery.



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Continuing pain is a common experience while recovering from a surgery. The type and degree of pain depend on the extent of the surgery and the type of surgery performed and the site and size of the surgical incision.

The presence of tubing, casts, and other devices can be painful and uncomfortable. Depending on how the person was positioned during surgery and how long the surgery lasted there may be lingering discomfort from muscle soreness.

The doctor will order pain relief drugs to promote comfort following a surgery, and the care team will use the nursing process to find ways to make the person more comfortable and allow them to rest. Always follow the person's care plan.

Excellent personal hygiene is important for the person's comfort, mental wellbeing, and for infection control. Frequent oral care, hair care, and a complete bed bath following surgery help a person feel refreshed and comfortable. Always change any wet or soiled clothing or linens immediately.

Observing and reporting

NAs must closely observe people in postoperative care. Even though their condition has stabilized, changes can occur quickly. The NA should report any of these symptoms to the nurse immediately:

- An opening of the incision or the presence of excessive bleeding
- Uncontrolled pain
- Respiratory distress or complications
- Increased swelling or discoloration
- Uncontrolled vomiting
- Concerning changes to the person's vital signs
- Any drastic change in the person's condition

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Cooling and Warming treatments

Sometimes doctors will order heat or cold applications for postoperative patients. NAs may not be permitted to perform hot and cold applications depending on facility policy. NAs should remember never to perform tasks they are not assigned or trained for.

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Neel, K. (2020, October 3). Heat and cold application [Video]. Youtube. <https://www.youtube.com/watch?v=B77CXAHKewE>

Heat application

The primary benefit of heat application is that it dilates (widens) the blood vessels, which promotes increased circulation. By increasing circulation, heat application promotes the removal of excess fluids and waste products, and promotes the provision of oxygen and nutrition to cells throughout the body. Heat can relieve pain, relax the muscles, promote healing and blood flow, reduce swelling, and decrease joint stiffness^[7].



“heat miser!” by [picturemommy](#) is licensed under [CC BY-NC-ND 2.0](#).

Some risk factors associated with heat application are burns and skin damage from the heat. People with diminished sensitivity to temperature, such as elderly persons, are especially vulnerable to negative side effects from heat application. Remember that after 15 – 20 minutes blood vessels contract rather than dilate, which is the opposite of the intended effect.

Types of heat application

Heat applications are either “moist” or “dry.” When using a moist heat application the warm water is in direct contact with the person’s skin. Water that is directly applied has a more potent and fast-acting effect than dry applications such as a warm pack. . Examples of moist heat applications include a hot compress, a hot soak, a sitz bath, and a hot pack.

- A hot compress involves laying a warm and moist compress or washcloth over an area for 15 – 20 minutes, or until the area

is red and/or uncomfortable. NAs should check the skin under a hot compress at least once every five minutes.

- A hot soak involves soaking an area of the body, such as a person's feet, in warm water for 15- 20 minutes, or until red and/or uncomfortable.
- A sitz bath involves soaking the perineal region using a specific basin. This may be done following a perineal surgery, to promote perineal hygiene, or to reduce perineal pain or swelling.

Dry applications are heat applications where water does not come into direct contact with the person's skin. Examples include hot packs and heating pads. Always follow the care plan and the nurse's instructions when administering heat application treatments.

NAs must always record the time of heat application, when the heat application is removed, and any changes to the person's condition.

Safety

Safety is one of the Big Three, so NAs should consistently reflect, "What safety concerns do I need to consider while giving this care? Am I missing anything?" Heat application come with some safety concerns NAs should keep in mind to avoid complications.



- Heat applications can cause burns. NAs should check the person's skin regularly.
- Be wary of blood pressure changes caused by heat applications. NAs should take vitals as ordered, and report symptoms such as dizziness and lightheadedness, nausea, and other changes in the person's condition.
- If the heat application is left on too long, blood vessels will constrict as a counter-response to prolonged heat exposure. When blood vessels constrict, the person's skin will become pale. Remember that heat applications left on too long perform the opposite of their intended effect.
- NAs should be aware of metal implants such as pacemakers and joint replacements. Metal responds to heat differently than tissue does. NAs should always check with the nurse and the person's care plan if unsure how to proceed with a heat application to a person with metal implants.

Cold application

Cold applications are useful when the doctor or nurse want a person's blood vessels to constrict and decrease blood flow. Cold applications are useful right after surgery to help stop bleeding, and decrease swelling and pain. Cold applications are also used to treat conditions like sprains, fractures, and blunt force trauma to prevent swelling and excessive bleeding.



InjuryMap, CC BY-SA 4.0

Moist cold applications include cold compresses (cold washcloth or similar), cold sponge baths and soaks, and any treatment where the cold water comes into direct contact with the person's skin. Dry cold applications include ice bags and ice packs, and cooling blankets.

Cold applications come with potential complications that NAs must observe for. Cold applications may cause pain; if a person reports pain from their cold application, NAs should either stop the cold application or give the person a short break before trying the cold application again.

- Cold applications reduce circulation, which means they may produce a numbing effect, or make the person's skin pale, red, blue, or otherwise discolored. If the person reports numbness, or if the NA observes notable discoloration on the area of application, then the cold treatment should be paused or stopped.
- If cold is applied too long, or if the treatment is too cold, it can cause cold burns and blisters to occur. Early indication that somebody has been overexposed to cold are shivering and discomfort.

Safety

When using hot and cold applications, keep some basic safety information in mind^[8].

- Hot and cold applications are only applied for 15 – 20 minutes at a time, and the person's skin needs to be checked at least every 5 minutes.
- Check the water temperature before starting a hot or cold application; make sure the temperature of the water matches the temperature listed in the care plan.
- Hot packs must never be placed under a person. Hot packs placed under a person are more likely to cause burns, and are less likely to be checked frequently.
- A person with a cold application should be offered blankets to help them stay comfortable.

Cooling and warming blankets

Cooling and warming blankets may be used when a person experience hyper- or hypothermia, respectively.

A person is considered hyperthermic when they have a body temperature significantly higher than the normal range. Cooling blankets may be used to cool someone down, and to quickly lower their body temperature if it reaches hyperthermic levels. Most cooling blankets used in healthcare facilities are electrically powered and can be set to a particular temperature. NAs must regularly check vitals to see how the treatment is affecting the person's body temperature.

Hypothermia occurs when somebody's body temperature is excessively low. Warming blankets may be used for persons

experiencing hypothermia. Warming blankets are similar to cooling blankets in that they are powered and can be set to a specific temperature; in this case, the powered blanket is used to warm somebody up rather than cool them down.

NAs must frequently measure a person's vitals while they are using a warming blanket. Once a person's temperature has been brought back to normal levels heat application should cease until it is required again. Overuse of heat and cold applications can have the opposite of their desired effect.

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Key Takeaways

- Supportive care involves preparing somebody for surgery, and meeting their recovery needs after their surgery. Recovering from a surgery comes with risks for dangerous complications; patients will need caring and attentive NAs to meet their needs and encourage them along their recovery journey.
- Preoperative supportive care includes providing an emotionally caring and communicative environment to calm the person, as well as assisting with any special diets, elimination needs, and preoperative personal care. Postoperative supportive care includes encouraging the patient, since they will be in pain; it also involves assisting with exercises to promote healthy breathing and circulation, regular repositioning, and heat and cold applications.
- Always practice safety and infection control when providing supportive care. Safety considerations include patient ambulation, oxygen tank safety, and remaining aware of wires and tubing when assisting with ADLs. Infection control considerations include keeping any tubing and catheters clean, and monitoring the surgical wound for inflammation and drainage. Always practice rigorous infection control practices when providing supportive care.

Comprehension Questions

1) Why is supportive care necessary?

- a. To help a person realize that they need surgery
- b. To help a person regain financial stability after surgery
- c. To help a person's family plan for care following a surgery
- d. To help a person heal fully and holistically from a surgery

2) Why are preoperative fluids restricted?

- a. To prevent vomiting and aspiration while under sedation or anesthesia
- b. To prevent vomiting and aspiration from nervousness
- c. To prevent vomiting from happiness when the surgery is over
- d. To prevent water retention edema

3) Please describe the nursing assistant's emotional and communicative role during preoperative care. How should NAs interact with preoperative residents? What should they avoid doing, especially when communicating with residents who are anxious about surgery?

4) A person recovering from surgery where anesthesia was used will begin their recovery ... where?

- a. The PDCU, or the pre-discharge care unit
- b. The PICU, or the post-incision care unit
- c. The PACU, or the pre-anesthesia care unit
- d. The PACU, or the post-anesthesia care unit

5) Respond to the following sentences with T (true) or F (false).

___ NAs will go and get the person from the PACU after they have reached a stable condition.

___ Postoperative patients should be repositioned regularly to promote respiration and keep pressure off of their incision site.

___ If a person's tubing appears clogged or dirty, NAs should gently clean it according to facility protocol.

___ Laying someone flat on their back promotes easy respiration.

___ Patients should be encouraged to ambulate after surgery to promote healthy circulation and respiration.

6) Please list at least three, and up to five, signs and symptoms of thrombus.

7) What are some techniques NAs can use to promote healthy circulation following a surgery? Select all that apply.

- a. Assisting with prescribed leg exercises
- b. Encouraging the person to embrace bed rest
- c. Providing support during ambulation soon after surgery
- d. Practice Standard Precautions
- e. Closely observe the person's skin when they use anti-embolism stockings

8) Excellent personal hygiene, including oral and skin care, is important following a surgery. Why? Select all that apply.

- a. It is an infection control measure
- b. Having bad breath is embarrassing
- c. It helps a person feel refreshed and comfortable
- d. It speeds the healing process by up to 2x

9) Please list at least 4 and up to 7 observations about someone recovering from surgery that NAs should immediately report to the nurse.

10) Respond to the following sentences with T (true) or F (false).

___ The primary benefit of heat application is that it dilates blood vessels, which promotes circulation, relieves pain and swelling, and relaxes the muscles.

___ Moist hot or cold applications are when water comes in direct contact with the skin.

___ Only hot applications can cause burns or blisters if left on for too long.

___ Cold applications, when properly used, increase circulation to the impacted area.

___ Hot packs are sometimes most effective when placed under a person.

11) Describe the importance of the Big Three to supportive care, with a focus on Infection Control and Safety. Why are infection control measures extra important when somebody is preparing for or recovering from surgery? How can NAs ensure excellent infection control when providing supportive care? What sort of safety considerations must NAs keep in mind when assisting recent postoperative patients with their ADLs (bathing, repositioning, changing clothes, etc)?

12) You are caring for a resident before their surgery; as the surgery approaches, they are uncomfortable due to hunger, and are expressing anxiety about how the surgery will go. You try to listen, but eventually become annoyed by the regular complaints of hunger and displays of anxious thinking for what you know is a routine and low-risk surgery. After a certain point, your replies go from “I’m sure it’ll all be fine” to simply “mmm-hmm” in response. When the resident gets back from surgery, you can tell by their face and movements that they are in pain, and they seem withdrawn and depressed. How might the resident’s emotional and social wellbeing impact their ability to receive good care? What would you do at this point in this scenario? How could you have communicated differently with the resident to make them feel more cared for?

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Module 12 – Rehabilitative and Restorative Care

Learning Objectives

- Demonstrate understanding of rehabilitative and restorative care
- Contrast reality orientation and validation therapy
- Demonstrate understanding of disease processes commonly requiring rehabilitation
- Apply effective communication techniques during the rehabilitative and restorative care process

The Focus of Rehabilitative & Restorative Care

Rehabilitative and restorative care aims to bring a person back to their normal level of functioning, or as close as possible to it, following an injury, illness, or medical intervention^[1]. All of the Big Three should be considered in everything NAs do; when doing rehabilitative and restorative care, the emphasis will be on Resident Rights. We all have the right to regain and maintain our highest level of functioning. Care should always be given with this Right in mind.



Some helpful vocabulary:

- ROM: Range of motion (ROM) refers to how extensively a person can comfortably move different parts of their body
- ADLs: Activities of daily living (ADLs) are those daily tasks required for basic personal upkeep, such as bathing, dressing, and performing oral hygiene.
- OBRA: The Omnibus Budget Reconciliation Act of 1987 (OBRA) is a landmark piece of federal legislation that sets quality of care standards in healthcare facilities.
- Prosthesis: Prostheses are artificial replacements for a body part. Prostheses may be removable, such as a prosthetic arm, or irremovable, such as an artificial knee.
- Acute: Abrupt onset with a short course, such as an aggressive cold that has run its course in two weeks.
- Chronic: A disease or medical problem with a long course. When a chronic illness is under control it is in remission, while it is not under control then it is exacerbated. Chronic illnesses are usually not cured.
- Disability: Permanent or temporary loss of physical or mental ability and function.
- Atrophy: Loss of muscle tissue resulting from underuse.

The purpose

Rehabilitation and restorative care are necessarily holistic processes. This means that a person receiving care is understood as a whole person, whose care is not reducible to an isolated medical problem. Holistic care means that a person's psycho-social, emotional, and spiritual needs are attended to, in addition to their basic physical needs.

Rehabilitation

Rehabilitation refers to the process of restoring a person to their highest level of physical, psychological, emotional, and economic function.

Part of holistic care is recognizing that all of these things go together; for example, if a person's physical healing experience leaves them depressed and anxious, then the rest of their care will not go as smoothly and they may be less likely to report problems or seek medical care in the future. If the person is financially anxious and doesn't have the tools to do effective financial planning, they may skip out on necessary care.



Image by [Stannah International](#), CC BY 2.0.

NAs play an important role in knowing the people they care for, so they are able to report changes in their holistic wellbeing and get them connected with the team member best equipped to meet their needs.

Restoration

Restorative nursing care is the process that helps a person regain their holistic health, strength, and independence.

Restorative nursing care involves caring for somebody on many different levels; for example, if a person leaves a facility technically healed, but with no confidence in their own ability to do something, then perhaps they had a need that was not effectively cared for.

Restorative nursing care aims to return a person to their regular level of functioning. Restorative care works to foster a person's independence in all areas of life, including meeting one's physical and psychosocial needs.

The team

It takes all of the many different roles on the rehabilitation team to care for someone holistically during the restorative nursing process^[2].

- Physical therapists (LPT) work with the person to cultivate healthy, strong, stable, and pain-free mobility.
- Occupational therapists (OT) work with the person to promote independence and ability with the person's ADLs, such as brushing their teeth, changing clothes, preparing meals, and socializing with others.
- Language and speech pathologists (LSP) work with the person on any issues that have with their mouth apparatus. Such issues may include difficulty with the mechanics of speaking, psychological and cognitive difficulties with language processing, and swallowing.
- Occupation therapy assistants (OTA) assist the OT, and physical therapy assistants (PTA) assist the PT.
- Registered nurses (RN) and licensed practical nurses (LPN) guide the nursing process by assessing the person's ongoing needs, and providing and delegating holistic care.
- Rehabilitative and restorative aides (RA) are NAs who have received specialized training in restorative care.

- Medical social workers (MSW) perform a variety of roles such as advocating for the person in medical contexts, assisting them with discharge, and helping them achieve financial wellbeing and independence.
- Clergy and other religious figures can tend to the spiritual needs of a person. Residents have a right to spiritual care that accords with their religious and cultural background.
- The patient's family and friends are a support system, a source of encouragement, and an important source of psycho-social fulfilment for the person. After the person is discharged, their family and friends will play an important part in the continuation of their restorative care at home.

Goals

The goals of rehabilitative and restorative care include fostering independence, promoting personal choice, providing opportunity for activity and exercise, and providing a safe environment.

Independence

Independence may look differently for everyone, though at a basic level it means being able to reliably meet one's basic needs and safely perform ADLs. NAs can foster independence in ADLs by prompting the person to do as much of their ADLs unassisted, or with minimal assistance, as they can^[3].

Always be patient and compassionate with restorative care patients. Persons have a right to unhurried care.

NAs can use verbal prompts and create a kind and supportive environment to help a person exercise their independence; for example, by suggesting that a resident change their clothing and brush their teeth, and then spend some time conversing with them while the resident performs these ADLs themselves if they are able.

Promoting a person's independence is important because it helps prepare someone for discharge and holistically fosters self-esteem.

Personal choice

A resident's personal choices should be honored and encouraged at all times, as long as they are within the scope of the care plan. Residents have a right to make personal choices about what they eat, how they spend their time, who they spend time with, which doctors they see, etc.

These rights are legally protected and are part of a good care practice. Promoting residents' personal choices is key to providing holistic, person-centered care.

Activity and exercise

Someone receiving restorative care will need to continue with as much exercise and activity as they can, as determined by discussions with the care team and the person's care goals. Activity and exercise are important physically because they help prevent muscle atrophy; if a person remains immobile then they may experience complications across their bodily systems.



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Activity and exercise are important for promoting independence. Regular movement can make a person feel physically better and allow them to feel more capable. It can benefit their self-esteem, especially if improvements are made.

Activity also promotes independence because a certain degree of mobility is necessary for independent living, and regular activity and exercise helps maintain mobility.

Safety

The restorative nursing team must create a safe environment for a person to heal. A safe environment is one with minimal accident risks, and with an attentive care team to anticipate risk factors before they arise. A safe environment is also one where a person feels safe, and where their full spectrum of needs are met.



A safe environment...

- is one where the residents are physically secure from danger and risk of harm.
- is comfortable in terms of the sensory environment.
- requires that residents' basic needs around nourishment, elimination, hygiene, and other ADLs are met kindly and promptly.
- includes privacy.

A safe environment is one where a person's psycho-social and self-actualization needs are met. It will include ample time for socializing with the resident community, as well as encouragement for inviting visitors, family, and friends to come spend time with them. NAs can also help a resident fulfill their social and psychological needs by being an attentive listener, an enthusiastic conversation partner, and an enjoyable person to spend time around.

Restorative interventions

Independence, choice, activity, and safety will not be immediately attainable; they are goals that will need to be worked towards. Helping someone work towards independence in their ADLs demands strategic restorative interventions over time.

Examples of interventions include bowel and bladder training and incontinence measures, regular repositioning to prevent pressure ulcers, assisted ambulation to prevent atrophy and contractures, and assistance with nourishment.

NAs will need to closely observe people for signs of depression during the restorative care process. Rehabilitation can be difficult, painful, and socially isolating^[4]. Depression is a common result. Signs of depression to watch out for include:

- social withdrawal
- appearing inattentive or vacant
- regular or excessive crying
- irritability and quickness to anger
- negative self-talk
- expressions of hopelessness

NAs should always provide a kind and encouraging presence to residents with depressive symptoms. If a resident is exhibiting signs of depression, NAs should document it and report it to the nurse so the care team can pay closer attention to the person's mental healthcare and wellbeing.

Who needs rehabilitative and restorative care?

People across the lifespan require rehabilitative and restorative care for illness and injury. Some people need rehabilitative care in some form for their whole life, while for others it will be a temporary process. It is always emotionally taxing, and can even affect a person's entire family.

The healthcare team is a provider of emotional and spiritual support, in addition to the physical and medical dimension of care.

An elderly person who has an accident, a bout of acute illness, or an exacerbation of a chronic illness may experience rehabilitative care differently than someone at other points of the lifespan. Older persons are more likely to have pre-existing co-morbidities and other conditions that may complicate or be complicated by their rehabilitative care.

Elderly people are at higher risk for injury both before and during the rehabilitative process; this means that they are more likely to need rehabilitative care in the first place, and more likely to experience a setback once they are there. Older adults heal more slowly than young people, so they will likely spend more time in rehabilitation than someone whose body heals quickly.

What does it mean to be independent?

Nobody is truly independent in the sense that we don't need anybody else. We all rely on each other, and each of us has a need for care that make us inter-dependent with one another.



Restorative care aims to promote the best quality of life a person can have. A person's independence should be encouraged up to the point where they reach their care goal, or where increasing their independence would not lead to their highest quality of life. A person has a right to their highest possible quality of life; they also have a right to the thoughtful and attentive care necessary to help them reach it.

The person and the healthcare team should remember that everybody has limitations, that personal and physical limitations are normal, and that there are ways to get human support and assistive devices to foster quality of life in ways other than promoting individual independence.

It can be helpful to think of “independence” and “dependence” as two poles of a very wide spectrum. Nobody is totally “independent” because we all need other people in order to have a high quality of life. Our place on the dependence – independence spectrum is not fixed; everyone will be more or less dependent on others at various points throughout our lives.



“Maintaining activity levels” by Oregon State University, CC BY-SA 2.0.

It is important to remember that independence is a healthcare goal because it promotes a higher quality of life, self-esteem, and self-actualization, and not because individual independence is inherently a better way to live. Steps should be taken to promote a person's independence by scheduling proper care and assistance, supplying appropriate assistive devices, and encouraging people to keep an active support system in place outside the facility.

Promoting healthy independence

NAs should always focus on a person's abilities and strengths, rather than on the person's perceived deficits. If a person can drink water on their own, but has difficulty with food, then the NA should encourage the person to drink on their own, assist as needed, and emphasize their capabilities and improvements.

Never encourage somebody to perform a task unassisted if unsure that the person can do so safely. If the person wants to perform a task unassisted that they usually require assistance with, the NA should stay with the person to make sure that they are safe and don't require help during the task.

There are many different kinds of adaptive equipment that somebody can use to foster their independence. Mobility aids like canes and walkers, or special ergonomic silverware are just a couple of examples. Residents with trouble communicating may find assistive technology and text-to-speech software useful.

When obstacles to independence arise that cannot be managed with assistive devices, support systems should be in place to ensure the highest possible quality of life for the person even if there are some tasks they cannot perform on their own.

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When is rehabilitative and restorative care necessary?

Rehabilitative care is necessary for a wide variety of conditions. In some circumstances, rehabilitation may be required for the foreseeable future or even a lifelong care need^[5].

- Myocardial infarction (heart attack) requires ongoing rehabilitation such as a special diet, exercise, medication, and lifestyle changes like quitting smoking and regulating stress.
- Brain injuries require rehabilitative care because they often result in neurological complications that can impact things like ease of movement, speaking and eating, memory and executive function, and other activities that involve the nervous system.
- Spinal cord injuries require rehabilitative care, especially when they need surgery. Persons recovering from spinal cord injuries will need assistive with ambulation and elimination, amongst other things.
- Stroke recovery requires rehabilitative care because of the way a stroke can impact a person's communication, eating, and movement.
- Chronic respiratory conditions require rehabilitative care in the form of respiratory therapy, lifestyle changes like quitting smoking, and additional oxygen.
- Fractures, joint replacements, and other musculoskeletal events require rehabilitative care to regain movement and manage pain.
- Severe wounds and burns may require rehabilitative care to regain mobility, manage pain, and control infection. Complicated chronic illnesses, such as diabetes, may also require rehabilitative care at different points along the disease process.
- Neurodegenerative diseases, or diseases that eat away at the brain over time like dementia, may require special rehabilitative care for people are too confused or disoriented to be cared for by family members or through home healthcare. Many facilities have specific memory care units for residents with neurodegenerative conditions that severely impact memory, orientation, awareness, and cognitive functioning.

Rehabilitation centers or floors can be found in hospitals, nursing homes and assisted living facilities, as stand-alone facilities, specific schools, and in home healthcare. Rehabilitative care will usually continue at home past the point of discharge – often, rehabilitative care is taken on by the person and their family, and maybe a home health aide^[6].

Reality Orientation and Validation Therapy

It is important for NAs to keep the social and emotional needs of rehabilitation patients in mind. Requiring rehabilitative care can be disorienting, distressing, frustrating, and physically painful. NAs should always listen in an attentive and engaged way, ask follow up questions, and remain calm and positive while helping residents work through their feelings about the care process.

NAs can work to meet a person's social needs by encouraging visitors, and promoting social relations amongst co-residents in a rehabilitation center.

Make the person feel as comfortable, safe, secure, and loved as they can. Everybody is worthy of care, respect, and security, and of being treated as an individual. NAs should check in with residents regularly to see if there is anything they need, and to just spend some extra time with them by telling them a story, writing them a kind note, and doing things that show the person they are not a burden and that they possess human value even when they do not currently have independence in most areas of their life. Such gestures of kindness will go a long way with anybody, but will be especially meaningful when somebody experiences disorientation, confusion, and loss-of-self that can come with neurodegenerative conditions.

Some people who require rehabilitative may be disoriented, confused, or cognitively impaired in some way. These limitations must be taken into account in communications in order to most fully meet the person's social and emotional needs. Two different approaches to communicating with disoriented or cognitively impaired residents are "reality orientation" therapy and "validation" therapy.

"Reality orientation therapy" is a way of communicating with residents who are confused or disoriented in a way that attempts to orient them to reality. It is contrasted with "validation therapy," which aims to communicate with residents in a way that affirms the world as they experience it rather than trying to correctly orient them to the external world.

Reality orientation therapy

Reality orientation therapy includes making sure that residents know their correct date, time, location, how to do their basic activities, and their name. It is important that residents are able to orient themselves to external reality in this basic way because it is a necessary step towards cultivating independence.

For example, if a person is having a bout of confusion and doesn't know their own name then the NA should correct the them about their name. Similarly, if a person is confused about the date, day of the week, or what time it is, the NA should gently correct the person's confusion in a kind and empathetic way.

If a person can usually perform one of their ADLs unassisted but seems to be having a bout of confusion, NAs should check in with them to make sure that they know how to perform the care task independently. If the person can verbally describe how to perform the task but still seems confused or disoriented, the NA should stay with them and observe just to make sure that the task is done safely and correctly.

Reality orientation therapy is appropriate when a person has temporary bouts of confusion and disorientation, and when they are not in a distressed or agitated state. Reality orientation therapy is especially appropriate when a person's confusion and disorientation is a symptom of a condition where improvement and cognitive recovery are anticipated, though it can also be used in the earlier stages of dementia.

Psychosocial needs

Reality orientation, when it is effective, can help a person meet their social and emotional needs. Remaining oriented to a shared external reality, even if the person sometimes needs a little extra help orienting themselves to that shared external reality, is an important step in being able to socialize with people. It is useful for sharing information about oneself, discussing current events, showing interest in others' lives, and other aspects of cultivating ongoing relationships with people in one's community.

Reality orientation helps a person meet their emotional needs because being disoriented can be distressing and frustrating. Reality orientation therapy helps a person situate themselves with regard to a clearer and a more concrete version of their external reality.

Being oriented to a shared external reality can help a person understand their circumstances and regulate their emotions in

response to their concrete environment.

Watch this video for some instructions on making an “orientation board.” Orientation boards can be helpful for residents who want a visual reminder of some key facts they can use to orient themselves.

YouTube Video

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[View this YouTube Video online](#)



Validation therapy

Validation therapy is different from reality orientation therapy, and requires training to utilize effectively. NAs should seek training on providing validation therapy if their facility offers it. If a person needs validation therapy it will likely be noted in their care plan.

Validation therapy involves meeting a confused or disoriented resident where they are. In other words, it means communicating with a disoriented resident from within their world, rather than trying to make them adjust their internal reality to fit the shared external reality. Practitioners “validate” the person’s experience, even if it is an experience that does not accord with their situation in the external world.

Under no circumstances should a person who requires validation therapy be corrected. Instead, they should be responded to in ways that work within their disorientation. For example, if a resident is convinced that he is late for work and needs to leave immediately, a validation therapy approach would be to ask why he is anxious to be on time. The goal is to let residents work through their feelings without imposing “reality” onto the resident; residents experiencing a misalignment between internal and external reality are often trying to process underlying feelings and experiences from their life.

Another example may be if somebody is anxious and worried that somebody is trying to find them. A validation therapy approach would not try to convince them that nobody is after them; instead, the response may be something like “the security in our building is good, and we are here with you. How can we help you feel safe?” This response does not explicitly affirm the resident’s experience, but tries to help ease the motivating emotion. Once they know that they are safe and listened to, the resident will be able to work through the underlying feelings behind their experience.

A another example may be that a resident is convinced a NA is their son or daughter. Rather than convince them that the NA is not part of their family, a validation therapy response may be to ask the person more questions about their children; help the resident feel what they are feeling in a safe and nonjudgmental way, without forcing them to relate correctly to their concrete external circumstances.

The goal of validation therapy is to make the person as comfortable as they can be, and to help them process whatever emotions they are feeling at the time. Validation therapy aims to calm the resident, without trying to make them feel or experience in a particular way.

YouTube Video

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TEDx Talks. (2015, June 3). Validation, communication through empathy | Naomi Feil | TEDxAmsterdamWomen [Video]. Youtube.

Always treat people with kindness, dignity, respect, and humanity no matter how disoriented or confused they are. Disoriented and confused residents are especially vulnerable to abuse, mistreatment, and neglect. If NAs see anybody acting abusively or neglectfully towards disoriented residents, they should alert the nurse immediately.

Query 2

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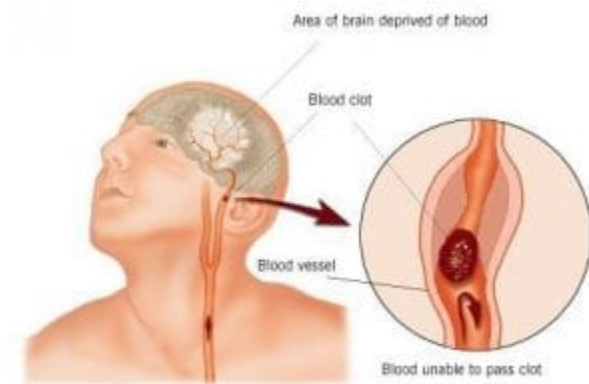
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Disease processes commonly requiring rehabilitative care

Stroke

A stroke, or a cerebrovascular accident (CVA), occurs when the brain's blood supply is cut off in an area, which causes the death of brain cells, brain damage, and swelling. Strokes can also occur due to a leak or a break in a cerebral blood vessel. Strokes that occur due to blocks in the brain's blood supply are called ischemic strokes, while strokes caused by bleeding in the brain are called hemorrhagic strokes^[7].



A person may be warned of an oncoming stroke when they experience a transient ischemic attack (TIA) brought on by lack of oxygen supplied to the brain. TIAs last anywhere from minutes to a full 24 hours.

Signs and symptoms of strokes and TIAs include:

- numbness
- paralysis and/or weakness on one side of the body
- confusion Image by [ConstructionDealMkting](#), CC BY 2.0.
- issues with speaking and language comprehension (both spoken and written)
- vision loss
- severe headache
- problems with movement coordination, balance, and walking

If NAs notice a resident experiencing any of these symptoms, they should alert the nurse immediately.

Effects

The effects of a stroke can last a long time, sometimes for the rest of a person's life. Rehabilitating and regaining functionality lost due to brain damage can be a difficult process and requires various therapies.

Effects of stroke include:

- loss of control in one's facial muscles, extremities, and limbs
- hemiplegia
- a change in emotional makeup and personality
- aphasia
- changes in senses
- memory impairment
- bowel and urinary incontinence
- emotional impact such as depression as frustration with one's circumstances

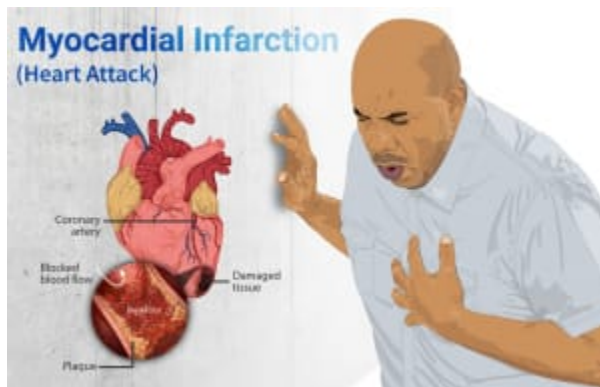
NAs will have to keep in mind that persons who have had a stroke will likely have a strong and weak side. Always take strong and weak sides into account when transferring somebody and helping them dress.

People who have had a stroke may have difficulty speaking and comprehending language. NAs should use their emotional intelligence to communicate with stroke victims. Patients with aphasia often have a difficult time accessing equitable care; they tend to have longer stays in hospitals, have less access to care, and promote frustration and dismissal from nursing staff due to their difficulties with communication^[8].

Always practice patience with persons who have difficulties with communication, and follow the care plan put together in collaboration with the speech-language pathologist for communicating effectively with people who have had strokes, or suffer from aphasia for another reason.

Myocardial Infarction (heart attack)

Myocardial infarction is a dangerous medical event in which blood flow to the heart is suddenly blocked, causing a part of the heart muscle system to die.



Heart attacks can occur for a variety of reasons, from vascular swelling, plaque build-up in the blood vessels, or because of embolisms or thrombosis^[9].

Symptoms of a heart attack include:

- chest pain and pain that radiates into the shoulders, neck, back and limbs
- heartburn
- dyspnea Image by Myupchar, [CC BY-SA 4.0](#)
- nausea

- dizziness
- sweating and clammy skin
- paleness
- sudden drop in blood pressure
- a weakened pulse

Symptoms may also be psychological, such as a deep existential fear and sense of doom, and an insistent denial of any heart problems.

In women symptoms can appear differently; women may have a myocardial infarction without experiencing chest pain, and instead will have pain across their body, nausea, dizziness and lightheadedness; symptoms of a heart attack in women can sometimes look like a sudden onset flu.

If NAs notice anybody experiencing these symptoms, they should make them rest comfortably and go get the nurse immediately.

Congestive Heart Failure (CHF)

Congestive heart failure (CHF) occurs when one side of the heart loses its ability to effectively pump blood. CHF can occur as a result of heart damage from a previous adverse cardiac event, such as a heart attack, or may occur due to another cause like a degenerative disease. CHF occurs once the heart is too weak to adequately supply the body with oxygen and nutrients from the blood^[10].

^[11]Someone experiencing CHF will have fatigue, difficulty breathing, irregular pulse and heartbeat, edema, chest and abdominal pain, confusion, and difficulty exercising. NAs should report any changes in the condition of persons with CHF immediately, especially changes in their vital signs, urination, and fluid retention.

CHF usually impacts one side of the heart more severely than the other. The symptom profile of CHF changes depending which side of the heart is most severely impacted.

If the left side of the heart is failing, blood collects in the lungs because it cannot be transferred into the left side of the heart. This leads to orthopnea, weight gain, increased pulse, and coughing.

Right-side failure involves a collection of blood in the abdomen and lower extremities like legs and feet. This leads to edema in the feet and ankles, weakness, bulging veins (especially in the neck) and arrhythmia.

NAs should always follow the care plan exactly. Treatments for people with CHF usually include following a low-sodium diet to decrease water retention, providing additional oxygen, regular vitals, and daily weight observation. NAs should assist the person with activity and encourage them to rest, depending on what is stated in the care plan.

CHF patients will need meticulous intake and output recording, since they may also be on a fluid-restricted diet. NAs may want to keep the head of the bed raised at an angle to promote circulation. It is important to always follow the care plan, and to ask for clarification or assistance if unsure about anything.

Parkinson's

Parkinson's disease causes the progressive deterioration of brain tissue. The disease gets worse slowly over time, and there is no cure^[12]. As brain tissue dies it can cause uncontrollable shaking and tremors, rigid and stiff muscles that impair mobility, slowed and uncoordinated movements, stooped posture, impaired balance, and mask-like facial expressions. Emotional and cognitive changes may also occur, such as mood swings, irritability, difficulty self-regulating emotions, memory loss, and disorientation.

NAs play important roles in caring for people with Parkinson's. A person with Parkinson's will have trouble controlling their elimination. NAs must practice attentive incontinence measures when caring for people with Parkinson's by always answering their call lights promptly, practicing meticulous infection control and skin-care measures when episodes of incontinence occur, providing careful perineal care, and remaining positive and kind when assisting somebody with elimination.

Persons with Parkinson's may need help with ADLs such as eating, bathing, and other self-care tasks. Lack of coordination and difficulties with movement can make ADLs difficult to perform unassisted. NAs should offer patient assistance, while allowing the person to perform the tasks they are able to do independently. Even if a person takes much longer to do a task unassisted, NAs should encourage them to do the task independently if they can and want to. Always maintain a person's dignity and autonomy no matter how much help they need, or how long they take to perform their own care tasks.

NAs will need to assist people with Parkinson's with ambulation and other tasks that require being upright. Safety measures must be taken to keep the person safe from falls and accidents. Always consult the care plan or the nurse with any questions about mitigating risk factors.

Dementia

Dementia is not a specific disease, but rather an umbrella term for groupings of symptoms such as amnesia, problems with communication and task completion, diminished coordination, impaired vision, and uncharacteristic behaviors. These symptoms result from brain damage caused by the buildup of protein cells, lack of blood supply, and nerve cell loss; the type of dementia that one has depends on what type of brain damage is occurring. Symptoms vary depending on what the damaged part of the brain controls.

The three most common types of dementia are Alzheimer's disease, vascular dementia, and mixed dementia^[13]. While a person can receive a general diagnosis of dementia, the more specific variant can only be determined by performing an autopsy. People with dementia often have more than one kind of dementia at one time. It cannot be cured or treated with medication.

Symptoms of dementia impact a person's memories, abilities, language abilities, and personality.

Types of dementia

Alzheimer's

Alzheimer's disease is caused by neurodegeneration resulting from protein buildup. It is the most common form of dementia; roughly 60 – 80 percent of dementia patients have Alzheimer's. It primarily impacts people over the age of 65.

Alzheimer's usually lasts roughly 8 years after the onset of symptoms, though it can last longer depending on age and overall health. Symptoms include progressive memory loss, confusion and cognitive dysfunction, difficulty with language and communication, and changes in personality and behavior.

Stages

There are three classificatory stages of Alzheimer's. During the "early" or "mild" stage, the person experiences short-term memory loss and trouble recalling specific facts, confusion, and difficulty recognizing people and things. With some accommodations and forethought, someone at this stage can still lead a rather independent lifestyle.

The "middle" or "moderate" phase is characterized by a loss of independence and the need for consistent care and attention to ensure safety and wellbeing. Usually care at this level is given by family, community support networks, and in-home health or adult day services. Admission to a long-term care facility may be considered depending on the person's symptoms and family circumstances. Memory loss continues to worsen, and more fundamental personality changes occur, and the person may lose the ability to remember how to dress themselves and perform other ADLs. This is usually the longest of the three stages.

The "late" or "severe" stage the person will lose all physical independence and will need 24-hour support care. Struggles with communication worse as language capabilities decline. Nutrition becomes difficult as the person forgets how to swallow, placing them at risk for choking and aspiration. Physical and cognitive cognition gradually worsens until they die. Care goals at this stage of the disease are not aimed toward promoting independence and instead seek comfort and a peaceful dying process^[14].

The brain

Alzheimer's disease usually begins in the entorhinal cortex and the hippocampus, each of which play important roles in memory,

task function, language processing, and sense of time. These parts of the brain are located in the temporal lobe, responsible for memory and general knowledge.

YouTube Video

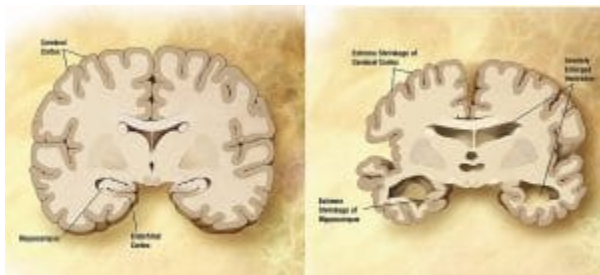
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Roche. (2022, September). Science in Seconds | Chapter 2 | How does Alzheimer's Disease change the brain? [Video]. Youtube. <https://www.youtube.com/watch?v=zB0dGQHTekg>

Buildups of toxic protein molecules inhibit neurons from making connections. As the neurons die and more protein builds up, more and more areas of the brain experience damage. As different parts of the brain degenerate, existing symptoms worsen and new ones develop.



[15]

Eventually neurodegeneration impacts the cerebral cortex in other areas like the frontal lobe, parietal lobe, and occipital lobes. Damage to these lobes occurs in later stages of Alzheimer's, although the progression of localized neurodegeneration depends on the type(s) of dementia present.

Frontal lobe damage results in impaired reasoning, issues with focus and task management, disinterest and lack of motivation, and problems navigating social situations. It also contains the motor cortex of the brain, which controls movement and tends to be damaged later during dementia progression.

The parietal lobes are located on either side of the brain, and control things like fine motor skills necessary for tasks such as putting on shoes or getting dressed. Parietal lobe damage is common in Alzheimer's. Damage to the parietal lobes decreases a person's fine motor skills, spatial awareness, and make coordinated tasks like writing difficult or impossible to accomplish.

The occipital lobe is located at the back of the brain, and usually degenerates later in the Alzheimer's process. The occipital lobe acquires and processes visual information; deterioration of the occipital lobe can create difficulties with recognizing objects and understanding what they are for, navigating an environment, and with vision itself. Sometimes hallucinations occur^[16].

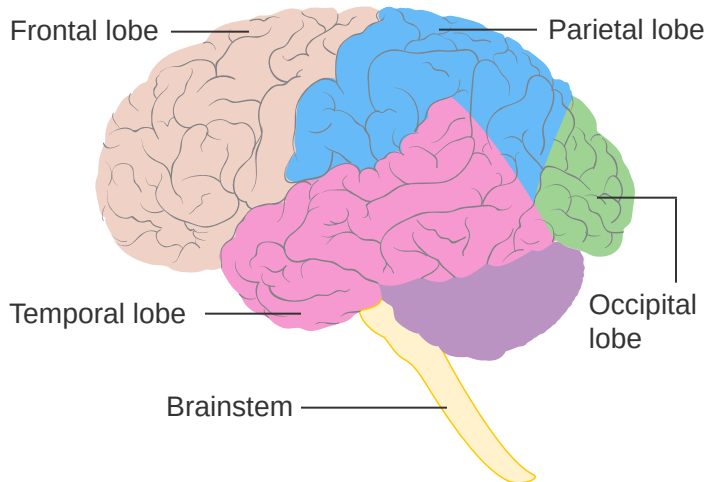


Image by Cancer Research UK, [CC BY-SA 4.0](#)

Vascular dementia

Vascular dementia occurs when limited blood supply to the brain causes brain damage; it can occur gradually or after a sudden ischemic event. The specific sections of the brain that are impacted determine which symptoms present, and often result in difficulties with memory, language, walking, confusion, vision, and mental health^[17].

The likelihood of vascular dementia increases with age as arteries are blocked by plaque or blood flow is reduced by vessels atrophying and becoming inelastic.

Mixed dementia

This form of dementia presents a wide mix of symptoms commonly associated with both Alzheimer's and vascular dementia, and is caused by both protein deposits and poor circulation to the brain.

Communicating with and caring for persons with dementia

Persons with dementia experience problems with memory, confusion, and time orientation. These symptoms can lead to difficulties communicating with people and behaviors that caregivers may find challenging or disruptive.

Communicating with a person with amnesia and confusion can be challenging; caregivers should use specific strategies so as not to trigger feelings that are unpleasant or difficult to process. The most important thing is to always respond from a place of kindness and empathy; imagine what it would be like to not know where you are, or to believe you are somewhere that you are not. Always treat persons with dementia with respect, care, and dignity.

- When a resident repeats the same question over and over, respond with kindness and consider writing the information somewhere visible.
- If the resident searches for lost things, whether they ever had them or not, always show concern and help them search. It can be helpful to label the storage in a resident's room so they know where to look for and put their objects, as well as labeling all personal objects.
- When a resident forgets the names of people or their relation, it can be helpful to slip it into conversation. Instead of saying "your visitor is here" you can say "your daughter Jackie is here," or "Jason will be the person taking care of you today" even if Jason takes care of them every other day.
- If a resident tries to leave the facility to get home, distraction and diversion can be useful. Try to redirect the resident's attention to an activity they enjoy in the facility, or come up with a reason why they must stay there, such as the weather or being on vacation.

- If a resident expresses a need to see a deceased loved one, invite them to talk about them as much as they want without confirming or denying that the loved one is alive. The more you know about a resident's life, the more positive details you can draw their attention back to, such as their mother's baking or their favorite activity to do with their spouse.
- Always speak in a calm and pleasant manner, and never allow annoyance or impatience to come through in your tone. Always speak in a way that conveys care.

YouTube Video

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[View this YouTube Video online](https://www.youtube.com/watch?v=QeaRogZQ-3Y)



Union Test Prep. (2018, May 14). CNA Skills: Caring For Dementia or Alzheimer's Patients [Video]. Youtube. <https://www.youtube.com/watch?v=QeaRogZQ-3Y>

Challenging Behaviors

As the brain continues to degenerate, more challenging behaviors may appear. A challenging behavior refers to a behavior that poses a problem or an obstacle for a caregiver, such as an emotional outburst or resisting care.

Questions such as “how was your day” should be avoided, because they rely on short-term memory

Rather than engaging with these behaviors at face value, caregivers should always approach them from the perspective of their triggers and underlying causes.

- Emotional and behavioral outbursts are often caused by an underlying sense of frustration or fear.
- Aggressively resisting care can be caused by feelings of vulnerable insecurity or embarrassment, physical discomfort from the sensory environment, or something about the caregiver's nonverbal communication or tone.
- Hoarding can be motivated by a fear of not having one's needs met. Consider having the resident's room cleaned at a time when they will be away, to clear away any stashed food. Make sure the person knows that they are being cared for, and that their needs won't go unmet.
- Other behaviors such as pacing, wandering, or becoming especially confused in the late afternoons can be caused by lack of activity or stimulation, an unmet basic physical need of rest, nourishment, or elimination, or an unpleasant sensory environment.

Always take note of the conditions under which challenging behaviors arise. Reporting and recording as many facts about challenging behaviors as possible can help the care team notice patterns in the locations, times, and triggers of challenging behavior.

Always respond to challenging behaviors with calmness and compassion. Residents with dementia will pick up on and respond to tone and body language, so remaining calm is essential to the resident's care and to your own ability to provide care. Do not react negatively to their behavior; instead, use redirection and distraction strategies^[18].

YouTube Video

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Teepa Snow's Positive Approach to Care. (2017, April 19). Challenging Behavior [Video]. Youtube. <https://www.youtube.com/watch?v=ZpXeeFZ2jAM>

Resident Rights and Safety

Persons with dementia have a right to be treated with kindness, dignity, and empathy. If you notice any staff members interacting with residents with dementia in an unkind, uncaring, unprofessional, or abusive way, alert the nurse immediately. Always be conscientious and aware of your reactions and tone if you feel yourself becoming impatient with residents.

Persons with dementia often experience difficulty recognizing objects and navigating a spatial environment. An inability to recognize objects or sounds can also make a person feel unsafe – for instance, being startled and confused by a passing siren, or being unable to recognize chemicals or medication. Safety concerns should be anticipated in a person's environment; hazardous chemicals, such as cleaning fluid and nail polish remover, medications, and any dangerous physical objects, such as a shaving razor, should be kept inaccessible to the person.

Query 3

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Fractures & Joint Replacement

Fractures and joint replacements are common in older populations due to frailer bone structures and diminished ease of movement. Older adults are more likely to fall or suffer another an accident that leads to a fracture. They may require joint replacement due to disease processes that impact joint health and functioning such as arthritis, or because of complications from injury^[19].

Some older adults will require a total joint replacement, which is a surgical removal of the biological joint and replacing it with an artificial joint. The most common forms of total joint replacement are hip replacements and knee replacements.

- After a hip replacement surgery the doctor will decide how much weight the person will be allowed to bear on their new joint as they recover. NAs must carefully follow the care plan when it comes to activity levels, range of motion, and positioning following a hip replacement; abduction pillows may be used to keep the hips aligned in away that prevents the replaced joint from becoming dislocated.
- Knee replacement postoperative care requires the same level of attentiveness to the care plan as a hip replacement. Recovering from a knee replacement takes a long time, and is an extremely painful process. NAs should only perform range of motion and physical therapy exercises that are explicitly ordered; NAs should always follow the care plan exactly and ask questions if unsure.
 - Persons recovering from joint replacement surgery should be encouraged to care for themselves, do things that make them feel good, and generally try to take their mind off the pain as much as possible. NAs can assist with this process by being positive and patient conversation partners, attending to the person's needs promptly, and making sure they are

eating and consuming enough fluids.

Excellent skin care and hygiene are essential when caring for somebody recovering from joint replacement surgery, since they will likely be totally or near-totally immobilized. Always follow the care plan with regard to positioning and activity.

If the NA observes signs of infection at the site of incision, changes in the person's vitals, edema in the legs, skin discoloration, numbness, and or changes in the person's vital signs, they should let the nurse know immediately.

Older adults are more prone to hip fractures; fractures are broken bones, and hip fractures are most often caused by a person falling and landing on their bottom or on their side. Hip fractures can sometimes heal on their own, or may require surgical interventions to heal properly.

Rehabilitation for a hip fracture can take up to 6 months, and comes with a variety of complications, many of them stemming from the immobility required for healing.

- Respiratory complications from immobility and reduced circulation
- People recovering from hip fractures are at risk of blood clots, especially in their legs. If the person reports pain in their calf or shortness of breath, the NA should report it to the nurse immediately.
- Persons recovering from hip fractures are at risk of developing immobility related complications such as UTIs, pressure ulcers, and constipation.
- Confusion, particularly in the geriatric population

People recovering from hip fractures will use a variety of assistive devices such as trochanter rolls and abduction wedges to position their body comfortably and safely. They will also likely use anti-embolism stockings to prevent blood clots in their legs, and raised toilet seats to help with elimination.

NAs should only use assistive devices as directed by the nurse; NAs play an important role in making sure that assistive devices are always clean and readily available, especially anti-embolism elastic stockings.

NAs should be extremely careful of the person's body positioning and movements. Someone recovering from a hip fracture should not cross, bend, or flex their legs unassisted, and they should never be positioned as such. NAs must be vigilant and careful when repositioning and transferring residents, since twisting and pivoting motions can result in pain or other complications during the fracture healing process.

NAs should never perform range of motion exercises with somebody recovering from a hip fracture. They should make sure to always review the care plan, and to ask the nurse any questions regarding what should and should not be done with hip fracture patients.

Amputations

Amputations involve the full or partial removal of a body part, usually an extremity such as an arm or leg. Amputations are performed when a person needs a part of their body with cancerous tissue removed, or when tissue in a specific area dies. When localized tissue dies and begins to decay, it is called gangrene.

After amputation, the person may be fitted with a prosthesis. A prosthesis is an artificial body part of some kind. Dentures are a prosthesis.

Always treat a person's prosthesis with care and respect; artificial body parts are expensive, specially made, and necessary for a person's independence and wellbeing.

Other forms of prosthesis include artificial eyes, arms, legs, hands, fingers, and more. Almost all prostheses are removable; NAs

should pay careful attention when the nurse shows them how to properly attach and detach prostheses.

Sometimes a person with an amputation will experience phantom pain, or pain in an area of their body that is no longer there. Phantom pain can be caused by many different things, including damaged nerve endings and illness. Phantom pain is real pain; NAs should be sensitive to persons experiencing phantom pain, and alert the nurse when it occurs so they can explore options such as medication, physical therapy, and psychotherapy.



“Kabul – prosthesis” by Barbara Millucci is licensed under [CC BY 2.0](#).

Phantom pain is different from pain in the stump of the amputation; pain in the person’s healed stump may be caused by an ill-fitting prosthesis.

NAs will need to provide emotional support to recent amputees. They should never indicate discomfort or disgust by the person’s stump, and should instead interact with it as they would with any other part of the person’s body. NAs should be positive and supportive as the person adjusts to their amputation or prosthesis. Receiving an amputation can induce anxiety, depression, frustration, and a sense of hopelessness. NAs should kindly and attentively listen to people, and remind them of their capabilities and human value.

Caring for recent amputees

The NA’s primary role in caring for a person who has received an amputation is to always follow the care plan when it comes to positioning, activity and range of motion exercises, and prosthesis care. Nurses will show the NA how to properly remove and attach the prosthetic; NAs should not handle prosthetics unless they have been trained to do so.

NAs must provide careful skin care for people with prostheses. When the prosthetic is removed at night, NAs should gently clean the stump area with a soap free of fragrance so the person’s skin does not become irritated. Perform other skin care around the prosthesis area as directed by the nurse.

If the NA notices any skin discoloration, redness or swelling, drainage or openings in the skin, or issues with the prosthesis they should alert the nurse promptly. They should also report and record any indications of stump pain or phantom pain from the person.

Hearing, Speech, and Vision Disorders

Hearing, speech, and vision problems may require rehabilitative care to heal the underlying cause, or to learn how to navigate the world with a different set of capabilities. Hearing, speech, and vision problems may be temporary due to illness, chronic disease, or physical accidents such as a brain injury. They may also be permanent and incurable, resulting from the aging process, injury, illness, or a congenital/birth defect.

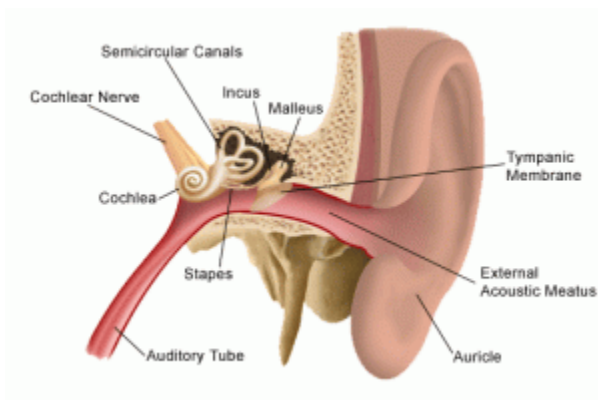
Hearing, speech, and vision problems relate to all aspects of the Big Three, but they relate to Resident Rights most closely.



Residents have a right to know what is happening to and around them, and they have a right to be able to communicate effectively with the people who are providing their care. Facilities must have measures in place to accommodate the communication needs of residents with impaired hearing, speech, and eyesight. Residents also have a right to be able to communicate effectively with their family, friends, and other residents.

Hearing

The ear is made of the outer external ear which captures noise as vibrations, which are then carried and vibrate against the ear drum, which separates the outer ear from the middle ear. As the ear drum and three small bones in the ear vibrate in response to sound waves, it activates the cochlear nerve in the inner ear which translates those vibrations into the sounds that most humans consciously experience. In addition to hearing, the ear apparatus is responsible for helping humans maintain balance. Hearing loss is often accompanied by problems with balance and coordination.



Anatomy and physiology of the ear. (n.d.). Stanford Children's Hospital. Retrieved May 31, 2023, from <https://www.stanfordchildrens.org/en/...-ear-90-P02025>

Hearing loss is a common problem across the human life span, though it is most common in older adults. Hearing loss is usually gradual, unless it results from an accident or an acute illness. Hearing loss may stem from an issue with the ear itself, or it can result from a problem with the brain or nervous system.

Hearing loss ranges from being very mild to total deafness. Someone experiences hearing loss whenever they are not able to hear a normal range of sounds. For example, not being able to hear high frequencies that most other humans can hear is an early indication of hearing loss.

Someone is considered "deaf" when it is impossible for them to understand speech just by listening to it. Deafness ranges from a person being able to hear some noises, to them hearing no sound at all.

Hearing loss can be caused by many different things. The most common causes of hearing loss are exposure to loud noises, and aging. Injuries to the ear or head that cause damage to any part of the ear or nervous system can also cause hearing loss. Tumors, hereditary characteristics, problems with circulation, chronic ear infections, and ear-wax build-up are other common causes of hearing loss.

Persons with hearing impairments have a wide variety of assistive devices they may have access to. The most common assisting device for those with hearing impairments is a hearing aid.



“Hearing aid” by Soitiki is licensed under [CC BY-NC-ND 2.0](#).

Hearing aids are small devices that are inserted into the person’s ear canal. Hearing aids are capable of amplifying sound, though they cannot genuinely improve a person’s hearing or language comprehension, nor can they make sounds clearer.

NAs should make sure that a person who needs a hearing aid is wearing it when they should be. NAs should always handle hearing aids carefully since they are fragile, expensive, and necessary for a person’s functioning and safety.

Communication

Residents have a right to be able to communicate properly with healthcare staff, their friends, family, and visitors, and the other residents. When communicating with hearing impaired residents, NAs should keep a few basic strategies in mind.

- Eliminate background noises so the resident can focus on their interaction.
- NAs should always stand so the resident can see the NA’s face, watch their mouth, and read their body language to develop the clearest idea of what is being communicated.
- NAs should speak clearly, slowly, in a low pitch, and at a good volume without yelling. Using short and simple sentences, and somewhat exaggerated mouth movements, will help hearing impaired residents gather the meaning of the interaction. Sometimes cues will be appropriate, such as acting out taking a sip of water when asking the resident if they are thirsty and prompting them to drink fluids.
- NAs should keep a pen and a pad of paper available for communicating with hearing-impaired residents. This may be a person’s preferred way of communicating, or it may be their last resort. Either way, it is important to make as many resources available as possible to assist with communication.

Speech and language

Speech disorders impact communication and make speech and language difficult (without assistive devices) or impossible; some speech disorders only impact a person’s ability to form speech, while others impact a person’s ability to comprehend speech and/or language. Common causes of speech disorders include hearing loss, developmental disabilities and congenital conditions, and brain injuries and strokes.

Some different kinds of speech and language disorders include aphasia, apraxia, and dysarthria.

Aphasia refers to a total or partial loss of one's ability to use and understand language. Aphasia is categorized as either expressive or receptive. Expressive aphasia relates to the way a person externalizes communication; a person with expressive aphasia will have difficulty expressing thoughts in language, whether verbal or written, though they may be able to comprehend language used by others.

Receptive aphasia relates to understanding language, or internalizing communication. A person with receptive aphasia will have difficulty comprehending language used by others, whether verbal or written. These two forms of aphasia are not mutually exclusive. When somebody experiences both forms of aphasia, it is called expressive-receptive aphasia.

Apraxia is a speech disorder relating to the muscles used for speech, rather than the comprehension of speech. A person with apraxia is unable to use their speech muscles to create understandable speech. This is due to damage in the area of the brain that controls motor speech. The person can understand speech, and knows what they would say if they could say it, but their brain cannot coordinate their speech muscles to make it happen. Apraxia deals with the capacity for speech itself, rather than the comprehension of language. A person experiencing apraxia can understand and create written language, whereas a person with total aphasia could not.

Dysarthria is difficult speech or speech that is hard to discern due to slurred words, speaking very slowly or softly, hoarseness, and drooling. Dysarthria occurs when a person's mouth and facial muscles are affected by nervous system damage. A person with dysarthria will not have their language comprehension affected, but they will have a difficult time using their facial muscles to effectively perform verbal communication.

NAs must always be emotionally supportive, patient, and understanding when caring for people with speech disorders. NAs can be emotionally supportive even when a person is incapable of understanding language; communication occurs through body language, tone, eye contact, and various other ways of telling and showing a person that they are cared for and safe. When a person has a speech disorder that allows for some verbal communication, NAs must be patient and attentive and never become frustrated with the person, or frustrated with their own difficulty understanding the person.

YouTube Video

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SingHealth. (2022, January 17). Aphasia (Language / Speech Disorder) – CAREGIVER GUIDE [Video]. Youtube. <https://www.youtube.com/watch?v=0gLbiHiGn80>

NAs can communicate with people with speech disorders through consistent care and reliance on care routines and repetitive scheduling. They can also use a combination of emotional intelligence and consistency to devise ways of communicating; for example, when explaining a menu to somebody aphasia, NAs can use pictures rather than words to describe the dishes.

NAs should always treat adults with speech disorders as they would other adults. In other words, simply because somebody has difficulty making or processing language does not mean that they want to be infantilized or that they won't recognize when somebody infantilizes them. NAs should remember that adults with speech disorders are humans with complex internal lives, and can be known and understood on a personal level even without conventional communication styles.

NAs must always fully explain the care they are going to give before they give it. NAs must continue to communicate throughout the care process even when the person receiving care has inability or difficulty with comprehending speech. If the person is best communicated with in some other way, such as by writing or by gestures, then the NA should explain the care in the way that will be best understood by the person. This is absolutely essential in promoting Resident Rights and person-centered care.

The goal of speech rehabilitation is to improve the person's ability to communicate. NAs should follow the care plan and therapies determined by the speech-language pathologist in collaboration with other members on the care team.

Speech rehabilitation works with the person to improve their affected language skills, use their remaining speech and language ability, and restore their language abilities to the highest possible extent. Other therapies involve muscle training to improve the person's strength, coordination, and control of their speech muscles.

Speech-language pathologists will also work with the person to learn other methods of communicating. These other methods may involve strategies such as sign language, or include assistive devices such as text-to-speech and pictorial communication through a communication board. There is a wide variety of speech and language oriented assistive devices to make communication easier for those with speech impairments^[20]; NAs should always closely follow the care plan, and familiarize themselves with any assistive technology used by those in their care.

Eye and vision

Eye disorders result in vision loss or impairment. Vision loss may be mild and partial, or it may be complete. Vision loss may be sudden or gradual, and occurring in just one or in both eyes. "Blindness" refers to the absence of sight, though somebody who is legally and functionally blind may still be able to make out vague shapes, colors, and light. Vision loss occurs due to a wide variety of causes, and can happen to anyone of any age, though it is most common in older adults.

Aging has notable effects on our vision and eye health.

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UMass Memorial Healthcare. (2018, December 13). The effects of aging on our eyes [Video]. Youtube. <https://youtu.be/MR9wZq4Hysg>

Cataracts are a common vision problem that involve a clouding of the eye's biological lens. Cataracts usually require surgical correction, in which the clouded lens is removed and replaced with an artificial lens.

Cataracts cannot be mitigated using corrective lenses. Surgery is the only treatment.

Symptoms of cataracts include cloudy, blurry, or dimmed vision, faded colors, sensitivity to bright lights and presence of a glare, poor nighttime vision, the presence of halos around lights, and double vision in the impacted eye. Cataracts make it seem as if the person is looking through a waterfall, or always looking through a smudged pair of optical lenses.

Risk factors for cataracts are aging (the primary cause), a family history of cataracts (they are hereditary), diabetes, smoking tobacco, regular alcohol use, frequent exposure to direct sunlight, high blood pressure, and eye injuries and surgeries.

Glaucoma is a progressive disease where a person gradually loses their vision due to damage to their optic nerve. If left untreated, glaucoma will eventually result in blindness. Optical nerve damage is caused by pressure that builds up inside the eyes; onset of glaucoma can either be sudden, in which pressure causes substantial damage to the nerve quickly, or gradual, where damage occurs more slowly over time.

People over the age of 60, and those with a family history of the disease, are at risk for glaucoma.

Glaucoma can occur in one or both eyes; if it occurs in both eyes, it may not affect each eye in the same way.

Glaucoma can be treated by surgery, medications, and anti-inflammation treatments. While glaucoma can be slowed and mitigated, there is not a known cure.

Ocular implants

Sometimes a person will need to have one of their eyeballs removed. If they decide they want one, they can be fitted with an ocular prosthesis, or an artificial eye. Some ocular prostheses are permanent implants, while others are removable. If the prosthesis is removable, the person will be taught how to remove, clean, and insert it on their own.

When caring for a person with an ocular implant, NAs must be extremely careful not to let the prosthesis become chipped, scratched, or damaged; always follow the care plan with regard to the storage and care of prostheses.

When communicating with people who have vision loss, NAs should always speak slowly, clearly, and directly face the person. NAs should knock before entering their room, as always, and carefully explain the care they are about to give before and during the care process.

Query 4

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Key Takeaways

- Rehabilitative and restorative care involves care that attempts to bring someone back to their highest available quality of life, independence, and capability. It involves care interventions that foster independence with one's ADLs, implementing assistive technology, and putting a reliable support network in place.
- Reality orientation and validation therapy are two different approaches to communicating with residents who are confused or disoriented. Reality orientation therapy aims to help a confused resident orient themselves to the external world, particular their time, date, and location. Validation therapy involves providing a safe place for residents to work through their feelings without trying to correct them.
- Disease processes commonly requiring rehabilitation include cardiovascular diseases like heart attacks and CHF, musculoskeletal conditions or spinal and joint surgeries, and neurodegenerative diseases like Parkinson's and dementia. Some diseases can be cured, while others are incurable and treatment only addresses symptoms. In either case, the goal of treatment is to return the resident to their highest available quality of life.
- Always be kind, patient, and attentive during the rehabilitative and restorative care process. Consider how a person's limitations change the ways that they need to be communicated with. Good communication techniques are essential, and someone with dementia or impaired senses will need a considered and thoughtful approach to communication. Access to effective communication is a right.

Comprehension Questions

1) What is rehabilitative and restorative care?

- a. A holistic, person-centered process of providing care interventions to promote a resident's independence and return them to their highest quality of life.
- b. A holistic, person-centered process in which NAs perform all of someone's ADLs for them to allow them to rest.
- c. A holistic, person-centered process to help someone get rid of addictive tendencies
- d. A holistic, person-centered process to ease someone's dying process

- 2) Residents receiving rehabilitative and restorative care may experience depression. Please list at least 3 and up to 6 symptoms of depression. What is one way that NAs can care for someone experiencing depression?
- 3) How can caregivers promote resident self-esteem and independence? Select any that apply.
- a. When someone has difficulty or takes a long time with an ADL, caregivers should jump in and do it for them.
 - b. NAs can find assistive devices for things like combs and silverware to allow a person to groom or feed themselves for as long as possible.
 - c. Focus on what a person can do, rather than on what they cannot. For instance, if someone can wash their arms but not their feet, have them wash their arms and provide assistance with the feet.
 - d. Leave the room when a person is performing an ADL by themselves, so they know the staff is confident in them.
- 4) Respond to the following sentences with T (true) or F (false).
- ___ Reality orientation therapy aims to orient a resident to concrete features of their external reality such as the date, time, location, their name, and their ADLs.
- ___ Reality orientation therapy should be used for residents with late-stage dementia.
- ___ If someone responds to reality orientation therapy well, it can help them meet their psycho-social needs.
- ___ Validation therapy does not correct a confused resident, and instead aims to give them the space to process whatever feelings are motivating their particular confusion.
- ___ Validation therapy and reality orientation therapy techniques cannot be practiced together for the same resident.
- 5) Please list at least 6 and up to 12 symptoms of myocardial infarction. Indicate whether the symptom is experienced by only men or women, if relevant.
- 6) Which of the following diseases are neurodegenerative diseases?
- e. Congestive heart failure
 - b. Dementia
 - c. Glaucoma
 - d. Parkinson's
 - e. Arthritis
- 7) How should NAs provide care for someone with Parkinson's disease?
- a. Pay close attention for edema and swelling in the legs
 - b. Use distraction and redirection techniques in conversation
 - c. Attend to elimination needs immediately, and take extra measures to prevent falls and accidents
 - d. Take meticulous input and out recordings because of fluid restrictions
- 8) What is dementia?
- a. Alzheimer's disease
 - b. A mental illness
 - c. A group of symptoms caused by neurodegeneration

d. Caused by the buildup of proteins or vascular damage

9) Whenever you wrap your arms around a specific resident with dementia to secure a transfer belt, they seem surprised and try to hit you. This behavior happens with all their caregivers, which comes as a surprise because this resident is usually very nice and calm. You realize that being touched in this way is a(n) ____ of the challenging behavior.

a. Involuntary movement caused by brain damage

b. Trigger

c. Outburst

d. Result

10) Respond to the following sentences with T (true) or F (false).

____ Prostheses are artificial body parts, except for dentures and artificial eyes.

____ Phantom pain, as its name suggests, is not a real pain.

____ When communicating with a resident with impaired hearing it can be helpful to eliminate background noise and speak clearly face-to-face.

____ Verbal speech is the only form of effective communication.

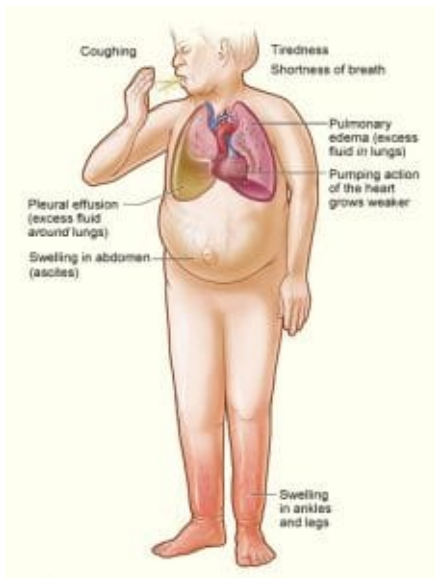
____ A person with aphasia cannot understand communication in gestures and pictures.

11) The Big Three are important when caring for someone with dementia. Can you discuss how Resident Rights and Safety, in particular, are essential to keep in mind when caring for someone with dementia? Why might the rights of a resident with dementia be compromised by ineffective care? What would you do as a NA to keep someone with dementia safe and minimize the risk of accidents in their environment?

12) When a resident has dementia, it is important to interact with them from a place of kindness, compassion, and respect no matter how the resident is behaving. This is an obvious dimension of respecting Resident Rights. Why might paying attention to tone, body language, and strategic approaches to communication be important for your ability to provide any care in the first place? Consider the ways these things may impact somebody who is confused, afraid, and lacks impulse control.

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19. Nursing Assistant, Chapter 9, by Chippewa Valley Technical College is licensed under a [Creative Commons Attribution 4.0 International License](#), ↵
20. Check out this video for more information on augmentative and alternative communication (AAC) devices: <https://www.youtube.com/watch?v=zmsdLzQW5G0> ↵

Module 13 – End of Life Care

Learning Objectives

- Apply knowledge of the impact of pain on quality of life
- Demonstrate understanding of the need for sleep
- Develop understanding of the need for end-of-life care
- Demonstrate understanding of the stages of grief

People need care at the end of their life, often in the form of palliative care. Palliative care means care that is given to make a person as comfortable as possible as they live with an illness that will be the cause of their death. Hospice care is ordered when the person's prognosis is less than six months. NAs who are assisting with end-of-life care should always use a compassionate, holistic, person-centered approach that keeps in mind the goal of comfort, rather than cure^[1].

Pain and Comfort

A person receiving palliative care or hospice care will likely experience pain and discomfort as part of their illness process. All the time, but particularly in the final stages of their life, residents have a right to comfort, rest, and sleep. Comfort, rest, and sleep are essential for a person's overall wellbeing. Disruptions in a person's comfort, rest, and sleep have a negative impact on a person's holistic wellbeing (physical, emotional, spiritual).

A person is only comfortable when they are free from pain, anxiety, and emotional distress. A person is only comfortable if they are relaxed and at ease. NAs should always ask a person what the NA can do to make them more comfortable. Rather than asking a yes-or-no question, asking "is there anything I can do to make you more comfortable" may allow a person more freedom to respond.

Pain looks different for everybody. NAs must never assume that somebody is free from pain, unless that person explicitly tells you they are free from pain. Sometimes a person in pain may need to be prompted more than once before they admit to being uncomfortable; NAs should get to know a person so they develop a sense of when the person is uncomfortable, and can ask follow-up questions when discussing their comfort.

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GeriCare. (2021, March 2). What is pain? [Video]. Youtube. <https://www.youtube.com/watch?v=att6sLZmKdU>

Pain is a warning from the body that signals that some kind of damage is present. Though not technically a vital sign, it is sometimes considered the "fifth vital sign" because it provides caregivers with important information that may require a nursing response.

If a person says they are in pain, *they are in pain*. NAs must never second-guess a person's testimony of pain. Refusing to believe somebody who says that they are in pain is an abusive behavior, and is not acceptable within a person-centered care framework.

The experience of pain

Pain is a subjective experience, which means that everybody experiences and relates to pain differently. Some people may be comfortable expressing their pain and distress to others, while others may not want to express their pain and would rather grit their teeth through it. NAs should be attentive to a person's pain signals when they are not comfortable expressing their pain openly.

- A person's past experiences with pain, the idea of pain, and the idea of "resilience" or "weakness" can make a person less inclined to express their pain.
- Anxiety may prevent a person from expressing their pain if the person is not usually comfortable asking for help, or who believe that by voicing pain they are a burden on someone. NAs should go out of their way to assure anxious residents that they are there to help, that they are happy to provide care, and that NAs always prefer when a person in pain directly expresses that pain to them.
- Rest and sleep and pain are in a cyclical relationship. If a person is not rested and cannot sleep properly then they are more likely to experience pain, well, painfully. If a person experiences heightened pain levels, then they are less likely to rejuvenate through sleep and rest.
- One's personal, familial, and cultural background plays a part in how they relate to pain. If somebody comes from a culture that discourages expressing one's pain, or if they have internalized the belief that pain is something that ought to be suffered through rather than alleviated, they may be less likely to be honest about their pain levels with the care team.

Types of pain

Pain is felt differently by everyone, but there are different kinds of general pain that people can use to communicate the character and quality of their pain.

- **Acute** pain is sudden onset pain due to tissue damage resulting from injury, disease, trauma, or surgery. Acute pain lasts less than 6 months and diminishes as the damaged tissue heals.
- **Chronic** pain is pain that lasts longer than 6 months and persists after any tissue damage has healed. Chronic illnesses such as arthritis may be at the root of chronic pain.
- **Radiating** pain is pain felt in one part of the body that is caused by a problem in another part of the body. Examples may be developing a headache because of a toothache, or pain in the left arm and jaw during a heart attack.

When asking about pain, NAs can use a 1 – 10 scale to ask the person to rate their pain, in addition to asking questions about how the pain feels; is it a burning sensation, a stabbing sensation, does it feel like a shock? etcetera. Always follow facility protocol and the care plan when it comes to how to ask patients about their pain levels and quality.



Image by Robert Weis, [CC BY-SA 4.0](#)

Reporting and recording pain

NAs must carefully report and record when residents relay information about their pain. When recording communications about pain, NAs should write down the exact words that the person uses to describe their pain. The specific language the person uses can give nurses and doctors important clues into the pain's underlying cause^[2].

These are some basic pieces of information NAs should make sure to record:

- Location of the pain (placement in the body)
- When the pain began, how long it lasted or is lasting
- The intensity of the pain over time, including any changes in the intensity of the pain throughout its duration
- Any other descriptive features the person can offer, including any observations they have about positions, activities, or conditions that alleviate the pain or make it worse.

Assessing pain in non-verbal residents

Sometimes a person will not be able to communicate their pain levels, or will display pain signals without admitting to being in pain. If a person is unable to or won't communicate their pain, NAs will need to observe them for other signs and symptoms of pain. If a resident displays or expresses any of the following symptoms of pain, NAs should report it to the nurse promptly and record it in the person's chart^[3].

- Changes in appetite
- Dizziness, lightheadedness, and vertigo
- Nausea and/or vomiting
- Numbness and/or tingling
- Increases in pulse, respirations, and blood pressure
- Pale skin
- Difficulty sleeping
- Sweating
- Crying and/or gasping, grunting, and sighing
- Tightening of the facial muscles, including squeezing the eyes closed, grinding teeth, clenching the jaw, grimacing or frowning
- Changes in behavior such as increased restlessness, agitation, or distraction

NAs and pain management

So what is the NA's role with regard to pain management during end-of-life care? NAs should focus on providing excellent basic care and making the person as comfortable as possible, including by being a calming and positive presence for them during moments of pain.

- Regular repositioning is an important aspect of pain management. Always follow the care plan and respond promptly to the resident's preferences.
- Keep the person's bed linens neat and wrinkle free. This goes hand in hand with repositioning as a strategy to prevent pressure injuries and ulcers. The last thing somebody needs during end-of-life care is to develop yet another source of physical discomfort.
- Assist with the person's elimination needs promptly. Pain increases a person's chance of incontinence, and having an unmet need to eliminate adds yet another source of discomfort.
- Apply cold and heat therapies as directed by the nurse, doctor, and by the care plan.

NAs can be a comforting presence to a person in pain by telling stories, conversing, and providing distraction and relaxation through guided imagery techniques. Recorded guided meditations or calming video and music compilations can also help relax a person. Ask a person what their favorite movie or music is, and see if you can play it as a pleasant means of distraction. The most important thing is to be attentive, responsive, and do one's best to anticipate ways the person can be distracted from their discomfort.

Other factors impacting comfort

Comfort is different for everybody, and different people will all feel most comfortable in slightly different conditions. NAs should be aware of some factors that relate to comfort so they can best meet the person's comfort preferences. Some factors that affect comfort are:

- Activity level – immobility comes with serious complication; if it is in the person's care plan, NAs should encourage activity and exercise. Regular activity promotes physical comfort and high-quality rest.
- Room temperature – older adults are more susceptible to cold. OBRA requires that nursing home facilities be kept between

71- and 81-degrees Fahrenheit. If a person still experiences chill at 81 degrees, NAs can offer blankets.

- Ventilation and airflow – rooms with stale and stuffy air are unpleasant to be in. NAs can improve the airflow in a room by opening the person's door, or opening a window depending on the outdoor air quality.
- Noise level – some people are bother by noise and prefer quiet. NAs can close the person's door, and request that anybody having audible conversations in the hallway move to a common area instead. If the person would prefer noise to silence, NAs can play some of the resident's favorite music.
- Odors – odors can be unpleasant and induce discomfort. NAs can reduce odors by providing attentive perineal, skin, and bathing care. NAs should not smoke on the job, but if they must they should make sure to thoroughly wash their hands, and be conscious of odors' tendency to stick to clothing. Breath odors can be controlled by regular teeth brushing, mints, and gum.
- Lighting – lighting should be comfortable and safe. If a person finds harsh overhead lighting uncomfortable, NAs can see about options for softer and ambient lighting. If the person has difficulty seeing, adequate lighting will be an important safety consideration.

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Sleep and Rest

Sleep is a basic need; without sleep, a person cannot function physically, cognitively, emotionally, or socially. Sleep is a state of unconsciousness that allows the mind and body to rest, restore its energy, and process information from the day. During sleep voluntary muscle activity is reduced and the metabolism is lowered. All of the person's vital signs are lower than when the person is awake.

Sleep allows for restoration and healing. Adequate sleep promotes physical healing and tissue repair. It also helps a person to lower their stress levels and anxiety, and gain emotional clarity.

YouTube Video

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The Economist. (2019, January 30). What happens when we sleep? [Video]. Youtube. https://www.youtube.com/watch?v=eTgNgGO_bLs

Sleep can sometimes be elusive, or difficult to achieve, especially when somebody is in a new and unfamiliar environment; their regular routines and rhythms will be disrupted and thrown out of balance, which may result in poor and dysregulated sleep^[4].

- Make sure that all rooms have sufficient pillows and blankets.
- Make oneself available for conversation as the resident goes to sleep; trying to sleep in an unfamiliar environment can be difficult, and some people may appreciate a friendly presence.
- Make sure the lighting, noise, ventilation, and odor needs are met. Try to maintain quiet when a resident is sleeping, whether at night or as an afternoon nap.
- Remember that people who are ill will need more sleep than usual.

- A person's nutrition and exercise can impact their sleep. If a resident is having difficulty sleeping and consumes caffeine regularly throughout the day, NAs can recommend that they lower or eliminate caffeine intake. Regular activity and exercise increases tiredness and can make it easier for a person to fall asleep.

Mental health problems such as anxiety and depression can negatively impact a person's sleep. If a resident reports feelings of anxiety and depression, tell a nurse so they can develop strategies to address the resident's mental wellbeing. Mental health professionals are available for persons with ongoing mental health concerns.

Sleep disorders

Sleep disorders can influence a person's ability to sleep. Sleep disorders can be caused by a variety of factors including illnesses (physical and mental), medication, problems with the environment such as noise and lighting, and embodied distractions such as pain or the need to urinate^[5].



Image by Videoplasty.com, CC BY-SA 4.0

Insomnia is a chronic condition where the person cannot fall asleep or cannot stay asleep through the night. Some people may require medication to manage their insomnia, while others may be able to mitigate it through lifestyle changes.

Sleep deprivation is a condition where the amount or quality of sleep is seriously decreased. Many different factors can cause sleep deprivation; the best way to address sleep deprivation is to diagnose the underlying cause and work from there. Minimizing caffeine and increasing activity levels is often a first step.

Sleepwalking occurs when a person remains asleep but gets up and performs activities that they normally would only perform while awake. The sleepwalker is usually unaware and will have no memory of the event. If NAs encounter somebody sleepwalking they should gently guide them back to bed. People can become startled when woken from a sleepwalking episode; NAs should always interact gently with a person sleepwalking.

Caring for residents with disordered sleep

NAs can care for people in ways that allow them to get as much rest as they can.

- Care should be planned for uninterrupted rest; do not waken somebody to provide care unless it is necessary.
- Flexible bed times and waking times allow residents to be on their own schedule and sleep in the way best suited to their body's rhythm.
- A warm bath or shower before going to bed can relax a person and soothe their muscles. A backrub can also help a person physically relax.
- Follow regular bedtime routines, offer the use of the bathroom, and make sure residents with incontinence are clean and dry.
- Provide a comfortable temperature, in addition to cozy and loose-fitting pajamas, and plenty of soft linens.
- Make sure the person feels safe. Sometimes this is accomplished by creating a pleasant sleeping environment, other times a person may need some conversation, music, or a guided meditation to mentally prepare for sleep.
- Pay attention to the resident's routines, body language, and stated preferences. NAs should ask residents what makes them most comfortable, and remember their answer.

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End-of-Life Care

Terminal illness

A terminal illness is a disease or injury for which there is no reasonable expectation of recovery^[6]. Many illnesses and diseases have no cure, and are known to eventually be the cause of death. Similarly, after some injuries the body is not able to function, and recovery is not expected. Examples include serious damage to the brain and internal organs. When a disease or injury is reasonably expected to end in death, it is deemed terminal.

Doctors cannot truly predict when a terminal illness will end a person's life. They may be able to make educated guesses, but so many different and sometimes inexplicable factors go into how a person responds to terminal illness that a precise prediction is ultimately impossible.



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The care outcome for a person with a terminal illness will be strongly influenced by a person's will to live and their experience of hope. A person with a terminal illness will likely prolong their life by engaging in activities they enjoy, remaining active in their community and social circle, and bringing an awareness of the value of their life into their daily reality.

At the same time, the nursing staff should be realistic about the person's impending death. Language should not be softened because of a desire to make things easier on a person, since this can have the opposite impact; shying away from the terms "death" and "dying" is infantilizing and may prevent the person from reckoning with their circumstance.

Everybody dies. Death is a reality that brings meaning to the living of a life. Rather than ruminating on the fear and anxiety of death, NAs should consider how they can talk about death in a way that treats it as a natural, necessary stage of the life process.

Attitudes towards death

People have many different attitudes about death. Some of these attitudes are personal, while others relate to someone's cultural and religious background. Some people believe in a paradise-like afterlife, others believe in reincarnation, and other believe that

nothing much happens at all. Death rites, prayer and scripture readings, and funeral services are common in various religious and cultural practices.

NAs should ask if the person they are caring for would be comfortable sharing some of their attitudes and beliefs about death, and simply listen to them. It may give someone comfort to remind themselves of a framework for understanding their own death in the greater scheme of things^[7].

Many people strengthen their religious convictions, or seek out new ones, when they are made aware of the immanence of their death. This sort of spiritual grasping may be based on a genuine sense of spiritual awakening, a response to fear and anxiety, or both.

Adults may fear or resent their death. They may fear experiencing pain and suffering upon death, dying fearful and alone, and having their privacy and dignity invaded as they are dying. They may fear being separated from their loved ones, or leaving their dependents and community without them. Perhaps they were not ready to die, and still had plans, hopes, dreams or ambitions. These are difficult things to make peace with; if a person is able to use their spirituality and religion to make peace with the fact of their death, this should be encouraged.

Religious attitudes towards death

A person's religious beliefs and cultural background will impact how they relate to their death, and the approaches to care that will be most helpful with the person's spiritual outlook in mind. Someone who believes that their soul is headed for an eternity of either paradise or torture may be comforted by the idea leaving the earthly plane, or concerned and anxious for the fate of their soul. A person's spiritual ideas about death may be a source of comfort, a source of anxiety, or both as they are dying.

Someone who believes in an afterlife with Heaven and Hell will likely want different spiritual care and communication than somebody who believes in reincarnation. When someone is reincarnated their essence or their constitutive elements returns to the total cycle of life and they are reborn, either as a human, animal, a celestial entity, or something else. They may want to reflect on their life and the aspects of it to which they assign high spiritual importance to consider their cyclical journey towards Nirvana.

In all cases, NAs will listen to residents' thoughts and feelings about their death, and tell the nurse if they request any spiritual or religious services. All residents have a right to meeting their spiritual needs.

Meeting a person's spiritual needs as they are dying is associated with better psychological and physiological outcomes. In other words, by fully meeting a terminally ill person's spiritual needs, the healthcare team can help them live longer and ease the discomfort and emotional turmoil of their passing^[8].

Spiritual Needs

A dying person has psychological, social, and spiritual needs. NAs will have to address the full scope of a person's needs in order to relieve their suffering as they are dying. A steady listening ear and comforting touch can be important to someone who feels scared and alone in these moments. Some people may request to see a spiritual leader or take part in religious practices; NAs should tell a nurse immediately if a person wants to see a religious official or to have religious rites performed.

- A dying person's religious objects may become especially important to them as they are dying. NAs must handle such objects with respect, and encourage the resident to find comfort in their religious practices if it is appropriate.
- NAs should provide a person with privacy when they want to pray or meditate, unless the person requests that they remain.
- A dying person may feel the need to take a confessional approach with whoever will listen. NAs must never judge anybody for the things they are told; a dying person deserves peace and dignity, even if they want to confess sources of guilt and other things they want to get off of their chest before passing. This information must be kept private and may only be shared with the person's nurse. NAs should avoid discussing their own spiritual and religious beliefs with the dying person.
- NAs should spend quality time with dying residents. They may be tempted to avoid dying people, especially if they are uncomfortable with death themselves. A dying person deserves opportunities for human connection, and may carry anxiety about the possibility of dying alone.
- Never respond to a resident's fear of death with clichés or personal stock-phrases. It is always best to acknowledge a

resident's fear and anxiety and attentively listen, and then inform the nurse. The person may benefit from the skilled care of a mental health professional or social worker.

Providing End-of-Life Care

End-of-life care is the care and support given to somebody and their family during the time surrounding their death. End-of-life care may range anywhere from a single day to multiple months. A person's death may come on suddenly, or be a gradual and drawn-out process. Healthcare teams see and interact with death regularly – a person's attitudes, feelings, and associations with death will impact the end-of-life care they provide.

Most people die either in a hospital or a long-term care facility, and hospice care is becoming a more widely used option^[9]. A person in hospice care will likely be aware that they are dying. Such awareness means that they will have a unique set of psychological and spiritual needs. The healthcare team should provide every service available to make the person as holistically comfortable and secure as possible.

In order to provide good care to someone who is dying, NAs will need to bring an awareness of the dying process into their communications to approach the person with caring, kindness, and respect. They will also need to bring an understanding of their own feelings about death and dying into their care to remain positive, un-phased, and authentic in their interactions with the dying person.

A person's emotional and spiritual experiences and beliefs regarding death can increase their suffering^[10]. Perhaps they feel that they are leaving things unattended to, or have not gathered closure on important questions; the experience of dying can be disempowering and leave someone feeling out of control.

Being able to participate in the decision-making process about one's own end-of-life care can help make someone feel more agential in their dying process. It also gives them an opportunity to prepare themselves for death. If somebody is unable to make their own decisions about end-of-life care, it may prevent them from reckoning frankly and honestly with their own death. Reckoning honestly with death is an important part of maintaining relationships and finding a sense of closure.

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TEDx Talks. (2018, August 14). Making end of life care matter | Deb Wilkes | TEDxSouthampton [Video]. Youtube. <https://www.youtube.com/watch?v=Lr6gvVnuW-0>

Palliative and Hospice care

One decision that persons with a terminal illness will face is whether to enter palliative care or hospice care^[11].

Hospice care is one form of palliative care, though palliative care is broader than hospice care. The goal of palliative care is symptom and pain management; while palliative care is given to people who have a terminal illness, it does not necessarily mean that somebody's death is immanent. Someone with congestive heart failure may live decades after diagnosis with the right kind of palliative care. Palliative care uses a person-centered approach to keep someone's holistic quality of life as high as possible while living with an incurable condition.

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GeriCare. (2021, February). What you need to know about palliative care [Video]. Youtube. <https://www.youtube.com/watch?v=KZ9ZXS4C3No>

Supporting the person's family is an important dimension of palliative care. Palliative care encourages residents to continue doing the things they enjoy, seeing the people they love, and generally leading a full life. Palliative care emphasizes symptom management, emotional wellbeing, and spiritual services and care.

Hospice care is palliative in the sense that it aims to make a person as comfortable and pain-free as possible; the goal is to facilitate a dignified death. Hospice also provides services to the person's family and the healthcare team after the person's death in the form of emotional care and support groups. Hospice care may be provided in a nursing facility or as home healthcare.

Stages of Grief

In her book *On Death and Dying* (1969), Dr. Elisabeth Kübler-Ross came up with the Five Stages of Grief model^[12]. She breaks down the grief process of a dying person, or somebody coping the dying of a loved one, into five general stages: Denial, Anger, Bargaining, Depression, and Acceptance.

A dying person may not move through these stages linearly, they may not even start with denial. A person can also occupy more than one stage at a time, or shift back and forth between different stages depending on the day. It is not guaranteed that each dying person will experience all five stages. The stages apply both to the person who is dying, and to others in their life who have to reckon with the impending death of a loved one.

- Stage 1, Denial: The person experiences a refusal to recognize that they are dying. Denial can manifest in a refusal to make arrangements for one's death, an insistence that the tests gave a false result, or an unwillingness to discuss one's feelings about their health and death.
- Stage 2, Anger: Once somebody recognizes that they are dying, they may respond to this realization with anger and rage. Their anger may be directed at their family, friends, the healthcare team, god, themselves, or at everything at once. NAs should always meet the anger of a dying person with compassion and empathy, and remember not to take their anger personally. Becoming angry is a normal part of reckoning with one's death.
- Stage 3, Bargaining: After admitting to themselves that they really are dying, the person may try to strike a deal with the universe, god or God, or some other higher power. Such bargaining usually involves a promise to live differently in exchange for elongated life, perhaps to see their children grow up or another event after which the person believes they will have achieved some closure.
- Stage 4, Depression: Depression is a condition where a person becomes too sad and mournful to function normally. Perhaps they question the meaningfulness of their remaining time, withdraw from the people around them, and cannot bring themselves to perform simple tasks or care for their own wellbeing. The care team must be kind, patient, and understanding with people who are experiencing this kind of depression.
- Stage 5, Acceptance: Some people will come to accept their own death before it happens. This allows them to make final arrangements and say goodbye. People at this stage may seem detached from the world, or they may seem extra present. However a person responds to accepting their death, the care team should be available to listen, talk with, and assist the person with anything they'd like to do before dying.

These stages are descriptive, rather than prescriptive. In other words, nobody should try to move a dying person through the stages of grief. Instead, the stages provide a framework for thinking about and interpreting how somebody is responding to their death. The care team's role is to listen and make the person as comfortable as possible, without trying to get the person to think or feel in a different way.

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[View this YouTube Video online](https://www.youtube.com/watch?v=9nRHY3oIIeU)



LevelUpRN. (2021, July 28). Stages and Types of Grief, Types of Comfort Care – Fundamentals of Nursing [Video]. Youtube. <https://www.youtube.com/watch?v=9nRHY3oIIeU>

Comfort

A central goal of caring for a dying person is to keep them physically comfortable. Residents have a Right to attentive and compassionate care at the time surrounding their death. As a person is dying all of their bodily systems will begin to slow down; their vitals will lower, they may lose control over their stomach and elimination, and they may become confused, disoriented, or appear vacant. They may become unable to express discomfort or ask for their needs to be met. NAs should remain attentive to the person's needs even as they move closer toward death. Residents have a right to comfort and attentive care^[13].

- Frequent oral hygiene
- Carefully clean the person's nose so it is free from crusts and drainage
- Regular skin care, bathing, and repositioning to promote cleanliness and prevent pressure ulcers
- Changing the bed linens and the resident's clothing as needed
- Careful perineal care, especially after elimination
- Good body alignment in bed to promote comfort and easy rest
- Attentive pain management. NAs should report to the nurse if the resident appears to be in pain or discomfort.



SMART CHOICE



A dying person may have personal objects with them, such as sentimental mementos, pictures of their family and friends, flowers, or religious objects. Such items should be positioned where the resident can always see them; carefully hand the objects to the person if they seem like they want to hold or touch them, and put them back when the person is finished.

Approaching death

A person's comfort needs will change as they approach the moment of their death. Their bodily systems will lose function, and they may become uncomfortable as their body loses the ability to keep itself alive^[14].

Respiration

- Dyspnea is common as a person is dying. Being placed in semi-Fowler's position can alleviate some pressure on their chest and make breathing easier. Additional oxygen can also be useful.
- The person may begin breathing with a wet sounding rattle called Cheyne-Stokes respiration; this occurs because mucus collects in the airway. A side-lying position, suctioning by the nurse, and mucus-reducing drugs can may be used to ease breathing.
- Air circulation is an important aspect of comfort. If a person is having trouble breathing, opening a window for fresh air or turning on a fan for increased circulation will help them breathe more easily.

Vision, hearing, speech

As a person approaches death, their vision, hearing, and speech systems will gradually fail.

- A person's eyes stop working as they approach death. The person's room at this moment should be well-lit but not bright; a dying person tends to turn towards sources of light.
- As a person progresses along their dying process, NAs must remember to verbalize their presence and their activities. Even if the person cannot respond, they are likely still hearing. Maintaining verbal communication with the person as they die is an important aspect of person-centered care, and may bring them comfort knowing that somebody is there with them.
- When speaking with the person, it is good to maintain a normal voice. NAs should not shout or whisper, but should instead engage with the person compassionately and under the assumption that the person can hear the NA and appreciates their presence and communication. NAs can use these moments to reassure the dying person and explain the care they are administering.
- A person will find it increasingly difficult to speak as they approach death. NAs should try not to put the person in a position of needing to provide long answers to questions, since this may be hard and exhausting if it is possible. NAs should do their best to anticipate the person's needs; rather than asking "would you like your eyes cleaned," NAs can notice when a resident's eyes are gunky and can simply say "it looks like your eyes are uncomfortable, I am going to gently clean them for you with a warm cloth." Similar approaches can be used for oral care, and for offering the person a bedpan.

It is necessary to maintain communication with the person, even if they are incapable of speaking or communicating. Since they can likely still hear, they may be calmed by knowing that care is being provided, or simply by the sound of another person's voice. Something as simple as talking about one's day or telling a story can help bring a dying person a moment of peace and distraction. What is one thing you could do or talk about to provide a dying person with a moment of comfort and connection? Write for 5 minutes, and share your response with a friend or classmate.

Nutrition and elimination

Nausea, vomiting, are common at the end of life. While nausea and vomiting can be mitigated using medications, loss of appetite is difficult to manage. NAs should never force somebody to eat or drink, as this will only make them more uncomfortable and emotionally distressed.

If a person is refusing to eat, alert the nurse promptly.

Some people may become too fatigued to eat and will require assistance, while others may simply refuse. Offering the person's favorite foods in small, regular meals can stimulate appetite.

Urinary and fecal incontinence are common as a person is dying. So are constipation and urinary retention; NAs should report to the nurse if the person is showing symptoms for edema and constipation.

NAs will provide attentive catheter care according to the care plan.

The person may receive enemas to help ease their bowel movements.

The person and the family should have full control over how the person's room is arranged. This helps the person and their family feel autonomous and in-control as they experience the end of life. Equipment that is unpleasant to look at such as suction machines, drainage containers, ventilators, and other devices should be removed or positioned out of sight of the resident. Personal items should be placed in view to help the person feel safe, peaceful, and at-home.

The family

A person's family also goes through the stages of grief as their loved one is dying. This can be an extremely difficult time for family members and friends of the dying person.

NAs must provide close, attentive care to the person while also giving them and their family space to grieve and be together. NAs should be available, friendly, and courteous without imposing themselves on the family's grieving process.

Some family members may want to participate in caring for the dying person. NAs should help family members care for the dying person, as long as it has been OK'd by the nurse.

Relationships with residents

NAs may develop close relationships with residents who are dying. Even if the NA feels especially close to the person, they should refrain from spending much time with the person while their family is present and instead focus on spending time with the person when they are not being visited by family and friends.

Be careful not to choose favorites among residents. Relationships are encouraged, because they genuinely improve a dying person's quality of life. However, NAs should also remember that their care responsibilities extend to all patients they are assigned to, and that everybody deserves friendly companionship at the end of their life.

Query 3

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Legal and ethical concerns

There are certain legal and ethical issues at play when a person is dying or when they have already died^[15].

Advanced directives

One important legal concept NAs must be familiar with is that of advanced directives. Advanced directives are instructions that the terminally ill person decides upon in advance should they die or become incapable of making or communicating their decisions (if they fall into a coma, for example).

Power of attorney, also called durable power of attorney or a health care proxy, is one form of advanced directive in which the dying person names another person as the arbiter of their medical care should they become incapable of making their own decisions. Power of attorney in this context only applies to what sort of care someone will or won't receive; it does not entail anything about control over their finances or assets.

A living will is a document that details what sort of care the person does or does not want while they are still alive. A living will may instruct doctors not to use measures that prolong a person's dying process, or to remove measures that prolong a dying process.

The healthcare team must always respect the wishes of a dying person, regardless of whether they accord with their own religious, spiritual, or personal beliefs.

A Do Not Resuscitate (DNR) or “no code” order is put in place when the dying person decides that they do not want CPR performed on them when they go into cardiac arrest. When their heart stops beating, they want that to be their death; they do not want a healthcare team member to try to save them in that moment. Honoring DNR orders is an important part of respecting patient autonomy and empowering someone with agency over their own dying process.

The healthcare team needs to respect the wishes and autonomy of the dying person. It is critical that doctors and nurses take the time to fully explain the implications of advanced directives, and to follow up with the person to make sure they understand exactly what their choices are. Doctors and nurses are responsible for giving the person a realistic picture of what end-of-life treatment is and is not capable of doing.

Rights



A person who is dying still has basic quality of life rights that must be upheld for all residents. People who are dying may find themselves dehumanized or objectified because of their proximity to death.

NAs must always respect the rights of people who are dying, and advocate on their behalf if they notice these rights being devalued or violated.

- The right to privacy before and after death. A person always has the right to ask someone to leave the room, including healthcare staff and visitors. A person also has a right to visit with others privately.
- A person should not be unnecessarily exposed to provide care, even after the person has died. Health team members must treat a person's body with respect and dignity before and after the person has died.
- A person always has a right to freedom from abuse, mistreatment, and neglect. They also have a right to freedom from physical and chemical restraints, unless they become and active danger to themselves or others.
- Residents have a right to a safe and home-like setting. They should be encouraged to arrange the room in the way that makes them most comfortable, and to decorate the room with personal possessions that bring them comfort.
- The right to make choices extends to the right to refuse care; at a certain point, a person and their family may make the decision to refuse any further medical treatment. NAs and the rest of the healthcare team must respect this choice, even though it amounts to the person choosing to die.

A dying person is less able to advocate for themselves, and is thus vulnerable to abuse and neglect. Make sure that all patients receive compassionate and attentive care.

Nearing death

The healthcare team, and the person themselves, may be able to tell when a person's death is approaching. In the weeks leading to someone's death, they may experience some or all of the following symptoms:

- Restlessness, agitation, and anxiety
- Depression
- Loss of appetite
- Nausea
- Dyspnea, shortness of breath, and pauses in breathing
- Drowsiness and persistent fatigue
- Confusion and disorientation
- Problems with elimination
- Swelling of the extremities and other areas
- Healing problems
- Changes in vital signs
- Diminished senses

The healthcare team may be able to tell when someone is about to die, or has just died. If NAs notice any of these signs they should alert the nurse immediately.

- Loss of movement, muscle tone, and sensation
- Abdominal swelling, vomiting, and involuntary emptying of the bowels and bladder
- The person's measured body temperature rises, they feel cool to the touch with pallor, and have heavy perspiration
- The pulse becomes fast, weak, and irregular. Blood pressure will fall quickly.
- Slow or rapid respirations that give a "rattle" due to mucus in the airway
- A person's pain decreases, and they may lose consciousness.
- When a person dies, they will have no pulse, no respirations, and no blood pressure. Their pupils will be dilated and fixed.

Postmortem

Postmortem care, or caring for the body of a person who has died, begins immediately after the doctor formally pronounces somebody as dead. A person's family and friends may want to spend time with the body after their loved one has passed, either to process their own grief or to perform any religious or spiritual rites that they and the person deem necessary. NAs should be patient, kind, and present for family members grieving with a dead body.

YouTube Video

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[View this YouTube Video online](https://www.youtube.com/watch?v=vtraSJQ6fsE)



Lecturio Nursing. (2022, October 19). How to Provide Postmortem Care After a Patient Death | Lecturio Nursing Clinical Skills [Video]. Youtube. <https://www.youtube.com/watch?v=vtraSJQ6fsE>

NAs provide postmortem care by turning off any machinery still hooked up to the person, and gently closing the eyes and mouth. Remember to provide for privacy, and to treat the body with gentleness and respect at all times.

NAs should position the body so it is properly aligned before rigor mortis sets in; rigor mortis is a stiffening of the body's muscles that sets in 2 -4 hours after death. Once the body is properly positioned, NAs can gently sponge-bathe the body with the designated soap or cleansing agent. Drainage pads should be placed under the body's head, buttocks, and anywhere else necessary to prevent leaking or mess.

NAs must practice Standard Precautions throughout the handling of a dead body.

The body should have a clean gown before being covered up to the neck with a sheet. Once the body is in good condition, visitors can enter and be with the body.

Once the visitors leave the body can be covered with a shroud, carefully transferred to a stretcher, and prepared for moving to a funeral home, morgue, or another location that prepares corpses for processing.

NAs should follow facility policy on cleaning the room and removing the person's personal belongings after the body has been transferred.

Grieving

It is normal for staff members to grieve, especially if they were close with resident who passed. NAs should make sure to talk with friends and loved ones about their grief, and to do activities that allow them to emotionally and spiritually recharge.

If it seems like it would be helpful, NAs can share their grief with the person's family, highlighting the positive experiences that the NA and the resident had together in the last stage of the resident's life. The family may find comfort in knowing their loved one was cared for by somebody who saw their value and connected with them^[16].

Query 4

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Key Takeaways

- Pain has a heavy impact on a person's overall quality of life. Towards the end of life, pain presents an obstacle to a resident's comfort, sleep, and wellbeing. Check in with residents about their pain levels, and communicate with the nurse about the frequency and quality of the residents' pain. Provide a comforting presence and atmosphere whenever possible.
- Sleep is essential for comfort at the end of life. Make sure that residents have good opportunities for rest by providing a comfortable atmosphere, helping them with sleep conducive activities and nutrition, and scheduling care tasks around a resident's uninterrupted sleep.
- End-of-life care is an important part of helping somebody die comfortably and with dignity. End-of-life care always involves a holistic approach, and tends to a person's physical need for comfort, as well as their psychological, social, and spiritual needs as they approach death.
- The stages of grief are denial, anger, bargaining, depression, and acceptance. A person may not go through all of these stages in the grieving process, and will probably not go through them in a linear order. Understanding each stage of grief can help the care team work with a terminally ill person and their family to provide dignity and autonomy throughout their dying process.

Comprehension Questions

1) When is a person comfortable? Select the best answer.

- a. When they are having their psychosocial needs fulfilled.
- b. When they are resting well, and free from pain.

- c. When they are free from pain and emotional distress, and the temperature is between 71- and 81-degrees Fahrenheit
- d. When they are free from pain and emotional distress, have the full scope of their needs met, and have agency over their sensory environment
- 2) If a resident tells you that they are in pain, how should you respond?
- a. Immediately tell the nurse that the resident needs pain medication
- b. Ask questions about the pain to learn more about what might be causing it and how it can be treated; report the pain and what you learn about it to the nurse
- c. Ask follow-up questions to make sure that the person is really in pain
- d. Record that the person is in pain and ask if they need anything else
- 3) What are some details NAs should include in their observations about a person's pain? Select all that apply.
- a. Non-verbal behaviors like crying, gasping, or tightening facial muscles
- b. What you think should be done about the pain
- c. The location, duration, and intensity of the pain
- d. Whether you think the pain is as bad as claimed
- e. Any positions or activities that might have caused or worsened the pain
- 4) Beginning with hygiene care, what are some things NAs can do to help residents wind down in the evening and have a comfortable and restful sleep? Try to write about a paragraph with 5 – 6 details of the care provided.
- 5) Respond to the following sentences with T (true) or F (false).
- ___ Doctors can exactly predict when a person will die once they are diagnosed with a terminal illness.
- ___ A person's attitude towards death will be influenced by their cultural, religious, and personal background. Nobody relates to death in exactly the same way.
- ___ People tend to have a more comfortable and dignified dying process when somebody else makes their practical decisions for them. This is to give them privacy and the space to introspect about their death.
- ___ Palliative care and hospice care are the same thing.
- ___ The number of people who use hospice services is increasing.
- 6) Please list the five stages of grief, and write a short description of each.
- 7) You are providing care for a dying resident named Ms. Haley. Even though she had been told she had weeks to live, Ms. Haley had been in good spirits until this morning. After breakfast, she yelled at you and blamed you for her illness. Rather than react, you try to comfort her, because you know that Ms. Haley is undergoing the grief process. Which stage of grief is Ms. Haley displaying?
- a. Denial
- b. Bargaining
- c. Anger
- d. Depression
- 8) As a person dies, their sensory systems will diminish and fail. Please describe two ways that NAs should communicate with a resident at this stage of their dying process.

9) Respond to the following sentences with T (true) or F (false).

- ___ A “DNR” order means that a dying patient does not want a defibrillator used; staff should use CPR instead.
- ___ Residents, or their power of attorney on their behalf, have the right to refuse care.
- ___ Residents who are dying are often the most shielded from abuse and negligence because they often have visitors.
- ___ As a person is about to die, their measurable body temperature falls and they become warm to the touch.
- ___ A person has a right to dignity and respect even after death. This matters for how their body is treated and handled.

10) What are some things NAs should do when providing postmortem care? Select all that apply.

- a. Position the body in alignment and place any incontinence pads under the buttocks and had before bathing the body.
- b. Allow the body to remain in the clothes the person was wearing when they died.
- c. Immediately tell the nurse so any religious rites can be performed.
- d. Have the family come in right away so they know what has happened.

11) Consider your own relationship to death and grief. How has your life experience shaped your relationship to death? How do you hope you will be able to relate to your own death when it eventually arrives? What is your experience or understanding of grief? What do you think it means to grief healthily, either for your own death or that of a loved one?

12) You have been able to form a friendship with a dying resident named Mr. Emma. Recently, Mr. Emma has started saying “I’m so scared of dying” every afternoon. What stage(s) of grief do you think Mr. Emma is experiencing? How could you converse with Mr. Emma in a way that provides comfort and allows him the space to work through some of his feelings? What questions might you use to start this conversation?

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Module 14 – Preparing for Clinicals

Learning Objectives

- Demonstrate understanding of Illinois Central College's clinical practicum policies
- Demonstrate understanding of professionalism in the clinical environment

Illinois Central College (ICC) Clinical Policies

In this section we'll be discussing the policies for nursing assistant clinical practicum listed in the [Illinois Central College CNA Student Handbook](#). The policies are specific to ICC and may not all apply universally across different programs, though the basic insights will be valuable to any nursing assistant student.

The purpose of clinicals

The purpose of the clinical is to prepare someone to transition from nursing assistant training to practice by practicing the skill in a real healthcare setting. Clinicals are graded, and a passing score must be achieved to graduate from the course.

While the Illinois Department of Public Health requires 40 hours of clinical training, ICC's program requires a minimum of 48 hours so trainees have enough time to become confident and reliable in caregiving.

Remember that NAs do valuable and needed work. By providing excellent care, nursing assistants improve someone's quality of life and care outcomes. They also help people feel dignified and respected in times of vulnerability.

Expectations

Attendance

- Attendance is mandatory and required by the state of Illinois. Even a single absence could affect your grade in a way that results in an F in the course.
- Absence results in a "Zero" score for the day. Every day of clinicals trainees are assigned a score based on how effectively they applied the Big Three; if you are not present, you cannot demonstrate the skills and growth required to succeed, so absences are marked as "zero."
- Lateness results in a "tardy," and two tardies may count for a full day's absence.
- If you are going to be late or absent due to unforeseen extenuating circumstances, contact your clinicals instructor right away.

Dress standard

- NAs should aim to dress in a way that allows for freedom of movement, is aesthetically neutral, free of adornment, and functional. Professional appearance will be an important dimension of clinicals evaluation.
- When trainees are wearing the clinicals uniform their appearance represents their institution. The NA clinicals uniform should be neat, clean, fit appropriately, and be the required teal blue color. There may be a patch for the uniform indicating which program you are from.
 - Pants should be ankle-length; they should not drag on the floor, and should not be cropped. There are no undergarments visible in a well-fitting uniform.
- Always wear your clip-on photo identification.
- Shoes must be either leather or vinyl; no canvas shoes are permitted, as they are more difficult to clean. Shoes must be worn with neutral white socks.
- Uniforms include a watch with a second hand to keep exact time. No smart watches permitted, since these are an extension of your phone.

- A pen and pocket notebook are required. Take notes on how you can develop your skills, and apply them during your next shift.
- Removing all jewelry is best, but there is some limited jewelry allowed. You may wear a wedding band if married, a single earring per lobe (no hoops, loops, or anything likely to catch on something).
- No visible body or facial piercings. Visible facial and body piercings should be removed, not just covered.
- No visible tattoos. Cover them with a bandage if they cannot be covered by long-sleeved clothing.
- Hair should be a natural color and away from the face and collar whether short, in a bun, braid, ponytail, or something similar. Hair carries bacteria and can get in the way of visibility and care tasks. Keep beards neat and trimmed.
- Use minimal makeup in neutral colors, if any makeup at all.
- Nails must be short, trimmed, and well-filed. Long nails can get in the way of some tasks requiring fine motor skills. They also allow for bacteria to build up under the nail, as do acrylic nails, gel nails, and tips. Nails must be well-groomed, natural, and free of nail polish.
- No cologne or perfume. Some people are sensitive to fragrances; not only could it create an unpleasant sensory environment for someone, it may even exacerbate breathing problems depending on the person and their space.
- Manage breath from smoking cigarettes, breath odors, and body odors using deodorant, mouthwash, and breath fresheners. Do not chew gum while at clinicals.
- **No smoking during clinicals.** Do not smoke in the uniform worn at clinicals either. If you think you'll need nicotine in order to stay focused, alert, and positive during clinicals, consider using a nicotine patch or similar product.

CPR Requirement

- "CPR for the Healthcare Provider" certification must be obtained before starting clinicals. You cannot begin clinical training if you have not completed this course.
- Not completing CPR training prior to clinicals will result in dismissal from the program.

Daily Preparedness

- Arrive to the area on time, meaning 5 – 10 minutes before the scheduled start time.
- Arrive in uniform, do not wait until you get there to change.
- Follow all facility policies, procedures, and rules for clinical students. If you are unsure about something, ask!
- Only perform tasks that you have practiced and have been trained on. If the facility asks you to perform a task that you have not practiced, you must tell them so they can provide the proper training, or assign a different task. Performing tasks you have not been effectively trained on is outside your scope of practice, and is both illegal and unethical.
- Report observations and care given during clinicals to the clinical instructor. Always observe the residents closely; if you need to take notes to remember important details, use your pocket notebook and do not include the resident's identifying information. Make sure you discuss your observations and care given with the clinical instructor before writing anything in the person's chart.
- Report off to clinical personnel before leaving for the day at the end of your shift. In other words, make sure to tell the facility that you are leaving, and pass along all relevant observations and care notes.

Transportation

- Students are responsible for getting to and from clinical facilities on time, and for following any facility rules about parking.
- Drive the route to your clinical site in advance, whether carpooling, using public transportation, or taking your own or another's vehicle; see exactly how long it takes, and whether the route will have traffic at the times that you'll be going to clinicals.
- Plan carefully, and plan in advance.

Employment

- Clinicals should be students' primary focus. Make sure to arrive at clinicals refreshed and ready to be present and attentive. Do not work a shift at another job right before clinicals.
- Never wear the ICC uniform anywhere other than clinicals, including another place of employment.
- Students are held personally responsible and liable for their actions at clinicals; if you mess up, it's on you. Be attentive, and remember your skills.

Evaluation

- All clinicals trainees will receive a daily score based on their application of the Big Three during care. A “1” will involve errors made and a lack of consideration for Resident Rights, Safety, and Infection Control; a “4” indicates excellent care given, thoughtful and consistent application of the Big Three, and expectations exceeded. A “3” is a great score for the day – it means you effectively applied the Big Three across patient care. A “0” means you were absent, or were so careless during work that you may as well have been.
- Scores are cumulative; at the end of clinicals, the total score will determine passing. Students should show up every day ready to be present, fully engaged, and constantly thinking critically about how to give the best possible care.
- Failing clinicals means failing the CNA course, regardless of score during the classroom portion. Students who fail clinicals can still be admitted to the program again.
- When thinking about performing care to get the best grade possible, remember to apply the Big Three using critical thinking and efficiency.
 - Critical thinking here means to always be thinking about the Big Three in the back of your mind whenever planning or giving someone’s care. “Am I respecting the full scope of this person’s right to care? Am I practicing good infection control measures? Is there anything in this environment that presents a risk to the resident, myself, or another staff member?”
 - Efficient here means planning out tasks so that you already have everything you need and know exactly what you’re going to do before you do it. Efficient does not mean rushed, it means that you’ve managed your time well.
- Honesty, integrity, and remaining within scope of responsibility are the basis of evaluation. Always be accountable, direct, candid, and kind in your interactions with your instructor and team members.
- Accountability for behavior and time management involves showing respect for others’ humanity by treating them as equals and collaborators, respecting the chain of command, and asking for help when you need it. Accountability and time management go hand in hand – everybody’s time is valuable, and being respectful of other people’s time involves being punctual and managing your daily work effectively.
- Approach everything with a growth mindset. Work on doing all care tasks carefully and thoughtfully, and think about every day with an attitude of constant improvement.

Instructors

- Your instructors are there to support you. You can talk to them about difficulties you have on the job.
- Instructors will provide feedback one-on-ones at least every three days, or at their discretion.
- Instructors will not step in unless you are about to violate the Big Three. They are there to evaluate you and to help you learn, but not to stop you from making mistakes.
- Instructors will grade fairly. The most important thing for you to do is to focus on constant improvement.

Professionalism

Being professional in a clinical environment means always practicing accountability, conscientiousness, and excellence in all interactions.

- Accountability means reflecting on your actions honestly and taking others into consideration. To be accountable, we have to own up to what we don’t know and any mistakes we might make. This is to make it so that all residents receive care in line with their right to dignity, and so that everyone involved can learn and grow. Being a nursing an understanding that effective teamwork, honesty, and integrity are necessary to providing good care.
- Punctuality means always being on time. “On time,” in this case, means ready for pre-shift discussion between 5 and 10 minutes before the scheduled start time. Being punctual is necessary because clinicals are valuable time spent learning. You don’t want to miss any information. It also means that the team will be short-staffed; when you are late for clinicals, it shows the instructor that you need to work on time management in order to be a good NA.
- Always be honest with yourself, with your team, and with your instructor. Be honest with yourself about what you don’t know, and the areas you need to improve. Be honest with your team about when you need help, and when you see an opportunity to provide each other with constructive feedback; you can also be honest about your struggles. You’re all in this together!
 - Be honest with your instructor about when you need help, and about what you need to succeed. Clinicals are difficult, but everyone is there to support you.
- Being a good team member means communicating with your colleagues clearly and compassionately. The nursing team is able to provide the best care when everybody trusts each other and holds one another accountable in a growth-oriented way.

- Conscientiousness means carefully reflecting in a self-aware way about your presentation and the quality of the care you provide. It also means thinking ahead.
 - Clinicals students should be conscientious about professional appearance.
 - Always be on time! Don't let yourself or your teammates down.
 - No smoking – smoking odors can create unpleasant sensory environments for residents.
 - No fragrances such as cologne or perfume. Even strongly scented soaps can create a negative sensory experience for someone who is sensitive to fragrances.
- Clinicals students should aim for excellence and kindness in all of their care and communications with residents and team members.
 - Show the utmost respect for the people you care for, for your team members, and for yourself. Always respect resident rights, and think carefully about how your actions, responses, and communication styles impact other people.
 - Show kindness in all of your interactions. Residents need kindness because it makes them feel cared for and respected, while team members need kindness because everybody is doing a difficult and high-stakes job. Similarly, show yourself kindness; you will be doing important work to improve the lives of vulnerable people. By recognizing your own human worth, you can extend that sense of human worth to others.
 - Maintaining a sense of enthusiasm will help create a positive learning environment for yourself and your fellow students. A sense of enthusiasm also translates into better care, and high-quality attention to the psychosocial needs of a resident. Enthusiasm helps you be present in your tasks, even when they feel mundane.
 - Show sincerity in your interactions, especially with residents. Try to be genuinely interested in their lives and who they are as people. The more sincere you are in your interactions the more residents will feel valued as individuals.
 - Empathy involves putting yourself in another's position. Whenever reflecting on your actions, try to consider them from the perspective of another. Practicing empathy means being nonjudgmental – it is only by being nonjudgmental that you can cultivate a sense of understanding for the people you care for and work with.
 - Lead with integrity. Integrity means that you practice the same high standards for ethical behavior and attentive care just because that is the right thing to do, even when nobody is watching.

Clinicals and the Big Three

Conscientiously and critically applying the Big Three at all times is an important aspect of professionalism as a nursing assistant, and will be the basis of your instructor's evaluation of you.



SMART CHOICE



- Safety is an important concern at all times. It refers to the mode of thought that help notice risky situations before they become an accident or emergency; it also refers to the calm and orderly execution of responding to an accident or emergency.
 - Never run in a facility. Always remain calm and if you need to get somewhere fast, walk at a brisk pace.
 - OSHA workplace standards exist to help staff members keep themselves and one another safe. Always follow safety guidelines, and take any trainings the facility offers on safety concerns like body mechanics and preventing work place violence.
 - Watch your back! Back injuries are a big problem among healthcare workers, and even a single bad back injury could limit your career. Knowing how to move your body in healthy ways that protect your musculoskeletal system is an important dimension of continuing to provide high-quality care.

- o If you are out of work with a back injury then your team will be short at least one member. Be a good team member and protect your back.
- Watch out for potential workplace violence. If you see something that you think could possibly lead to a violent situation, tell the nurse right away. Workplace violence could come from residents and patients, their visitors and families, and other staff members.
- Incident reporting is essential for facility risk management. Always report incidents like accidents, workplace violence, or errors in care.

A resident reports being uncomfortable in bed. She is in the supine position. What would you do, and why? Make sure to give as detailed of a description as possible. Write for 5 minutes, then discuss your answer with a friend or classmate.

- Infection Control

- Wash your hands! Wash them often, and wash them thoroughly. Always wash your hands before patient contact, before any tasks that require asepsis (such as peri-care or changing a dressing), after potential body fluid exposure, after contact with the patient, and after contact with any objects in the patient's unit or surroundings.
 - Hand hygiene is the most important factor in infection control!
- Break the chain of infection by practicing great hand hygiene, wearing proper PPE, and closely observing patients for early signs of infection.
- Wear appropriate PPE; if you think it's possible that a piece of PPE will help keep you from contracting and spreading infection, then you should just wear it. Gloves should be worn almost all of the time. Helpful pieces of PPE include face masks and respirators, gloves, gowns, and face shields.

You are assigned to a person being treated for MRSA in a wound. The nurse does not realize you have not taken care of this resident and has given you little information on what precautions to take. What should you do? Write for 5 minutes, then discuss with a friend or classmate.

- Clean patient-care devices, such as a bedpan or incentive spirometer, after every use. Clean them after every use even if the patient is the only one using that piece of equipment.
 - Low-level disinfection for all surfaces and equipment after contact, such as bed rails and the side table, as well as equipment like blood pressure cuffs and lifting devices.

You are completing beginning tasks to assist in a Hoyer transfer. While positioning the lift pad, you notice it is damp and smells of urine. At the same time, the nurse comes by, telling you to hurry because the resident has a Dr. Appt and needs transferred to the W/C immediately. What should you do? Write for 5 minutes, then discuss with a friend or classmate.

- Residents' Rights

- Do not abuse or neglect residents. Abuse occurs whenever someone harms a resident physically, psychologically, emotionally, or financially. Examples include hitting, pushing, calling someone names, speaking in a harsh tone of voice, speaking in a way that lacks respect and care, and making them feel bad or less-than because of their condition. Neglect is when someone is harmed because they were ignored by someone who is meant to care for them. An example of neglect is when a resident wets themselves because their call light went unanswered.
- Always show kindness in your interactions with residents. If a resident behaves badly toward you, never retaliate and always maintain self-control.
- Be attentive to the needs of the people in your care.
 - HIPPA exists to protect peoples' rights to privacy. Privacy is an important element of patient care.
 - Do not gossip about the lives and experiences of patient and residents. It is unethical, mean-spirited, and produces a hostile living condition. Similarly, do not gossip about your colleagues, even the ones who you don't like or find annoying.
 - o Necessary discussions of residents, the nursing unit, and staff members and peers should be handled discretely and behind a closed door.
 - o The difference between gossip and a necessary conversation is that the latter is important for

providing good care as a team, while the former is done for entertainment. Discussions of resident care and the happenings on the unit must be held in private, outside of anybody else's earshot.

- Don't discuss medical matters, conditions, or give advice to residents and their families. This is irresponsible, and lies far outside the scope of NA responsibilities. Refer to the doctor.
- Do not discuss a patient or a patient's condition with your friends. It is not appropriate under any circumstances; you also never know what someone's relation is. The person whose conditions you want to discuss with your friend may be their loved one.
- No photos ever. Keep your cell phone turned off and out of site for the duration of your shift.
- Do not take anything with patient info away from the medical site. This is an express violation of HIPPA.

A co-worker does not show up for work, causing staff to adjust their assignments. You stop at the nurse's station to get an updated resident list. While at the station, you hear staff, talking about the aide who did not come in. You overhear, the aide may get fired as it is her 3rd call off this month. As you are getting Mrs. Smith up and prepared for breakfast, Mrs. Smith asks if you are short staffed today. What do you do to protect everyone's right to adequate care and to privacy? Write for 5 minutes, then discuss it with a friend or a classmate.

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GLOSSARY

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